STATE PLAN UNDER TITLE XIX

OF THE SOCIAL SECURITY ACT

MEDICAL ASSISTANCE PROGRAM

HCFA-AT-80-38 (BPP)
MAY 22, 1980

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA (WA-CA-82-3)

Type of Waiver

- ☐ 1915(b)(1) - **Case Management System**
- ☐ 1915(b)(2) - **Locality as a Central Broker**
- ☐ 1915(b)(3) - **Sharing of Cost Savings (through:)**
  - **Additional Services**
  - ***Elimination of Copayments***
- ☐ 1915(b)(4) - **Restriction of Freedom of Choice**
- 1915(c) - ☐ **Home and Community-Based Services Waiver (non-model format).**
  - ☐ **Home and Community-Based Services Waiver (model format).**
- ☐ **1916(a)(3) and/or (b)(3) - Nominality of Copayments**
- ☒ Other - Section 1115 (Medicaid) and Section 222 (Medicare)

Title of Waiver and Brief Description: ON-LOK

A comprehensive care organization for dependent adults, formerly a Medicare demonstration project covering Medicare and Medi-Cal. Capitation reimbursement for comprehensive long term care; containing costs and sharing risks.

Approval Date: May 20, 1983 **Renewal Date(s):** ~~October 31, 1984~~ January 31, 1986

Effective Date: November 1, 1983

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability: 1902(a)(10); 42 CFR 440.240(b); State Plan Sec. 3.1(a)

Statewideness: 1902(a)(1); 42 CFR 431.50; State Plan Sec. 1.3-page 8

Freedom of Choice: 1902(a)(23); 42 CFR 431.51; State Plan Sec. 4.10-page 41

Services: Includes case management; physician services; SNF; physical, occupational and speech therapies; optometry; audiology; dental; pharmacy; lab and x-ray; adult day health care; housing assistance; in-home supportive services; respite care; transportation; meal services; protective services; and special communications.

Eligibility:

For long term care certified elderly frail Medi-Cal recipients residing in San Francisco.

Reimbursement Provisions (if different from approved State Plan Methodology):

1903(m)
A risk-sharing capitated rate of reimbursement, including cost sharing and co-payment, for an organization which is not a federally qualified HMO.

Peter Rank
Signature of State Medicaid Director

Peter Rank

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA (WA-CA-82-4)

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☒ 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - ☐ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: Hospital Contracting (Selective Provider Contracting Program)

This waiver was granted to California to allow selective contracting with hospitals to provide services to Medi-Cal beneficiaries.

Approval Date: September 21, 1982 **Renewal Date(s:)** September 30, ~~1984~~

Effective Date: October 1, 1982

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Single State Agency:	1902(a)(5); 42 CFR 431.10; State Plan Sec. 1.1-pg. 2
Statewideness:	1902(a)(1); 42 CFR 431.50; State Plan Sec. 1.3-Pg. 8
Freedom of Choice:	1902(a)(23); 42 CFR 431.51; State Plan Sec. 4.10-pg. 41
Utilization Control:	1902(a)(30); parts of State Plan Sec. 4.14-pg. 46

Eligibility: All categorically ane medically needy beneficiaries.

Reimbursement Provisions (if different from approved State Plan Methodology):

1902(a)(13)(A): 42 CFR 447, Subpart C; State Plan Sec. 4.19

Reimbursement is accomplished through at risk fixed rate per diem contracting.

Signature of State Medicaid Director

Peter Rank

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA (WA-CA-82-6)

Type of Waiver

- [X] 1915(b)(1) - Case Management System
- [ ] 1915(b)(2) - Locality as a Central Broker
- [ ] 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- [ ] 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - [ ] Home and Community-Based Services Waiver (non-model format).
  - [ ] Home and Community-Based Services Waiver (model format).
- [ ] 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: Primary Care Case Management Program (PCCM)

his waiver allows the State to contract with selected providers for primary are case management.

Approval Date: December 20, 1982 **Renewal Date(s:)** December 31, 1985

Effective Date: January 1, 1984 (originally December 20, 1982)

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Statewideness: 1902(a)(1); 42 CFR 431.50; State Plan Sec. 1.3-pg. 8

Freedom of Choice: 1902(a)(23); 42 CFR 431.51; State Plan Sec. 4.10-pg. 41

Services: Mandatory case manager services: physician, lab and x-ray. Optional case manager services: vision care, pharmacy, dialysis, occupational, speech and physical therapies, audiology, psychology, transportation. In addition, case manager must approve all other services.

Eligibility:

Cash grant Medi-Cal beneficiaries residing in selected areas.

Reimbursement Provisions (if different from approved State Plan Methodology):

Case managers are reimbursed under capitated at risk contracts (98% of fee-for-service) for services they provide; other providers are reimbursed under State Plan methodologies.

Signature of State Medicaid Director

Peter Rank

WAIVERS OF STATE PLAN PROVISIONS

State: *CALIFORNIA #0141 (MSSP)*

Type of Waiver *(Replaces #0004 MSSP Waiver) (7/1/83-6/30/87)*

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - ☒ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: *Multipurpose Senior Services Program (MSSP) #2*

Provides for HCBS to frail, elderly Medi-Cal recipients at ICF and SNF LOC, to prevent or delay institutionalization.

Approval Date: *June 24, 1987* *Renewal Date: June 30, 1990*

Effective Date: *July 1, 1987*

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability Waiver: 1902(a)(10)(B)

Statewideness Waiver: 1902(a)(1)

Services: Case management, adult social day care, housing assistance, in-home supportive services, respite care, transportation, meal services including home-delivered meals and congregate meals, protective services and special communications.

Eligibles: Categorically and medically needy, aged and disabled

LOC: ICF and SNF

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA (WA-CA-83-3) - *#0004*

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- ☒ 1915(c) - ☒ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: Multipurpose Senior Services Project (MSSP). This waiver allows provision of H&CBS for frail elderly Medi-Cal recipients to prevent or delay long term care institutionalization. MSSP was formerly a Sec. 1115 demonstration project.

Approval Date: June 17, 1983 **Renewal Date(s:)** June 30, 1986?

Effective Date: July 1, 1983 *Expired June 30, 1987 (Replaced by #0141)*

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability: 1902(a)(10); 42 CFR 440.240(b); State Plan Sec. 3.1(a)

Statewideness: 1902(a)(1); 42 CFR 431.50; State Plan Sec. 1.3-pg. 3

Services: Case management, adult social day care, housing assistance, in-home supportive services, respite care, transportation, meal services, protective services and special communications.

Eligibility: Functionally impaired categorically and medically needy who do not have a share of cost, aged 65 and over, who meet the level of care requirements for SNF or ICF.

Reimbursement Provisions (if different from approved State Plan Methodology):

Reimbursement methodology; by fixed rate contracts with local agencies to serve as MSSP sites to provide case management services. Waiver services are reimbursed through annually negotiated rate contracts with providers/ vendors.

Peter Rank

Signature of State Medicaid Director

Peter Rank

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA (WA-CA-83-2)

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- ☒ 1915(c) - ☒ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: In Home Medical Care (IHMC).

This waiver allows provision of in-home medical and support services to recipients who are at the acute level of care and stable, and without IHMC services would be in an acute care facility.

Approval Date: October 18, 1983 **Renewal Date(s:)** June 30, 1986

Effective Date: July 1, 1983 *Expired June 30, 1987 (Replaced by #0164)*

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability: 1902(a)(10); 42 CFR 440.240(b); State Plan Sec. 3.1 (a).

Services: Case management, home health aide services, respite care services, minor physical adaptations to the home, utility coverage and 24-hour nursing care.

Eligibility: Categorically and medically needy Medi-Cal beneficiaries who meet the level of care requirements.

Reimbursement Provisions (if different from approved State Plan Methodology):

Methodology and rate of reimbursement is accomplished through written agreement between the provider of services and DHS on a case by case basis.

Signature of State Medicaid Director

Peter Rank

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA (WA-CA-83-2)

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- ☒ 1915(c) - ☒ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: In Home Medical Care (IHMC).

This waiver allows provision of in-home medical and support services to recipients who require a SNF or ICF level of care but, as such care has not been made available, would otherwise be in an acute facility.

Approval Date: October 18, 1983 **Renewal Date(s:)** June 30, 1986/7

Effective Date: July 1, 1983

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability: 1902(a)(10); 42 CFR 440.240(b); State Plan Sec. 3.1 (a).

Services: Case management, home health aide services, respite care services, minor physical adaptations to the home, utility coverage and 24-hour nursing care.

Eligibility: Categorically and medically needy Medi-Cal beneficiaries who meet the level of care requirements.

Reimbursement Provisions (if different from approved State Plan Methodology):

Methodology and rate of reimbursement is accomplished through written agreement between the provider of services and DHS on a case by case basis.

Signature of State Medicaid Director

Peter Rank

WAIVERS OF STATE PLAN PROVISIONS

State: *CALIFORNIA #0164 (IHMC)*

Type of Waiver

(Replaces #0005 IHMC Waiver)
(7/1/83-6/30/87)

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - ☑ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: *In Home Medical Care (IHMC) #2*

Provides HCBS to physically disabled Medi-Cal recipients who would otherwise require a hospital level of care, and who are directly discharged from a hospital into the waiver program.

Approval Date: *June 12, 1987* *Renewal Date: June 30, 1987*

Effective Date: *July 1, 1987*

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability Waiver: 1902(a)(10)(B)

Services: Case management, home health aide, skilled nursing services, minor physical adaptions to the home, and utility coverage.

Eligibility: Categorically and medically needy, physically disabled

LOC: acute hospital

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA

Type of Waiver

- ☐ **1915(b)(1) - Case Management System**
- ☐ **1915(b)(2) - Locality as a Central Broker**
- ☐ **1915(b)(3) - Sharing of Cost Savings (through:)**
  - **Additional Services**
  - **Elimination of Copayments**
- ☐ **1915(b)(4) - Restriction of Freedom of Choice**
- **1915(c) -** ☐ **Home and Community-Based Services Waiver (non-model format).**
  - ☐ **Home and Community-Based Services Waiver (model format).**
- ☐ **1916(a)(3) and/or (b)(3) - Nominality of Copayments**

** ☒ Other - Section 1115 Demonstration Project.

Title of Waiver and Brief Description: Santa Barbara Health Initiative (SBHI).

Waiver allows Santa Barbara to operate a county-wide capitated brokered competitive Health Initiative Program to provide health care services to eligible Medi-Cal beneficiaries.

Approval Date: September 30, 1981 Termination Date: September 1, 1986

Operational Date: September 1, 1983

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Utilization Control:	1902(a)(30) and (33)(A); 42 CFR 456.2 and .3; State Plan Sec. 4.14-pg. 46
Contracts:	1902(a)(4); 42 CFR 431.12; State Plan Sec. 4.23-pg. 71
Statewideness:	1902(a)(1); 42 CFR 431.50; State Plan Sec. 1.3-pg. 8
Freedom of Choice:	1902(a)(23); 42 CFR 431.51; State Plan Sec. 4.10-pg. 41
Redeterminations:	1902(a)(10); 42 CFR 435.916(c)(1) and (2); State Plan Sec. 2.1-pg. 10

The plan covers all categories of Medi-Cal beneficiaries resident in Santa Barbara County, and all Medi-Cal services covered Statewide with the exception of dental services and CHDP.

Reimbursement Provisions (if different from approved State Plan Methodology):

Reimbursement is accomplished through at-risk capitation contract with the SBHI.

_____

Signature of State Medicaid Director

** 1115 demonstration incorporated for reference, although not required by HCFA Pub. 45-13.

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - ☐ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments
- ☒ Other - 1115 Demonstration

Title of Waiver and Brief Description: SCAN Health Plan - A Social/Health Maintenance Organization Demonstration Project
A waiver only demonstration.

Approval Date: 8/17/84 Renewal Date: ~~10/1/85~~ 3/31/86

Effective Date: 10/1/84 Termination Date: 3/31/88

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Statewideness: 1902(a)(1); 42 CFR 431.50(b); State Plan Sec. 1.3

Comparability: 1902(a)(10); 42 CFR 440.240; State Plan Sec. 3.1(a)

Reimbursement: 1902(a)(30) and 1903(i)(3); 42 CFR 447 Subparts C & D; State Plan Sec. 4.19

HMO Provisions -

- 6-month guaranteed eligibility: 1902(e)(2)(A); 42 CFR 435.212
- 75% federal: 1903(m); 42 CFR 434.26

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA (WA-CA-83-6)

Type of Waiver

- [X] 1915(b)(1) - Case Management System
- [ ] 1915(b)(2) - Locality as a Central Broker
- [ ] 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- [X] 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - [ ] Home and Community-Based Services Waiver (non-model format).
  - [ ] Home and Community-Based Services Waiver (model format).
- [ ] 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

San Mateo Organized Health System - local administration of the Medi-Cal program in San Mateo County, with OHS organized as an HIO, at risk for all services; network of capitated case managed primary care.

Approval Date: 1/14/85 Renewal Date: 7/13/87

Effective Date: 7/14/85

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Statewideness: 1902(a)(1); 42 CFR 431.50; State Plan Sec. 1.3-pg. 8
Single State Agency: 1902(a)(5); 42 CFR 431.10; State Plan Sec. 1.1 - pg. 2
Comparability: 1902(a)(10); 42 CFR 440.240(b); State Plan Sec. 3.1(a)
Freedom of Choice: 1902(a)(23); 42 CFR 431.51; State Plan Sec. 4.10 - pg. 41

Services: All Medi-Cal covered services except dental and Short-Doyle mental health.

Eligibility: Categorically needy and medically needy.

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: CALIFORNIA - (WA-CA-34-1)

Type of Waiver

- [X] 1915(b)(1) - Case Management System
- [X] 1915(b)(2) - Locality as a Central Broker
- [ ] 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- [X] 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - [ ] Home and Community-Based Services Waiver (non-model format).
  - [ ] Home and Community-Based Services Waiver (model format).
- [ ] 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description: Expanded Choice of Health Care Plans - A pilot project up to six geographic areas of the State, providing Medi-Cal recipients a choice of two or more HMOs contracting with the State in each area.

Approval Date: 2/6/85 Renewal Date: 8/5/87

Effective Date: 8/6/85

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Statewidness: 1902(a)(1); 42 CFR 431.50; State Plan Sec. 1.3-pg. 8
Single State Agency: 1902(a)(5); 42 CFR 431.10; State Plan Section 1.1-pg. 2
Comparability: 1902(a)(10); 42 CFR 440.240(b); State Plan Section 3.1(a)
Freedom of Choice: 1902(a)(23); 42 CFR 431.51; State Plan Section 4.10-pg. 41

Services: Most Medi-Cal covered services, except LTC, Short-Doyle mental health, dental and CA Childrens Services case management.

Eligibility: Categroically and medically needy except medically needy with a share of cost and medically needy LTC.

_____

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: California #WA-CA-0129 (Replaces #WA-CA-0002)

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - ☒ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

HCBS waiver for the developmentally disabled.

Approval Date: February 13, 1986 Renewal Date: September 28, 1988

Effective Date: September 29, 1985

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability: 1902(a)(10)

Services:
Homemaker, home health aide, adult day health, habilitation, nonmedical transportation, personal care,respite and Regional Center direct client support (case management)

Eligibility:
categorically and medically needy

Level of Care:
ICF/MR

_____

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: California #WA-CA-0139 (SNF LOC)

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - ☒ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

SNF LOC HCBS waiver for the chronically ill (aged and disabled)

Approval Date: 7/28/86 Renewal Date: 10/1/89

Effective Date: 10/01/86

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Waivers: Comparability
Individual cost-effectiveness

Services: Home Health Aide
Skilled Nursing
Family Therapy
Physical Adaptions to Home

Eligibility: Categorically needy
MNO's without Share of Cost

Limited to 50 individuals

LOC: SNF only

_____

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: California #WA-CA-40136 (Model)

Type of Waiver

- ☐ **1915(b)(1) - Case Management System**
- ☐ **1915(b)(2) - Locality as a Central Broker**
- ☐ **1915(b)(3) - Sharing of Cost Savings (through:)**
  - **Additional Services**
  - **Elimination of Copayments**
- ☐ **1915(b)(4) - Restriction of Freedom of Choice**
- **1915(c) -** ☒ **Home and Community-Based Services Waiver (non-model format).** *
  - ☐ **Home and Community-Based Services Waiver (model format).**
- ☐ **1916(a)(3) and/or (b)(3) - Nominality of Copayments**

*Although this is a "Model" HCBS waiver, the shortened Model format was not used.

Title of Waiver and Brief Description:

Model HCBS Waiver for the physically disabled (limited to 50 individuals at any one time.

Approval Date: 12/18/86 Renewal Date: 4/1/90

Effective Date: ~~4/1/87~~ 7/1/87

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Waivers: Comparability
Individual cost-effectiveness

Services: Skilled Nursing
Home Health Aide
Family Therapy
Physical Adaptions to Home

Eligibility: Categorically and Medically Needy who would otherwise be covered by Medi-Cal only if institutionalized.
Blind or Disabled
Deinstitutionalized from a SNF.
Limited to 50 individuals at any one time.

LOC: SNF only

Signature of State Medicaid Director

WAIVERS OF STATE PLAN PROVISIONS

State: California WA-CA-0183 (AIDS)

Type of Waiver

- ☐ 1915(b)(1) - Case Management System
- ☐ 1915(b)(2) - Locality as a Central Broker
- ☐ 1915(b)(3) - Sharing of Cost Savings (through:)
  - Additional Services
  - Elimination of Copayments
- ☐ 1915(b)(4) - Restriction of Freedom of Choice
- 1915(c) - ☒ Home and Community-Based Services Waiver (non-model format).
  - ☐ Home and Community-Based Services Waiver (model format).
- ☐ 1916(a)(3) and/or (b)(3) - Nominality of Copayments

Title of Waiver and Brief Description:

HCBS Waiver to provide services to AIDS/ARC patients at an ICF/SNF/Acute LOC who would otherwise require care in an acute hospital.

Approval Date: 11/14/88 **Expires:** 12/31/91

Effective Date: 1/01/89

Specific State Plan Provisions Waived and Corresponding Plan Section(s:)

Comparability - Section 3.1

Services: Case management/skilled nursing/attendant care/ psych-social counselling/homemaker/minor physical adaptions to the hime/ Medi-Cal supplement for infants and foster care children

Eligibility: Cat. and MNOs

_____

Signature of State Medicaid Director

LIST OF ATTACHMENTS

No.	Title of Attachments
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
	* Supplement 1 - Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
	* Supplement 2 - Definitions of Blindness and Disability (Territories only)
	* Supplement 3 - Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (States only)
	* Supplement 1 - Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
	* Supplement 2 - Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
	* Supplement 3 - Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
	* Supplement 4 - Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

No.	Title of Attachment
* Supplement 5 -	Section 1902(f) Methodologies for Treatment of Resources that Differ from those of the SSI Program
* Supplement 5a-	Methodologies for Treatment of Resources for Individuals With Incomes Up to a Percentage of the Federal Poverty Level
* Supplement 6 -	Standards for Optional State Supplementary Payments
* Supplement 7 -	Income Levels for 1902(f) States - Categorically Needy Who Are Covered under Requirements More Restrictive than SSI
* Supplement 8 -	Resource Standards for 1902(f) States - Categorically Needy
* Supplement 8a-	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
* Supplement 8b-	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act
* Supplement 9 -	Transfer of Resources
* Supplement 10-	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 11-	Cost-Effective Methods for COBRA Groups (States and Territories)
*2.6-A	Eligibility Conditions and Requirements (Territories only)
* Supplement 1 -	Income Eligibility Levels - Categorically Needy, Medically Needy, and Qualified Medicare Beneficiaries
* Supplement 2 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 3 -	Resource Levels for Optional Groups with Incomes Up to a Percentage of the Federal Poverty Level and Medically Needy
* Supplement 4 -	Consideration of Medicaid Qualifying Trusts--Undue Hardship
* Supplement 5 -	More Liberal Methods of Treating Income under Section 1902(r)(2) of the Act
* Supplement 6 -	More Liberal Methods of Treating Resources under Section 1902(r)(2) of the Act

*Forms Provided

TN No. 92-09
Supersedes TN No. 87-08
Approval Date NOV 18 1993
Effective Date JAN 01 1993
HCFA ID: 7982E

No.	Title of Attachment
*3.1-A	Amount, Duration, and Scope of Medical and Remedial Care and Services provided to the Categorically Needy
	* Supplement 1-- Case Management Services Supplement 2-- Alternative Health Care Plans for Families Covered Under Section 1925 of the Act
*3.1-B	Amount, Duration, and Scope of Services Provided Medically Needy Groups
3.1-C	Standards and Methods of Assuring High Quality Care
3.1-D	Methods of Providing Transportation
*3.1-E	Standards for the Coverage of Organ Transplant Procedures
3.1-F	Community Supported Living Arrangements Services Provided to the Developmentally Disabled
3.2-A	Coordination of Title XIX with Part B of Title XVIII
3.7-A	Medi-Cal Managed Care/Two Plan Model
3.7-B	Medi-Cal Managed Care/Geographic Managed Care Model
4.4-A	California MMIS Alternative Claims Processing Assessment System
4.11-A	Standards for Institutions
4.14-A	Single Utilization Review Methods for Intermediate Care Facilities
4.14-B	Multiple Utilization Review Methods for Intermediate Care Facilities
4.16-A	Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies and with Title V Grantees
4.17-A	Determining that an Institutional Individual Cannot Be Discharged and Returned Home
*4.18-A	Charges Imposed on Categorically Needy
*4.18-B	Medically Needy -- Premium
*4.18-C	Charges Imposed on Medically Needy and other Optional Groups

*Forms Provided

No.	Title of Attachment
*4.18-D	Premiums Imposed on Low Income Pregnant Women and Infants
*4.18-E	Premiums Imposed on Qualified Disabled and Working Individuals
4.19-A	Methods and Standards for Establishing Payment Rates – Inpatient Hospital Care
4.19-B	Methods and Standards for Establishing Payment Rates – Other Types of Care
	• Supplement 1 – Methods and Standards for Establishing Payment Rates for Title XVIII Deductible/Coinsurance
4.19-C	Payments for Reserved Beds
4.19-D	Methods and Standards for Establishing Payment Rates – Skilled Nursing and Intermediate Care Facility Services
4.19-E	Timely-Claim Payment – Definition of Claim
4.20-A	Conditions for Direct Payment for Physicians' and Dentists' Services
4.22-A	Requirements for Third Party Liability—Identifying Liable Resources
*4-22-B	Requirements for Third Party Liability—Payment of Claims
*4.22-C	Cost –Effective Methods for Employer-Based Group Health Plans
*4.32-A	Income and Eligibility Verification System Procedures: Requests to Other State Agencies
*4.33-A	Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals
4.34-A	Requirements for Advance Directives Under State Plans for Medical Assistance
4.35-A	Criteria for the Application of Specified Remedies for SNFs
4.35-B	Alternative Remedies to Specified Remedies for SNFs
5.3-A	Training Programs; Subprofessional and Volunteer Programs
7.2-A	Methods of Administration – Civil Rights (Title VI)
7.2-B	Methods of Administration -- Section 504 Rehabilitation Act

*Forms Provided

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: California

TABLE OF CONTENTS

SECTION — PAGE NUMBERS

SECTION PAGE NUMBERS

SECTION PAGE NUMBERS

SECTION PAGE NUMBERS

TN No. 87-03 Approval Date OCT 2 6 1987 Effective Date JUL 0 1 1987
Supersedes TN No. ____
HCFA ID: 1002P/0010P

SECTION — PAGE NUMBERS

TN No. 92-09
Supersedes TN No. 87-08
Approval Date NOV 18 1993
Effective Date JAN 01 1993
HCFA ID: 7982E JAN 01 1993

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: CALIFORNIA

Citation

42 CFR
430.10

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the

Department of Health Services
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

Citation
42 CFR 431.10
AT-79-29

1.1 Designation and Authority

(a) The Department of Health Services is the single State agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation
Sec. 1902(a)
of the Act

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The State agency so designated is

_____

_____.

This agency has a separate plan covering that portion of the State plan under title XIX for which it is responsible.

☒ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
Intergovernmental Cooporation Act of 1968	1.1(c)	Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☐ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

☒ Not applicable. No waivers have ever been granted.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 431.10 AT-79-29	1.1(d)	☐ The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this plan. ☒ Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

Revision: BCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 431.10 AT-79-29	1.1(e)	All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.
	(f)	All other requirements of 42 CFR 431.10 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation
42 CFR 431.11
AT-79-29

1.2 Organization for Administration

(a) ATTACHMENT 1.2-A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the State agency, the Medical Care Standards Division has been designated as the medical assistance unit. ATTACHMENT 1.2-B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

☐ Not applicable. Only staff of the agency named in paragraph 1.1(a) make such determinations.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation	
42 CFR 431.50(b) AT-79-29	1.3 Statewide Operation The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50. ☒ The plan is State administered. ☐ The plan is administered by the political subdivisions of the State and is mandatory on them.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: California

Citation 42 CFR 431.12(b) AT-78-90	1.4		State Medical Care Advisory Committee There is an advisory committee to the Medicaid agency director on health and medical care Services established in accordance with and Meeting all the requirements of 42 CFR 431.12.
42 CFR 438.104		X	The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

TN # 03-037 Effective Date AUG
Supersedes TN # Pg. 9 of HCFA-AT-80-33 May 22, 1980 Approval Date JAN 2 3 2004

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: California

Citation

1.5 Pediatric Immunization Program

1928 of the Act

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928(b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915(b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: California

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

___ State Medicaid Agency

___ State Public Health Agency

__X__ State Department of Health Services

SECTION — PAGE NUMBERS

TN No. 87-03
Supersedes
TN No. ____

Approval Date OCT 26 1987

Effective Date JUL 01 1987

HCFA ID: 10225/0010P

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State: CALIFORNIA

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation
42 CFR
435.10 and
Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM- (MB)

State/Territory: California

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after The end of the month which the individual is first Determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.
1902(a)(47) and	X	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

TN # 03-037
Supersedes TN # 93-015

Effective Date AUG 1 [illegible]
Approval Date JAN 2 3 [illegible]

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State: California

Citation
42 CFR 435.530(b)
42 CFR 435.531
AT-78-90
AT-79-29

2.4 Blindness

All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State: California

Citation	2.5 Disability
42 CFR 435.121, 435.540(b) 435.541	All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: CALIFORNIA

Citation(s)

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Revision: HCFA-PM-86-20 (BERC) OMB-No. 0938-0193
SEPTEMBER 1986

State/Territory: CALIFORNIA

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

SECTION PAGE NUMBERS

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: CALIFORNIA

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided to the extent that nurse-midwives are authorized to practice under State law or regulation. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

/_/ Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/X (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902(a)(10)(F)(VII)

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: CALIFORNIA

Citation			3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)
		(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.
1902(a)(7) of the Act		(vii)	Inpatient services that are being furnished to infants and children described in section 1902(l)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	____	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.
1902(a)(52) and 1925 of the Act		(ix)	Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.
1905(a)(23) and 1929	____	(x)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA (BERC) OMB No.: 0938-0193

State/Territory: California

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation		
42 CFR 440.130(c) Section 1905(a) of the Act USC Section 1396(d)	[x] (xi)	**"Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law to:** **(1) Prevent disease, disability and other health conditions or their progression;** **(2) Prolong life; and** **(3) Promote physical and mental health and efficiency.**

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy and specifies all limitations on the amount, duration and scope of those services.

State of California
PACE State Plan Amendment Pre-Print

Citation	3.1(a)(1)	Amount, Duration and Scope of Services: Categorically Needy (continued)
1905(a)(26) and 1934	(xii) X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-A ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: CALIFORNIA

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR Part 440, Subpart B (a)(2) Medically needy.

/X/ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act
440.220

(i) If services in an institution for mental diseases or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1)through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.

/_/ Not applicable with respect to nurse-midwife services under section 1902(a)(17). Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: CALIFORNIA

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

/X/ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.

/ / Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160 Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act

/X/ (vii) Services in an institution for mental diseases for individuals over age 65..

440.160

/X/ (viii) Services in an intermediate care facility for the mentally retarded.

1920(a)(10)(C)

/X/ (ix) Inpatient psychiatric services for individuals under 21.

TN No. 92-09
Supersedes TN No. 88-08

Approval Date NOV 18 1993

Effective Date JAN 01 1993

HCFA ID: 7982E

Revision: HCFA-PM-93- 5 (MB)
MAY 1993

State: CALIFORNIA

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1902(e)(9) of Act

___ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

1905(a)(23) and 1929 of the Act

___ (xi) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State of California
PACE State Plan Amendment Pre-Print

Citation			
	3.1(a)(2)		Amount, Duration, and Scope of Services: Medically Needy (continued)
1905(a)(26) and 1934	(xii)	X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-B Attachment 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage that is in excess of established service limits for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: CALIFORNIA

Citation	3.1	Amount, Duration, and Scope of Services (continued)
	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.
1902(a)(10)(E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10)(E)(iv)(I)1905(p)(3)(A)(ii), and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals - 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

Citation

1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(iv)(II), 1905(p)(3) the Act	(iv)	Other Required Special Groups: Qualifying Individuals - 2 The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.
1925 of the Act	(a)(5)	Other Required Special Groups: Families Receiving Extended Medicaid Benefits Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: CALIFORNIA

Citation

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L.96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: CALIFORNIA

Citation 3.1(a)(6) Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)

1902(a) and 1903(v) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) /_/ and 1920 of the Act	(a)(8)	Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

State: California

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT Services (continued)

42 CFR 441.60 /_/ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.**

42 CFR 440.240 and 440.250

(a)(10) Comparability of Services

1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g), 1925(b)(4), of the Act

Except for those items or services for which sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

/_/ (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

** Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff makes periodic on-site reviews to monitor the provider's record of case management.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

☒ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☐ Yes, to individuals under age 21; SNF services are provided

☐ No; SNF services are not provided

☐ Not applicable; the medically needy are not included under this plan

State/Territory: California

Citation 3.1 Amount, Duration, and Scope of Services (continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 440.260 AT-78-90	3.1(d)	Methods and Standards to Assure Quality of Services The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 441.20 AT-78-90	3.1(e)	Family Planning Services The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Revision: HCFA-PM-87-5 (BERC) OMB No.: 0938-0193
APRIL 1987

State/Territory: California

Citation
42 CFR 441.30
AT-78-90

3.1 (f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

/ / Yes.

/ / No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

/X/ Not applicable. The conditions in the first sentence do not apply.

1903(i)(1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

/ / No.

/X/ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

vision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: California

Citation
42 CFR 431.110(b)
AT-78-90

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902(e)(9) of the Act, P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

/ / 30 consecutive days;

/ / ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

/ / Yes. The requirements of section 1902(e)(9) of the Act are met.

/X/ Not applicable. These services are not included in the plan.

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: CALIFORNIA

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902(a)(10)(E)(i) and 1905(p)(1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

___ Part A _X_ Part B .

___ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: _____

Citation		
1902(a)(10)(E)(ii) and 1905(s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual-1 (QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act.
1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act	(v)	Qualifying Individual-2 (QI-2) The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902(a)(10)(E)(iv)(II) and subject to 1933 of the Act.

Revision: HCFA-PM-97-3 (CMSO)
December 1997

State: _____

Citation

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

_X_ All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under title XVI; or c) withing a group listed at 42 CFR 431.625(d)(2).

_X_ Individuals receiving title II or Railroad Retirement benefits.

_X_ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

__X__ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B). (See Attachment 4.22-C for methods of determining cost-effectiveness.)

Revision: HCFA-PM-93-2 (MB)
MARCH 1993

State: CALIFORNIA

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905(a),and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

X For the entire range of services available under Medicare Part B.

___ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligible--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

Revision: HCFA-PM-91-8 (MB) OMB No.:
October 1991

State/Territory: CALIFORNIA

Citation		Condition or Requirement
1906 of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).
1902(a)(10)(F) of the Act	(d)	/__/ The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

STATE/TERRITORY: _____

(i) Optional Minimum Enrollment Period - Up to 6th Month Eligibility

/__/ The Medicaid agency deems that individuals required to enroll in cost-effective employer-based group health plans remain eligible for benefits under this state plan for a "minimum enrollment period" from the date the individuals' enrollment becomes effective, but only with respect to the benefits which are provided to the individual as an enrollee of the group health plan.

If so, the minimum enrollment period is: _____.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation		
42 CFR 441.252 AT-78-99	3.4	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State: CALIFORNIA

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

☒ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: CALIFORNIA

Citation 3.5 **Families Receiving Extended Medicaid Benefits** (Continued)

- /_/ Private duty nursing services.
- /_/ Physical therapy and related services.
- /_/ Other diagnostic, screening, preventive, and rehabilitation services.
- /_/ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- /_/ Intermediate care facility services for the mentally retarded.
- /_/ Inpatient psychiatric services for individuals under age 21.
- /_/ Hospice services.
- /_/ Respiratory care services.
- /_/ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: CALIFORNIA

Citation 3.5 Families Receiving Extended Medicaid Benefits
(Continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

☐ 1st 6 mos. ☐ 2nd 6 mos.

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Revision: HCFA-PM-4 (BPD)
August 1991

OMB No: 0938-

State: California

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency –

☐ (i) Pays all premiums and enrollment fees imposed on the family for such plan(s)

☐ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

Citation 3.6 Unemployed parent

For purposes of determining whether a child is deprived on the basis of the unemployment of a parent, that agency

☐ uses the standard for measuring unemployment which was in the AFDC State plan in effect on July 16, 1996.

☒ uses the following more liberal standard to measure unemployment:

A child will be considered deprived if the parent and his/her spouse's net non-exempt earned income is at or below 100 percent of the federal poverty limit based on the family size regardless of the number of hours the parent is employed, or the principal wage earner is employed less than 100 hours per month (AFDC Standard).

PJO

SECTION — PAGE NUMBERS

SECTION PAGE NUMBERS

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: California

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation
42 CFR 431.15
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation	4.2 Hearings for Applicants and Recipients
42 CFR 431.202 AT-79-29 AT-80-34	The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: California

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F are met.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: California

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h) and (k).

/ / Yes.

/XXX Not applicable. The State has an approved Medicaid Management Information System (MMIS).

Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

State/Territory: California

Citation	4.5 Medicaid Agency Fraud Detection and Investigation Program
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 431.16 AT-79-29	4.6	Reports The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation
42 CFR 433.37
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

New: HCFA-PM-99-3
JUNE 1999

State: California

Citation	4.10 Free Choice of Providers
42 CFR 431.51 AT 78-90 46 FR 48524 48 FR 23212 1902(a)(23) P.L. 100-93 (section 8(f)) P.L. 100-203 (Section 4113)	(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.
	(b) Paragraph (a) does not apply to services furnished to an individual –
	(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
	(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or
	(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,
Section 1902(a)(23) Of the Social Security Act P.L. 105-33	(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or
Section 1932(a)(1) Section 1905(t)	(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, subject to the limitations in paragraph (c).
	(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or, managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation
42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Department of Health Services

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are):

Department of Health Services

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Department of Health Services _____ (agency) which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

Revision: HCFA-AT-80-38 (BPP)

State California

Citation
42 CFR 431.105 (b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b)

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b)

☒ Yes, as listed below:

Any licensed facility requesting consultative services to the extent the Department is budgeted to provide such services.

☐ Not applicable. Similar services are not provided to other types of medical facilities.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107 (a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D (c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

X Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Revision: HCFA-PM-91-9 (MB) OMB No.:
October 1991

State/Territory: California

Citation
1902 (a)(58)
1902(w) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

AUG 13 2003

TN # 03-037 Effective Date
Supersedes TN # 91-29 Approval Date JAN 23 2004

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as Recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law Or court decision exist regarding advance directives.

AUG 1 3 2003

Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991
State/Territory: California

Citation		
42 CFR 431.60 42 CFR 456.2 50 FR 15312 1902(a)(30)(C) and 1902(d) of the Act, P.L. 99-509 (Section 9431)	4.14	Utilization/Quality Control
	(a)	A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:
		X Directly
		X By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —
		(1) Meets the requirements of §434.6(a):
		(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
		(3) Identifies the services and providers subject to PRO review;
		(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
		(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.
1932(c)(2) and 1902(d) of the ACT, P.L. 99-509 (section 9431)		A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.

California contracts with California Medical Review, Inc. (CMRI), the federally designated PRO, for acute hospital utilization review in six counties, i.e., Alpine, Amador, Calaveras, Kern, San Joaquin, and Tuolumne; and in 39 cities in Los Angeles County.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: California

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

/X/ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

/X/ All hospitals (other than mental hospitals).

/ / Those specified in the waiver.

/ / No waivers have been granted.

CMRI, the PRO, performs utilization review for acute hospitals in six counties; i.e., Alpine, Amador, Calaveras, Kern, San Joaquin, and Tuolumne; and in 39 cities in Los Angeles County.

Revision: HCFA-PM-85-7 (BERC) OMB NO.: 0938-0193
JULY 1985

State/Territory: California

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

/X/ All mental hospitals.

/ / Those specified in the waiver.

/ / No waivers have been granted.

/ / Not applicable. Inpatient services in mental hospitals are not provided under this plan.

:vision: HCFA-PM-85-3 (BERC)
AY 1985

State: California

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

/ / Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

/X/ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

/X/ All skilled nursing facilities.

/ / Those specified in the waiver.

/ / No waivers have been granted.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: California

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 /XX/ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provide through:

/ / Facility-based review.

/XX/ Direct review by personnel of the medical assistance unit of the State agency.

/ / Personnel under contract to the medical assistance unit of the State agency.

/ / Utilization and Quality Control Peer Review Organizations.

/ / Another method as described in ATTACHMENT 4.14-A.

/ / Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

/ / Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: California

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)	For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354 42 CFR 438.356(b) and (d)	The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.
_____	Not Applicable

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation
42 CFR 456.2
AT-78-90

4.15 Inspections of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

☐ Not applicable with respect to intermediate care facility services; such services are not provided under this plan.

☐ Not applicable with respect to services for individuals age 65 or over in institutions for mental diseases; such services are not provided under this plan.

☐ Not applicable with respect to inpatient psychiatric services for individuals under age 22; such services are not provided under this plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation
42 CFR 431.615(c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

4.17 Liens and Adjustments or Recoveries

Citation
42 CFR 433.36 (c)
1902 (a) (18) and
1917 (a) and (b) of the Act

(a) Liens

____ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

____ The State complies with the requirements of section 1917 (a) of the ct and regulations at 42 CFR 433.36 (c) - (g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

__X__ The State imposes liens on real property on account of benefits incorrectly paid.

State imposes TEFRA liens 1917 (a) (i) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

__X__ The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h) – (i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

__X__ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) _____ The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under section 1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

__X__ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

All services included in State plan except those payments made for personal care services provided under In-Home Support Services, or the cost of premiums, co-payments and deductibles paid on behalf of either Qualified Medicare Beneficiaries or Specified Low-Income Medicare Beneficiaries (QMB/SLMB).

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

(4) X The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

____ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

____ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

X The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

The Department will reduce its claim in accordance with Title 22, California Code of Regulations, Section 50453.7 (b), for insurance benefits received under the California Partnership for Long Term Care.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917 (b) (2) of the Act and regulations at 42 CFR section 433.36 (h) - (i)

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
April, 2000

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

(4) Japanese Reparation payments, or where the reparation payments described above have been converted to another form, amounts of resources equal to the amount of these reparation payments, received by the deceased Medi-Cal beneficiary or inherited by the deceased spouse of that beneficiary, or both, shall be exempt from estate recovery.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CRF 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, tenancy in common, survivorship, life estate, living trust, annuities purchased on or after September 1, 2004, life insurance policy that names the estate as the beneficiary or reverts to the estate, or any retirement account that names the estate as the beneficiary or reverts to the estate.
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

53e

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

(4) Describe the standards and procedures for waiving estate recovery when it would cause substantial hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Revision: HCFA-AT-91-4(BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: California

Citation 42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

*[X] Age 19

[ ] Age 20

[ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

*Children under age 21 living in boarding homes or institutions for foster care are exempt.

Citation 4.18(b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

[X] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[ ] Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

[X] Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

* ☒ 19 or older

☐ 20 or older

☐ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

* Children under age 21 living in boarding homes or institutions for foster care are exempt.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation
42 CFR 447.51
through 447.58

4.18(b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

/X/ Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation		
1916(c) of the Act	4.18(b)(4) ☑	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5) ☑	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6) ☑	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation

42 CFR 447.51 through 447.58

4.18(c) /X/ Individuals are covered as medically needy under the plan.

(1) /_/ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

* /X/ Age 19

/_/ Age 20

/_/ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

*Children under age 21 living in boarding homes or institutions for foster care are exempt.

Revision: HCFA-PM-91- 4 (BPD) AUGUST 1991 OMB No.: 0938-

State/Territory: California

Citation 4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

/X/ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

/X/ Not applicable. No such charges are imposed.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation 4.18(c)(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

/ / Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

/ / 18 or older

* /X/ 19 or older

/ / 20 or older

/ / 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

* Children under age 21 living in boarding homes or institutions for foster care are exempt.

Revision: HCFA-PM-91- 4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: California

Citation 4.18(c)(3) (Continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

X/ Not applicable. There is no maximum.

STATE California

Citation(s)	4.18 (d)	
1916 of the Act. Section 6408(d)(3) of P.L. 101-239	_____	For qualified disabled working individuals (QDWI's) whose income exceeds 150 percent of the Federal income poverty level, the State imposes a premium expressed as a percentage of the Medicare cost sharing described in Section 1905 (p)(3)(A)(i), according to a sliding scale, in reasonable increments, as the individual's income increases between 150 and 200 percent of the Federal income poverty level.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation 4.19 Payment for Services

42 CFR 447.252
1902(a)(13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

Section 1902(e)(7) of the Act

/X/ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

/_/ Inappropriate level of care days are not covered.

State/Territory: California

Citation

42 CFR 447.201
42 CFR 447.302
52 FR 28648, 1902 (a) (13) (E)
1903 (a) (1) and
(n), 1920, and
1926 of the Act

4.19 (b) In addition to the services specified in paragraphs 4.19 (a), (d), (k), (l) and (m), the Medicaid agency meets the following requirements:

(1) Section 1902 (a) (13) (E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905 (a) (2) (C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA – Pub. 45 – 6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the methods of payment and how the agency determines the reasonable cost of the services (for example, cost-reports, cost or budget reviews, or sample surveys).

(2) Sections 1902 (a) (13) (E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these facility services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902 (a) (10) and
1902 (a) (30) of the Act

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

SUPPLEMENT 2 to ATTACHMENT 4.19-B describes the methods and standards used for the payment of prescribed drugs dispensed by pharmacists.

SUPPLEMENT 3 to ATTACHMENT 4.19-B describes the standards and methods used to adjust claiming for the federal drug rebate program.

SUPPLEMENT 4 to ATTACHMENT 4.19-B describes the methods and standards used for establishing payment rates for rehabilitative mental health services for seriously disturbed children screened under the early periodic diagnosis, screening and treatment program and served through the Short-Doyle/Medi-Cal program.

SUPPLEMENT 5 to ATTACHMENT 4.19-B describes the methods and standards used for reimbursement at 100 percent of reasonable costs to clinics providing specified Medi-Cal ambulatory services to Medi-Cal beneficiaries and are operated by, or contracted with a county participating in a sub-state Medicaid Demonstration Project authorized under Section 1115 of the Act.

Revision: HCFA - PM - 93 - 6 (MB) OMB No.: 0938 -

August 1993

State/Territory: California

7 RTD

SUPPLEMENT 6 to ATTACHMENT 4.19-B describes the methods and standards used for reimbursement of rural health clinics outpatient services.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation		
42 CFR 447.40 AT-78-90	4.19(c)	Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

Revision: HCFA-PM-87- 9 (BERC) OMB No.: 0938-0193
AUGUST 1987

State/Territory: California

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 (d)

/XX/ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

/XX/ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

/ / At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

/XX/ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

/ / Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

/ / (4) Section 4.19(4)(1) of this [illegible] applicable with respect to [illegible] facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

Citation		
42 CFR 447.45(c) AT-79-50	4.19(e)	The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Revision: HCFA-PM-87-4 (BERC) OMB No.: 0938-0193
MARCH 1987

State/Territory: California

Citation		
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g)	The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State CALIFORNIA

Citation		
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h)	The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i)	The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State: CALIFORNIA

Citation

42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: California

Citation		
1903(i)(14) of the Act	4.19(1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physican to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: California

Citation		
4.19	(m)	Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program
1928(c)(2)(C)(ii) of the Act	(i)	A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administed as follows.
	(ii)	The State:

___ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

_X_ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine:

Federally Qualified Health Centers: reimbursed at cost;
Rural Health Clinics: reimbursed at cost;
EPSDT providers: $4.52 + fee for any EPSDT screen;
Other Medi-Cal providers: $3.94 + fee for any office visit or preventive medicine service.

1926 of the Act	(iii)	Medicaid beneficiary access to immunizations is assured through the following methodology:

Access to pediatric immunizations will be demonstrated together with access to other pediatric services as part of the state plan amendment which is required by Section 1926(a)(2) of the Social Security Act and which is due to be submitted to the Health Care Financing Agency by April 1, 1995.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: California

Citation
42 CFR 447.25(b)
AT-78-90

4.20A Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

X Yes, for X physicians' services
X dentists' services

Attachment 4.20-A specifies the conditions under which such payments are made.

☐ Not applicable. No direct payments are made to recipients.

Citation
42 CFR 431.250

4.20B Direct Payments to Recipients in Other Circumstances –

X Yes, for X services covered by the plan

Attachment 4.20-B specifies the conditions under which such payments are made.

Revision: HCFA-AT-81-34 (BPP) 10-81

State CALIFORNIA

Citation	4.21 Prohibition Against Reassignment of Provider Claims
42 CFR 447.10(c) AT-78-90 46 FR 42699	Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

TN # 82-11
Supersedes
TN #

Approval Date 7-16-82 Effective Date 4-1-82

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: California

Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.

1902(a)(25)(H) and (I) of the Act

(4) Sections 1902(a)(25)(H) and (I) of the Act.

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A --

(1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii) and (2)(ii)

(2) Describes the methods the agency uses for meeting the followup requirements contained in §433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources; and

42 CFR 433.138(g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: California

Citation

42 CFR 433.139(b)(3)(ii)(A) ___ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(C) (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C).

42 CFR 433.139(f)(2) (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3) (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20 (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

State/Territory: CALIFORNIA

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

X State Title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State agency(s) --

_____

_____

___ Other appropriate agency(s) of another State--

_____

_____

___ Courts and law enforcement officials.

1902(a) (60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under Section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost-effectiveness of an employer-based group health plan by selecting one of the following:

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

_X_ The State provides methods for determining cost-effectiveness on ATTACHMENT 4.22-C.

Revision: HCFA
April 1994

STATE: CALIFORNIA

CITATION		CONDITION OR REQUIREMENT
Citation		
~~42 CFR 433.160~~ ~~58 FR 49276~~	4.22(i)	Referral of Medicaid cases to child support enforcement (CSE)
		(1) ~~The Medicaid agency meets all requirements of 42 CFR 433.160~~
~~433.160(a)~~		~~(2)~~ Attachment 4.22-D
~~58 FR 49276~~		(a) Describes the methods by which requirements for referral are met~~,that are contained in Section 433.160(a).~~
~~433.160 (b) and (c)~~ ~~58 FR 49276~~		(b) Describes the criteria and procedures by which the Medicaid agency implemented referral of Medicaid cases to the CSE agency.
~~42 CFR Part 433~~ ~~42 CFR Part 435~~ ~~42 CFR Part 436~~ ~~58 FR 4907-8~~	~~4.22(j)~~	~~Exemption of poverty level pregnant women from the cooperation requirements of establishing paternity and obtaining medical support and payments as a condition of eligibility. The Medicaid agency has included this exemption in its medical support regulations and procedures.~~

PJD

TN No. 94-002
Supersedes

Approval Date JUN 11 2001

Effective Date 4/1/94

TN No. _____

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: California

Citation	4.23	Use of Contracts
42 CFR 434.4 48 FR 54013		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.
		/_/ Not applicable. The State has no such contracts.
42 CFR Part 438		The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):
		_X_ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2
		_X_ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2
		_X_ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
		_X_ Not applicable.
		Contracts with Local Initiatives (LIs) have a sole source exemption approved by Centers for Medicare & Medicaid Services (CMS) through December 31, 2008. After this date the State must determine if there is interest in competing for any of the LI contracts. If the State determines that there is interest, the State must conduct an open and free competitive reprocurement to have new contracts awarded and operational by the end of the five-year exemption period.

TN # 03-037
Supersedes TN # 84-17

Effective Date AUG 13 2003
Approval Date JAN 23 2004

Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: CALIFORNIA

Citation	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826		With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation		
42 CFR 431.702 AT-78-90	4.25	Program for Licensing Administrators of Nursing Homes The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM-93-3 (MB)
MARCH 1993

State/Territory: California

Citation

1927(g) 4.26 Drug Utilization Review Program
42 CFR 456.700

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A) 2. The DUR program assures that prescriptions for outpatients drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927(g)(1)(A)
42CFR 456.705(b) and
456.709(b) B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

Revision: HCFA-PM-93-3 (MB)
MARCH 1993

State/Territory: California

Citation

1927(g)(1)(B) 42 CFR 456.703 (d) and (f)	c.	The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: - American Hospital Formulary Service Drug Information - United States Pharmacopoeia-Drug Information - American Medical Association Drug Evaluations
1927(g)(1)(D) 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in: X Prospective DUR X Retrospective DUR.
1927(g)(2)(A) 42 CFR 456.705(b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

Revision: HCFA-PM-93-3 (MB)
MARCH 1993

State/Territory: California

Citation

Citation		
1927(g)(2)(A)(i) 42 CFR 456.705(b), (1)-(7)	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: - Therapeutic duplication - Drug-disease contraindications - Drug-drug interactions - Drug-interactions with non-prescription or over-the-counter drugs. - Incorrect drug dosage or duration of drug treatment - Drug allergy interactions - Clinical abuse/misuse - Therapeutic overlap - Overutilization and underutilization - Therapeutic appropriateness
1927(g)(2)(A)(ii) 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.
1927(g)(2)(B) 42 CFR 456.709(a)	F.1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: - Patterns of fraud and abuse - Gross overuse - Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Revision: HCFA-PM-93-3 (MB)
MARCH 1993

State/Territory: California

Citation

1927(g)(2)(C) 42 CFR 456.709(b)	F.2.	The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: - Therapeutic appropriateness - Overutilization and underutilization - Appropriate use of generic products - Therapeutic duplication - Drug-disease contraindications - Drug-drug interactions - Incorrect drug dosage/duration of drug treatment - Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3.	The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1.	The DUR program has established a State DUR Board either: X Directly, or _ Under contract with a private organization
1927(g)(3)(B) 42 CFR 456.716 (A) AND (B) 1 6	2.	The DUR Board membership includes health professionals (at least one-third licensed actively practicing pharmacists and at least one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: - Clinically appropriate prescribing of covered outpatient drugs. - Clinically appropriate dispensing and monitoring of covered outpatient drugs. - Drug use review, evaluation and intervention. - Medical quality assurance.

Revision: HCFA-PM-93-3 (MB)
MARCH 1993

State/Territory: California

Citation

1927(g)(3)(C) 42 CFR 456.716(d)	3.	The activities of the DUR Board include: - Retrospective DUR, - Application of Standards as defined in section 1927(g)(2)(C), and - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	4.	The interventions include in appropriate instances: - Information dissemination - Written, oral, or electronic reminders - Face-to-Face discussions - Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D) 42 CFR 456.712 (A) and (B)	H.	The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the State's report.
1927(h)(1) 42 CFR 456.722	I.1.	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: - real time eligibility verification - claims data capture - adjudication of claims - assistance to pharmacists, etc. applying for and receiving payment.

Revision: HCFA-PM-93-3 (MB)
MARCH 1993

State/Territory: California

Citation

1927(g)(2)(A)(i) 42 CFR 456.705(b)	2.	Prospective DUR is performed using an electronic point of sale claims processing system.
1927(j)(2) 42 CFR 456.703(c)	J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State _____

Citation		
42 CFR 431.115(c) AT-78-90 AT-79-74	4.27	Disclosure of Survey Information and Provider or Contractor Evaluation The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Revision: HCFA-PM-93-1 (BPD)
January 1, 1993

State / Territory: California

Citation	4.28 Appeals Process
42 CFR § 431.152; AT-79-18 52 FR 22444; Sections 1902 (a)(28)(D)(i) and 1919 (e)(7) of the Act; P.L. 100-203 [Section 4211(c)]	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR § 431.153 and 431.154. (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR § 483.12; and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission screening and resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3
JUNE 1999

State: California

Citation

1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29 Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932(d)(3) 42 CFR 438.58	The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

State/Territory: California

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

Attachment 4.30 describes sanctions for psychiatric hospitals.

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

☒ **The agency, under the authority of State law, imposes broader sanctions.**

State law in California requires a broader application of sanction than those required by 42 CFR Part 1002 Subpart B in the following areas.

Section 1002.211 states that the Medicaid suspension must be as long as required under the federal action, but that the State may suspend for a longer period under its authority. California generally suspends a provider who has been suspended from Medicare for the same length of time as the federal action. However, for federal actions that result in automatic suspensions based on conviction of program related crimes California suspends the provider of service for a longer period.

Section 1002.232 states that the provider may petition for reinstatement anytime after the date in the notice. California Welfare and Institutions Code, Section 14123 permits providers to submit a petition for reinstatement when the established time of the suspension has run out or, in the case of indefinite suspensions, the petition may be submitted no sooner than one year after the date of the decision. The one year limitation applies to all petitions submitted where the original petition was denied.

Revision: HCFA-AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: California

Citation		
	(b)	The Medicaid agency meets the requirements of –
1902(p) of the Act		(1) Section 1902(p) of the Act by excluding from participation
		(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
42 CFR 438.808		(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that
		(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
		(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.
1932(d)(1) 42 CFR 438.610		(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438,610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PIHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

TN # 03-037
Supersedes TN # 88-16

Effective Date AUG 1 2003
Approval Date JAN 2 3 2004

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193
4.30 Continued

State/Territory: California

Citation	
1902(a)(39) of the Act P.L. 100-93 (sec. 8(f))	(2) Section 1902(a)(39) of the Act by--
	(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
	(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
	(c) The Medicaid agency meets the requirements of--
1902(a)(41) of the Act P.L. 96-272, (sec. 308(c))	(1) Section 1902(a)(41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and
1902(a)(49) of the Act L. 100-93 ec. 5(a)(4))	(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

evision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: California

Citation	
455.103 44 FR 41644 1902(a)(38) of the Act P.L. 100-93 (sec. 8(f))	4.31 Disclosure of Information by Providers and Fiscal Agents The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.
435.940 through 435.960 52 FR 5967	4.32 Income and Eligibility Verification System (a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: California

Citation
1902(a)(48) of the Act, P.L. 99-570 - (Section 11005) P.L 100-93 (sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: California

Citation
1137 of
the Act

P.L. 99-603
(sec. 121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

/ / The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

/ / The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

/ / Total waiver

/ / Alternative system

/ / Partial implementation

Revision: HCFA-PM-90- 2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: California

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

/ / Not applicable to intermediate care facilities; these services are not furnished under this plan.

/ / (b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h)(2)(B)(ii) of the Act

/X/ (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act

/X/ (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

/X/ (1) Public recognition. ATTACHMENT 4.35-C describes the incentive (Best Practices) program.

/X/ (2) Incentive payments. ATTACHMENT 4.35-H describes the incentive (Quality Awards) Program.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: California

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(3) and 4

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)&(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.404(b)(1)&(2)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

___ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: California

Citation

c) Application of Remedies

42 CFR §488.410 the

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove threat within 23 days.

42 CFR §488.417(b) an §1919(h)(2)(C) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to NF that has not come into substantial compliance within 3 months after the last day of the survey.

42 CFR admissions §488.414 §1919(h)(2)(D) of the Act.

(iii) The State imposes the denial of payment for new remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

(d) Remedies

42 CFR §488.406(a) and (b) §1919(h)(2)(A) of the Act.

(i) The State has established the following optional remedies defined in 42 CFR 488.406(a).

x (1) Directed Plan of Correction
x (2) Directed in-service

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: California

Citation

(ii) The State has established the mandatory remedies defined in 42 CFR 488.406(b).

- x (1) Termination
- x (2) Temporary Management
- x (3) Denial of Payment for New Admissions
- x (4) Civil Money Penalties
- x (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- x (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

42 CFR §488.406(a) §1919(h)(2)(B)(ii)

(iii) ___ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

- ____ (1) Temporary Management
- ____ (2) Denial of Payment for New Admissions
- ____ (3) Civil Money Penalties
- ____ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
- ____ (5) State Monitoring.
- ____ (6) Termination of Provider Agreement.
- ____ (7) Directed Plan of Correction
- ____ (8) Directed In-Service Training

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303(b) 1919(h)(2)(F) of the Act.

(e) ___ State Incentive Programs

- X (1) Public Recognition
- ___ (2) Incentive Payments

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: California

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C) and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91- 10 (BPD)
DECEMBER 1991

State/Territory: California

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	4.38	Nurse Aide Training and Competency Evaluation for Nursing Facilities
		(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	X	(b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	X	(c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
		(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	___	(e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	___	(f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

State/Territory: California

Citation	
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
	(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
	(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
	(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
	(k) For program reviews other than the initial review, the State visits the entity providing the program.
	(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(m)	The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.
		(n)	The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.
		(o)	The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).
		(p)	The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).
	X	(q)	The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.
		(r)	The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

Revision: HCFA-PM-91-10
DECEMBER 1991

State/Territory: California

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	(s)	When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.
	(t)	The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.
	(u)	The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.
	(v)	The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.
	(w)	Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.
___	(x)	The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).
	(y)	The State has a standard for successful completion of competency evaluation programs.

State/Territory: California

Citation			
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).		(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	X	(aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
		(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	___	(cc)	The State includes home health aides on the registry.
	___	(dd)	The State contracts the operation of the registry to a non State entity.
	___	(ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).
	___	(ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1
January 1, 1993

(BPD)

State / Territory: California

Citation

Section 1902 (a)(28)(D)(i) and 1919 (e)(7) of the Act;
P.L. 100-203 (Section 4211 (c));
P.L. 101-508 (Section 4801 (b)).

4.39 Preadmission Screening and Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the state mental health and mental retardation authorities that meet the requirements of 42 CFR 431.621(c).

(b) The State operates a preadmission screening and resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening and resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State Plan" the cost of NF services to individuals who are found not to require NF services.

(e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1, 1993

State / Territory: California

4.39 (Continued)

(f) Except for residents identified in 42 CFR 483.118 (c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Revision: HCFA-PM-92-3 (HSQB) APRIL 1992 OMB No.:

State/Territory: California

Citation Sections		
1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.
1919(g)(1) (B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.
1919(g)(1) (C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.
1919(g)(1) (C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1) (C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1) (C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

Revision: HCFA-PM-92-3 (HSQB) OMB No:
APRIL 1992

State/Territory: California

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

Revision: HCFA-PM-92- 3 (HSQB) OMB No:
APRIL 1992

State/Territory: California

1919(g)(2) (D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. **Attachment 4.40-D** describes the State's programs.
1919(g)(2) (E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2) (E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2) (E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. **Attachment 4.40-E** describes the State's complaint procedures.
1919(g)(5) (A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5) (B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5) (C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5) (D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92- 2 (HSQB)
MARCH 1992

State/Territory: CALIFORNIA

Citation	4.41 Resident Assessment for Nursing Facilities	
Sections 1919(b)(3) and 1919 (e)(5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b)(3)(A) of the Act.
1919(e)(5) (A) of the Act	(b)	The State is using:
	X	the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§1919(e)(5)(A)]; or
1919(e)(5) (B) of the Act	___	a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§1919(e)(5)(B)].

TN No. 87-08
Supersedes TN No. ____
Approval Date OCT 2 6 1987
Effective Date JUL 0 1 1987

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State California

SECTION 5 PERSONNEL ADMINISTRATION

Citation
42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

5.2 [Reserved]

Job-Required Training

This category represents the training required to meet performance standards of the individual's present job.

Job-Related Training

This category represents the training required to improve performance above the acceptable level of competency of the individual's present job.

Upward Mobility Training

This category represents the individual's access to movement, such as:

1. From low paying classes with minimal career opportunities into higher paying classes with broader career opportunities;
2. Up within class series from entry level into journey levels; and
3. Into classifications which traditionally have had little or no utilization of minorities, women and the disabled.

Career-Related Training

This category represents the training required to assist an individual to achieve his/her career potential.

In-Service Training

This category represents any training that the Department staff sponsors or provides.

Out-Service Training

This category represents any training that is offered outside of the provision or sponsorship of the Department.

Volunteers

Counties utilize the services of volunteers as demonstrated in the Sacramento County Welfare Department (CWD). This CWD uses volunteers as Driver Escorts to transport Medi-Cal patients to and from medical appointments.

The Department utilizes volunteers throughout various programs. For example, the Department's Employees Assistance Program utilizes a college student who is majoring in medical social work. This student consults with employees who are experiencing personal or work-related problems. Another example is the Department's Training and Recruitment Section which utilizes a Student Assistant who may represent the Department at colleges to discuss the Department's affirmative action program. Volunteers are trained and provided with the necessary materials related to the project in which the volunteer is assigned. In addition, the Department's External Affairs Division utilizes volunteers as appointees to various advisory committees including the Medicaid Advisory Committee. These volunteers report to the Department on their findings on a particular issue and make recommendations/suggestions.

Merit System

The Department provides for a Merit System which grants annual salary increases to individuals who have been certified as meeting the standards of efficiency required.

TN: 85-69

APPROVED: SEP 24 1985 EFFECTIVE: JUL 1 1985

SECTION — PAGE NUMBERS

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

SECTION 6 FINANCIAL ADMINISTRATION

Citation
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

Revision: HCFA-AT-81- (BPP)

State California

Citation
42 CFR 433.34
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State California

Citation
42 CFR 433.33
AT-79-29
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☐ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☒ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

TN #91-15
Supercedes
TN ~~#HCFA-TA-8038~~
#76-1
Approval Date: FEB 25 1992

AUG 17 1991
Effective Date: ~~July 5, 1991~~

TN No. 92-09
Supersedes TN No. 87-08
Approval Date NOV 18 1993
Effective Date JAN 01 1993
HCFA ID: 7982E JAN 01 1993

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: California

SECTION 7 - GENERAL PROVISIONS

Citation	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: California

Citation 7.2 Nondiscrimination

45 CFR Parts 80 and 84

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

Revision: HCFA-PM-91- 4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: CALIFORNIA

Citation

RESERVED

Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
AUGUST 1991

State/Territory: California

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

/X/ Not applicable. The Governor--

/X/ Does not wish to review any plan material.

/_/ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department of Health Services
(Designated Single State Agency)

Date: 3-19-93

(Signature)

Jose Fernandez
Deputy Director
Medical Care Services
(Title)

TN No. 92-09
Supersedes TN No. 86-05
Approval Date NOV 18 1993 Effective Date JAN 01 1993

HCFA ID: 7982E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Attachment 1.1-A MEDICAL ASSISTANCE PROGRAM

State of California

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

the Department of Health Services, State of California is the single State agency responsible for:

[X] administering the plan

The legal authority under which the agency administers the plan on a Statewide basis is Welfare and Institutions Code Sections 10722, 10740, and 14100.1, (regulatory authority: 10725, 14105 and 14124.5)

(statutory citations)

[ ] supervising the adminstration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(statutory citation)

The agency's legal authority to make rules and regulation that are binding on the political subdivision administering the plan is

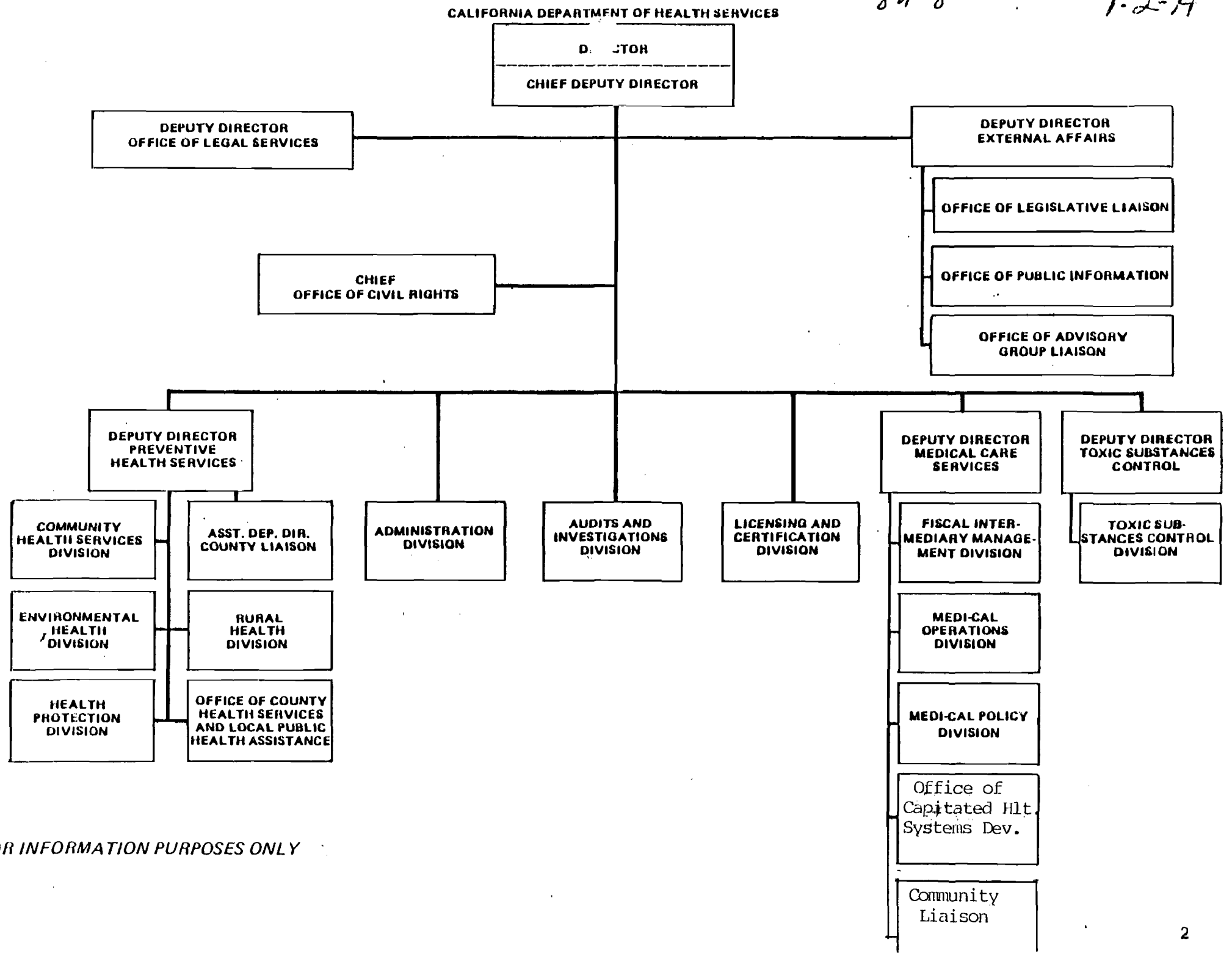
(statutory citation)

24 May 1984
DATE

Thomas W Warren
Signature

Assistant Attorney General
Title

848 1-2-A



FOR INFORMATION PURPOSES ONLY

DIRECTOR'S OFFICE

The Director's Office provides the executive leadership for the Department. It includes the Director and Chief Deputy Director. Reporting directly to the Executive Office are the Deputy Directors of External Affairs; the Office of Legal Services; Preventive Health Services; Medical Care Services; Toxic Substances Control; the Office of Civil Rights; and the Chiefs of the Administration Division, the Audits and Investigations Division, and the Licensing and Certification Division.

A. Deputy Director for External Affairs

Under the administrative direction of the Directorate of the Department of Health Services, the Deputy Director for External Affairs will advise and assist the Director and Chief Deputy Director in the formulation, implementation, and evaluation of departmental programs, policies, and procedures, and to manage the Office of Legislative Liaison, Office of Public Information, and Office of External Affairs.

The incumbent, as the manager of the Office of Legislative Liaison, Office of Public Information, and Office of External Affairs will:

1. Serve as principal advisor to the Directorate on all matters related to legislation.
2. Serve as the legislative advocate for the Department.
3. Provide or direct testimony given by departmental experts before the Legislature.
4. Make recommendations to the Director on the Department's position on legislation.
5. Serve as the principal spokesperson for the Department to the media and other legislative, governmental, and private interest groups.
6. Oversee operation of the Department's advisory boards.

B. Deputy Director, Office of Legal Services

The Office of Legal Services provides legal advice, counsel, and representation to all Department of Health Services programs. The Office provides written and oral responses to specific requests for legal advice; reviews legislation, regulations, and contracts; and represents the Department in provider audit hearings. This Office is the liaison between the Department and the Attorney General's Office and other agencies on legal matters.

C. Office of Civil Rights

The Office of Civil Rights ensures equity and fairness in all aspects of Department personnel management, ensures that the health service delivery system is equally accessible to all California citizens, and ensures that Department operations do not infringe upon the civil rights of its employees or any of the individuals served by the Department.

COMMUNITY HEALTH SERVICES DIVISION

The Community Health Services Division promotes and integrates personal health services at the community level with particular emphasis on services to individuals and populations who have special needs and medically underserved populations and geographic areas.

This Division consists of:

- California Children Services Branch
- Child Health and Disability Prevention Branch
- Family Planning Branch
- Genetic Disease Branch
- Maternal and Child Health Branch
- Office of Long-Term Care and Aging
- Primary Health Care Grant Unit

A. The California Children Services Branch is a joint state-county effort to assist children with severe, physically handicapping conditions by providing high-quality comprehensive medical and related services. These services are provided to correct, ameliorate, or eliminate handicaps, and they are made available to children whose parents are not able to pay for all or part of the costs of care. Families which are able to pay are required to share in the cost of care.

The California Children Services Branch consists of the following sections:

1. The Regional Operations Section provides case management services for clients in 26 counties and handles program responsibilities throughout the State.
2. The Special Care Section administers the statewide Genetically Handicapped Persons Program, provides case management services, and purchases necessary medical and related care.
3. The Operational Support and Consultation Section develops and implements program standards, consults with county and provider staff, supervises school therapy services, and reviews county programs.
4. The Fiscal and Administrative Support Section provides necessary support services and oversees related projects and programs.

B. The Child Health and Disability Prevention Branch carries out federal and state statutory requirements aimed at reducing the incidence of preventable physical and mental illness and disability among California's children and youth. The Branch also monitors the school entry program and other local programs that are operated by local health departments.

1. The Administration and Claims Review Section provides fiscal coordination, budget development, and control.
2. The Data Management and Evaluation Section produces management information and periodic program reports, and carries out studies to evaluate the effectiveness of the program on the health of children served.
3. The Policy and Program Development Section plans the implementation of new program elements; analyzes proposed legislation and regulations; prepares plans for implementation of new federal requirements; and coordinates a variety of programs relating to federal and state laws.
4. The Regional Operations Section provides consultation and technical assistance to local health and welfare departments in program planning, implementation, and evaluation; and assures local program compliance with federal and state requirements.

C. The Family Planning Branch provides services relating to contraception, sterilization, infertility, and information and education by contracting with more than 180 public and private nonprofit agencies statewide.

D. The Genetic Disease Branch promotes information and services aimed at the prevention of genetic or congenital disorders and defects or the amelioration of their impact on the individual and the family concerned. The services include public and professional education and information dissemination.

1. The Genetic Education and Counseling Section administers programs of information, dissemination, promotion of genetic counseling, prenatal diagnosis of genetically affected fetuses, carrier screening, and counseling for Tay Sachs and hemoglobinopathies.
2. The Newborn Screening Section administers a comprehensive program involving a system for collection, transmission, accurate analysis, and follow up of results on blood screening tests on all infants born in California.

E. The Maternal and Child Health Branch reduces and prevents maternal infant, and childhood morbidity and deaths; reduces the incidence of hereditable diseases; limits disability resulting from hereditable diseases; and provides maximal nutrition for mothers, infants, and children.

1. The Maternal and Infant Health Section improves the care and health of mothers and infants in the prenatal period, and emphasizes special care for high-risk pregnant women and children.
2. The Women, Infants, and Children Section administers the federally-funded nutrition program, provides vouchers for nutritional foods, and provides consumer nutrition education.
3. The Regional Operations Section provides liaison and consultation with county health departments and administers Title V grant funds.

F. The Office of Long-Term Care and Aging stimulates the development of state policies, activities, and programs designed to promote the development of a comprehensive system of community-based long-term care services.

The Adult Day Health Care (ADHC) program is administered within the Office. The goals of ADHC are to restore or maintain the optimal capacity for self-care for chronically ill and functionally impaired adults and to prevent inappropriate, premature or personally undesirable institutionalization in long-term care facilities.

G. The Primary Health Care Grant Unit provides financial assistance to community clinics, free clinics, and associations of clinics for use in maintaining health care operations for medically underserved and/or high risk populations.

RURAL HEALTH DIVISION

The Division is responsible for the overall coordination of the contract counties health services, farmworkers' health services, Indian health services, rural health development programs, and the California health services corps.

The Division consists of the following:

• Rural Health Services Branch • Policy and Program Development Section • Support Services Branch • Farmworkers Health Services Section • Indian Health Branch

A. The Rural Health Services Branch is divided into the Public Health Services Section and the Health Services Development Section.

The Rural Health Services Branch, through the regional offices, negotiates and monitors contracts with counties, Indian health projects, and rural health projects; provides basic public health services to contracting counties; assists in recruiting, hiring, and evaluating health personnel; provides needed consultation and technical assistance; and relates to pertinent federal and state programs and to health systems agencies, health officers, providers, and consumers.

Each regional office has a small administrative and nursing consultant staff which directs public health nurses, sanitarians, members of the California Health Services Corps, and other direct care providers assigned to the counties and the projects.

1. The Public Health Services Section protects, maintains, and improves the personal and environmental health status of persons living in the rural counties contracting with the Department for services provided through public health nurses, registered sanitarians, and child health and disability personnel. The Branch's overall program strategy assures equitable access to preventive public and environmental health services in rural counties by providing for coordinated delivery of public health services.

   The Sacramento Regional Office provides program implementation in an area of Central California encompassing 20 counties.

   The Redding Regional Office provides program implementation in a nine county area of Northern California.

2. The Health Services Development Section, through the three regional offices of the Northern Region, Central Region, and Santa Rosa Region, negotiates and monitors contracts with counties, Indian health projects, and rural health projects, and provides basic public health services to contracting counties.

B. The Policy and Program Development Section will provide Medi-Cal, nursing, and public health consultation and will consist of individuals with expertise in addressing the problems of particularly underserved populations. Consultation will be provided directly to the regional offices on a routine basis and will be available on request to deal with priority situations.

C. The Support Services Branch processes contracts and invoices, conducts personnel transactions, prepares budgets, maintains a central recruiting file for the placement of health professionals, and conducts ongoing research and data collection.

D. The Farmworkers Health Services Section maintains a health program consisting of studies of health services for seasonal, agricultural, and migratory workers and their families throughout the State. In addition, technical and financial assistance is provided to local agencies concerned with the health of the workers and their families.

E. The Indian Health Branch provides contractual funds to existing rural and urban Indian health programs making available ambulatory health care services to Native American Indians in California, many of whom experience difficulties in access to health care. The Branch also conducts studies of health and health services to Indians; provides technical assistance to local agencies; and coordinates with similar programs of the Federal Government, other states, and voluntary agencies.

FISCAL INTERMEDIARY MANAGEMENT DIVISION

The Fiscal Intermediary Management Division (FIMD) ensures that fee-for-service medical claims are processed in a timely manner and in accordance with Medi-Cal policy.

The Division is comprised of the following:

• Headquarter's Management Branch

A. The Headquarters Management Branch is generally responsible for all Division activities related to analysis and development of new and revised Medicaid Management Information System policy and procedures, support and control of FI fiscal and contract matters, and for liaison activities with the Medi-Cal provider community.

1. The Provider Services Section is responsible for all related activities involving written or verbal contact between the Medi-Cal provider community and the State, concerning payments.

   The Section Support Unit is responsible for the control of second-level appeals, the processing of second-level appeals (shared function), the processing of state-responsible claims, and various Provider Services Section administrative support functions.

   The Provider Support Services Unit is responsible for all provider payment complaints (shared function), including second-level appeals processing, Board of Control claims analysis, court action research involving Medicaid Management Information System (MMIS) claims suits, and interim payment policy setting.

   The Provider Information Services Unit is responsible for state/provider liaison activities and for monitoring FI/provider contacts.

   The Provider Master File (PMF) Operations Unit is responsible for providing analytical support to the Provider Enrollment Services Section, including development of provider enrollment policy and answering general PMF policy inquiries from providers.

   The Provider Enrollment Services Unit is responsible for the maintenance of the MMIS and Denti-Cal Provider Master Files through the enrolling and disenrolling of and the changing of file data on providers.

2. The Change Management Section is responsible for analyzing, planning, and developing timely and cost effective changes to both the automated and manual California Medicaid Management Information System (CA-MMIS) in response to Department-approved requirements. This Section performs all liaison and tracking functions necessary to carry out these responsibilities.

3. The Contract Administration Section is responsible for divisionwide activities, including the control and coordination of audit reviews, federal Systems Performance Reviews (SPR), tracking systems, and MMIS documentation-related activities.

   The Management Services Unit is responsible for the control and coordination of Division tracking systems, FI contract-related fiscal activities, and monitoring the FI for contract compliance in the area of corporate personnel and fiscal matters.

   The Contract Services Unit is responsible for the control and coordination of FI contract deliverables (including MMIS documentation), System Performance Reviews, the FI contract transition, and change order negotiations and fiscal analysis.

   The Compliance Services Unit is responsible for legislative bill and regulation reviews, and also the research, analysis and resolution of FI contract compliance activities.

B. The On-Site Management Branch is responsible for the implementation of new and revised MMIS policy, MMIS deficiencies correction and documentation review.

• Medical Policy Branch

C. The Medical Policy Monitoring Branch is responsible for ensuring that medical and administrative policies developed by the Department are correctly implemented and applied by Computer Services Corp through its system edits/audits and claim examiner actions in the adjudication of claims.

• On-Site Management Branch

1. The Performance Analysis Section and Program Analysis Unit are responsible for monitoring the operational MMIS policy relating to accurate payments of claims and edit/audit reviews.

   The System Performance Analysis Unit is responsible for the monitoring of operational MMIS policy, edit/audits (shared function), claims cycle times, reports accuracy and timeliness, and the Provider, SUR and MAR Subsystems. This Unit is also responsible for program error reviews, utilization of compass-developed software, live claims testing, and review of the FI's quality control program.

   The Fiscal Analysis and Control Unit is responsible for the control and coordination of MMIS reviews and responding to claims payment-related audit findings, as well as for the accurate payment of claims (shared function), claim adjustment processing, problem identifier statement processing, and State Controller's Office error reviews.

2. The Change Implementation Section is responsible for ensuring proper implementation of MMIS changes, Systems Development Group management, and providing data processing support to the rest of the Division.

   The Data Processing Support Unit is responsible for divisionwide data processing support, and detailed technical data processing analysis of implemented MMIS policy.

MEDI-CAL OPERATIONS DIVISION

The Medi-Cal Operations Division covers three functional areas related to cost containment operations of the Medi-Cal program:

- Recovery Branch
- Field Services Branch
- Hospital Contracts Coordination Section

A. The Recovery Branch administers a program to collect money due the Medi-Cal program from Medicare and insurance companies, and to recoup debts due from health and casualty insurance companies, providers, and beneficiaries. Staff in the Recovery Branch make aggressive efforts in four major areas. The Health Insurance Unit seeks out and collects monies from private insurance carriers, self-insured entities, trust funds, and other related payors. The Casualty Insurance Unit seeks to collect monies due the Medi-Cal program from worker compensation carriers and related payors. The Compliance Unit collects monies due from program beneficiaries and providers of health care services or from their representatives. The Buy-In Unit attempts to maximize federal payments for services by identifying and paying premiums for persons eligible for Medicare, Part B insurance. Some of the responsibilities of these units are to detect and utilize health insurance assets, to develop a system of accounts receivable, to pursue debts from beneficiaries, to develop probate collection, to encourage, and then, assist the Federal Government in third-party asset detection and collection, and to define and recover provider overpayment. During the last fiscal year, this Branch was able to recover $31.1 million.

B. The Field Services Branch consists of 12 Medi-Cal field offices located throughout the State and a headquarters office. It is a highly cost-effective branch, granting authorization for payment of certain medically necessary services to Medi-Cal providers who, in turn, treat program beneficiaries. The field offices annually process 1.4 million requests for services to Medi-Cal beneficiaries. Related functions performed by this Branch include administering the State's Short-Doyle/Medi-Cal program which provides mental health services to county residents being treated in county-operated mental health facilities, performing on-site review of long-term care facilities to ensure their compliance with Medi-Cal regulations, and assuming the utilization control activities of professional standards review organizations in California.

C. The Hospital Contracts Coordination Section is responsible for coordination of the Department's management and monitoring of inpatient hospital contracts under the selective provider contracting program. This responsibility includes review of all proposed contracts and amendments serving as the contractors' focal point in the Department for problem resolution, investigation of incidents reported as a result of contracting, coordinating the Department's monitoring activities by other departmental units in a decentralized mode, reviewing contractors' beneficiary grievance procedures and patient questionnaires and providing staff support to the Department's liaison function with the California Medical Assistance Commission.

MEDI-CAL POLICY DIVISION

The Medi-Cal Policy Division serves as the central point for policy recommendations within the Department of Health Services, particularly policy formulation for the Medi-Cal program, and policy development and coordination.

The Division has three major branches as well as the Medi-Cal Planning and Medi-Cal Relations Units:

- Benefits Branch
- Medi-Cal Eligibility Branch
- Rate Development Branch
- Medi-Cal Planning Unit
- Medi-Cal Relations Unit

A. The Benefits Branch is responsible for policy development and recommendations regarding the scope, quality, and methods of providing Medi-Cal program benefits. As a major policy setting unit of the Medi-Cal program, the two sections comprising the Benefits Branch also develop and disseminate new program regulations governing providers, the claims processing contractor, and Medi-Cal field office consultants who must approve services which require prior authorization.

B. The Medi-Cal Eligibility Branch is responsible for assuring Medi-Cal eligibility criteria and determination rules are clear, complete, and in conformance with federal and state statutes and regulations; issuing eligibility rules, forms, and instructions to county welfare departments; assuring that eligibles receive their monthly Medi-Cal identification cards in a timely manner; ensuring accuracy in eligibility determinations; arranging for county and Social Security Administration reporting of eligibility data needed for provider claims payments, federal cost sharing, etc.; assuring that beneficiaries who have a share-of-cost meet their share-of-cost prior to receiving an identification card for that month; assuring that providers do not bill share-of-cost beneficiaries and the Medi-Cal program for the same services; and assuring the Medi-Cal eligibles have an opportunity to choose an organized health system form of health delivery when eligibility is determined.

C. The Rate Development Branch establishes the provider payment schedule for covered services; conducts rate studies, recommends rate adjustments consistent with rate studies, Medi-Cal program priorities, and General Fund budgetary resources; develops and implements systems to constrain the rate of increase of Medi-Cal hospital inpatient costs and reimbursement; evaluates proposed contracts negotiated with hospitals by the California Medical Assistance Commission and provides technical assistance in implementing such contracts; develops capitation rates for prepaid health and organized health systems and at-risk pilot and special projects; conveys payment policy to the fiscal intermediary and provides technical assistance to assure proper implementation of rate policy; develops evidentiary bases to support payment policy presented at regulatory public hearings; and provides expert testimony and technical support regarding litigation involving rates and rate policy.

D. The Medi-Cal Planning Unit is the Medi-Cal program's resource for planning and evaluating program changes and exploring newly emerging health issues that may impact the Medi-Cal program.

The Unit identifies and analyzes emerging systemwide health care delivery issues; defines and explores options for reforming or restructuring the Medi-Cal program; evaluates the impact of existing policy and changes to the Medi-Cal program; and prepares speeches, fact sheets, and briefings for the executive staff of the Department and the Health and Welfare Agency.

E. The Medi-Cal Relations Unit is the Department's public inquiry and response unit for the Medi-Cal program.

Inquiries originate from state and federal legislators, Medi-Cal beneficiaries and providers, their agents and representatives, the press, other agencies, and the general public. Inquiries relate to all areas of the Medi-Cal program, including benefits, eligibility, fraud and abuse, organized health systems, hospital contracting, treatment authorization, and billing.

Activities of the Unit include:

- Preparing responses to controlled and non-controlled correspondence which account for 80 percent of the Director's correspondence. Preparation includes researching beneficiary problems, working with program to resolve problems or develop comments and preparing draft responses.
- Responding to telephone inquiries, totalling over 1,500 per month.
- Responding to in-person beneficiary inquiries.

OFFICE OF CAPITATED HEALTH SYSTEMS

The Office of Cap. Hlth. Sys develops, promotes, and manages the State's financial interest in securing high-quality, cost-effective health care through organized health systems for Medi-Cal beneficiaries; initiates and operates new pilot projects; and conducts experiments, through federally funded research grants and/or waivers, with innovative approaches for improving or using organized health systems.

The Division is comprised of the following:

- Program Management Branch
- Program Development Branch

A. The Program Management Branch manages established contractual relationships with prepaid health plans, health maintenance organizations, and health insuring organizations; assists in resolving issues related to contract requirements, statutes, and audit findings; develops contract sanction processes and studies; resolves policy issues; and implements regulations.

1. The Division Support Section studies and implements policy on membership issues and other policy issues, develops contract language stemming from policy issues, develops and maintains the Division's Operations Manual, and maintains liaison with the Medi-Cal fee-for-service program.

2. The Contract Support Section maintains prepaid health plan data processing systems; processes enrollments, disenrollments, and complaints by enrollees in prepaid health plans; issues monthly capitation payments and adjustments; performs fiscal analysis of prepaid health plans; and monitors fiscal viability and security.

3. The Contract Operations Section manages existing prepaid and fiscal intermediary at-risk contracts; reviews and approves marketing member materials, grievances, disenrollments, and other systems; approves and coordinates all contract renewals and amendments; and tests and certifies enrollers of beneficiaries into the health plan.

B. The Program Development Branch promotes the development of cost-effective alternatives to the fee-for-service system, provides technical assistance to potential contractors, and implements appropriate quality assurance monitoring systems for organized health systems.

1. The Pilot Projects Section develops new prepaid health plans and pilot projects contracts for health delivery/payment systems that provide alternatives to the fee-for-service system, evaluates feasibility of pilot projects for quality and cost-effectiveness, and implements appropriate quality assurance monitoring systems.

2. The County Health Maintenance Organization Development Section develops county-government-sponsored models of health delivery/payment systems as a means to further Medi-Cal cost containment.

3. The Dental Contract Procurement Project is in the process of awarding a nonpilot contract for dental health care services on a competitive bid basis.

LICENSING AND CERTIFICATION DIVISION

The Licensing and Certification Division regulates, licenses, and certifies public and private health facilities throughout the State and enforces the Long-Term Care, Health Safety, and Security Act. These facilities include general acute and acute psychiatric hospitals, psychiatric health facilities, clinics (specialty and primary care), intermediate care facilities, intermediate care facilities-developmentally disabled, intermediate care facilities-developmentally disabled habilitative, skilled nursing facilities, home health agencies, referral agencies, adult day health care centers, chemical dependency recovery hospitals, and special hospitals.*

The Division has two branches:

- Policy and Support Branch
- Field Operations Branch

A. The general functions of the Policy and Support Branch are to administer the policy matters of health care programs (i.e., nursing homes, adult day health centers, acute care hospitals, etc.), and the fiscal, management, time reporting, contract coordination, and staff support services for the entire Division operations.

1. The Operations Support Section provides fiscal control and budget administration, management of the time reporting system, facilities information system, and general staff support for the Division.

2. The Policy Support Section establishes statewide program objectives, develops changes in program policies and procedures, and assists in developing the overall fiscal resources required to carry out the Division's responsibilities.

3. The Provider Participation Section coordinates the certification of institutional Medi-Cal providers.

B. The Field Operations Branch, through nine district and suboffices, carries out the health facilities licensing responsibilities of the Department by issuing licenses, maintaining the mandated standards of care through annual inspections, complaint investigations, and issuance of citations to long-term facilities. The Branch also provides to health facilities and their associations consultation and training designed to upgrade the care provided to patients.

C. Los Angeles County, via a contract, through the Northern, Eastern, Western, and San Gabriel Regional Offices, carries out the health facilities licensing responsibilities of the Department by issuing licenses, maintaining the standards of care through annual inspections, and complaint investigations.

To ensure adequate and safe care for patients and residents, the Division develops, implements, and enforces licensing regulations specific to each category of health care facility, clinics, and agency listed above. In addition to its licensing and enforcement responsibilities, the Division is responsible for conducting initial and annual certification surveys of all health care facilities, clinics, and agencies that are certified as providers of services under the Title XVII (Medicare) and/or Title XIX (Medi-Cal) programs.

AUDITS AND INVESTIGATIONS DIVISION

The Audits and Investigations Division includes functions that are concerned with Medi-Cal client and provider fraud and abuse, internal and external audits, and quality control.

This function operates independent of program operations and provides the public with a single locus for investigation of fraud and abuse and expresses the Director's commitment to deal firmly with such problems.

The Division consists of five major program elements:

- Investigations Branch
- Surveillance and Utilization Review Branch
- Multidiscipline Audits Branch
- Quality Control and Evaluation Branch
- Financial Audits Branch

A. The Investigations Branch is responsible for investigating alleged provider and beneficiary fraud in the Medi-Cal program. A full investigation is made of complaints concerning possible commission of a crime or a violation of a statute or regulation, particularly those violations that have potential for serious harm to a beneficiary, involve a significant amount of Medi-Cal or other funds, or show a repetitive pattern suggesting systematic abuse of the program. Investigations are conducted in full cooperation with law enforcement agencies. If fraud appears to exist, cases are referred to the Medi-Cal Fraud Unit in the Department of Justice for further investigation and possible prosecution.

B. The Surveillance and Utilization Review Branch performs postpayment reviews of services provided under the Medi-Cal program to identify unnecessary or inappropriate utilization and excess payments; assess the quality of care; recommend and initiate program; and administrative corrective action. These tasks are accomplished by licensed medical professionals assisted by technical, administrative, and clerical support staff.

C. The Multidiscipline Audits Branch conducts audits which integrate the review of both financial and medical operations of acute care hospitals and postpayment reviews of pharmacies participating in the Medi-Cal program.

The Multidiscipline Audits Sections—North and South—provide the only postpayment medical review capability within the Department for pharmacies and acute care institutions.

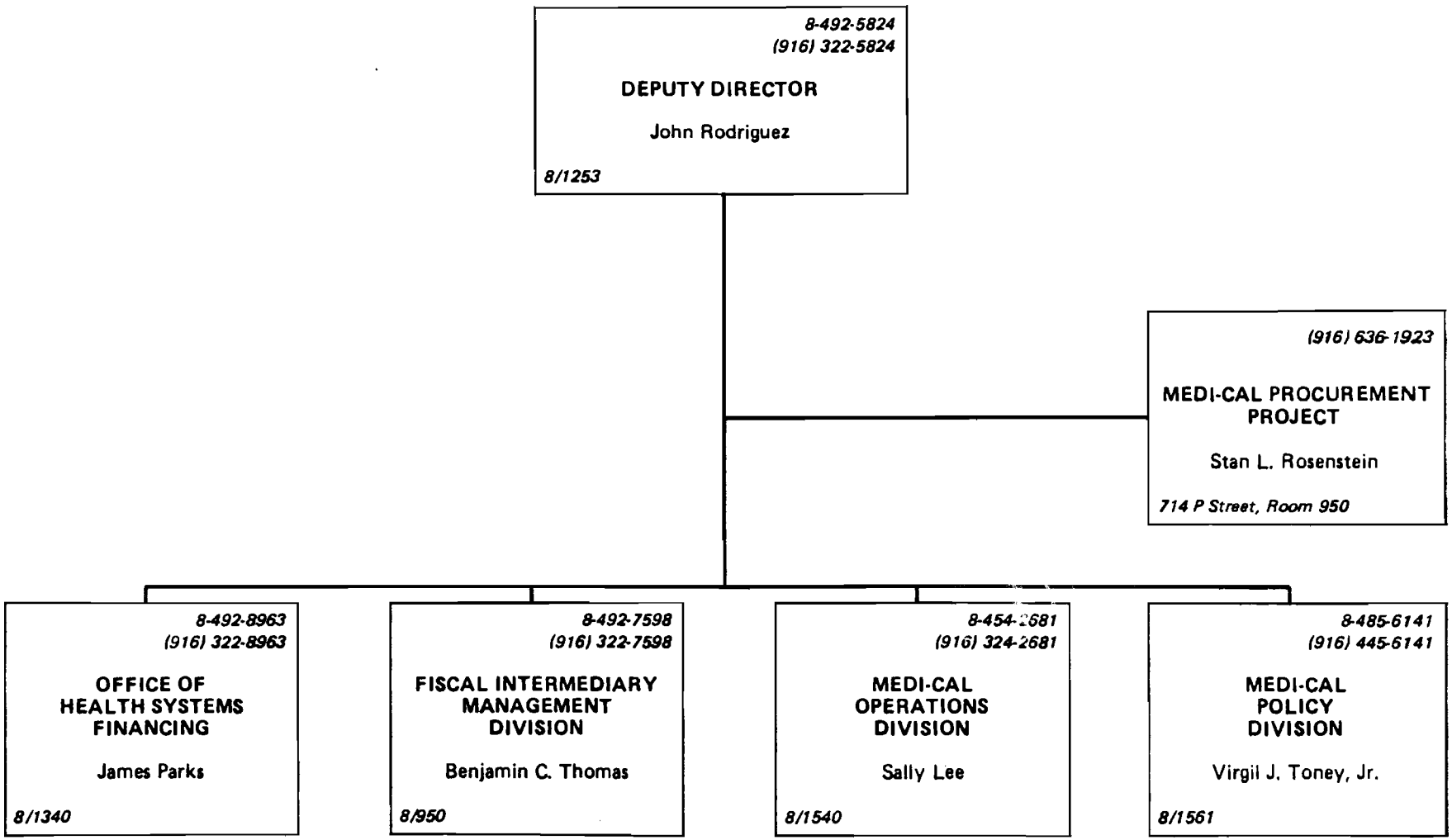
D. The Quality Control and Evaluation Branch element is responsible for conducting the federally required Medicaid Quality Control Program. A statistical sample of Medi-Cal eligibles is reviewed to test the validity of the eligibility/liability determinations, the claims payment process, and third-party liability/other health coverage collection activities. The purpose of this review is to provide Department management with valid estimates of misspent Medi-Cal expenditures and analysis of the major problem areas and causes.

E. The Financial Audits Branch is responsible for the fiscal, medical, and management audits of institutional providers under the Medi-Cal program and contract providers under public health programs. Other special reviews are conducted as requested by the Health and Welfare Agency, the Attorney General, and the Auditor General.

F. The State Controller's Office will perform audits of Medi-Cal expenditures on behalf of DHS and will submit its findings and recommendations to DHS for appropriate action.

12-B

CALIFORNIA DEPARTMENT OF HEALTH SERVICES
MEDICAL CARE SERVICES



John Rodriguez

November 1987

This April 1988 update is to provide current Department staff, address, and telephone changes.

CALIFORNIA
State

Content: A description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the program and their responsibilities.

INTRODUCTION

Professional medical personnel used in the administration of the program are contained in two Branches - Program Benefits Branch and Field Services Branch. These two Branches are discussed in detail below.

Benefits Branch

The professional medical personnel and supporting staff in this Branch are as follows:

TYPE	NUMBER
Medical Consultant (M.D.)	6
Dental Consultant (D.D.S.)	1
Pharmacy Consultant	4
Nurse Consultant II	1
Optometric Consultant II	1
Staff Services Manager	5
Health Program Manager	1
Associate Governmental Program Analyst	12
Staff Services Analyst	1
Clerical Staff	6

(See also attached organization chart)

The responsibilities of the professional medical and supporting staff of this Branch are: to develop and recommend medically sound policy and legislation relating to the scope, provision and payment for health care services; to determine that such recommendations are consistent with existing legislation and achieve the most economical use of funds while providing a benefit structure that corresponds to what is available to the general public and to ensure there is uniform and consistent interpretation and application of regulations and policies.

CALIFORNIA
State

Field Services Branch

The professional medical personnel and supporting staff in this branch are as follows:

TYPE	NUMBER
Field Office Administrators	13.0
Medical Consultant	56.0
Staff Svcs Mgr	2.0
Medi-Cal Technician	34.0
Nurse Consultant	1.0
Nurse Evaluator	153.0
Social Svcs Consultant	16.0
Audio and Speech Pathology Consultant	1.0
Pharmaceutical Consultant	8.0
Analyst	2.0
Clerical	145.0
TOTAL	431.0
Chief, Field Svcs Branch	1.0
Staff Svcs Mgr	2.0
Nurse Evaluator	2.0
Analyst	9.0
Clerical	6.0
TOTAL	20.0
TOTAL BRANCH STAFF	451.0

The primary responsibility of the Field Services staff (both professiona medical and support staff) is to insure that those health services which require prior authorization and/or medical review, are medically necessary and appropriate for the patient's medical needs before they are authorized for payment.

State: California

DESCRIPTION OF STAFF PERFORMING ELIGIBILITY DETERMINATIONS

Single State Agency

The Department of Health Services is the single state agency which supervises the administration of the Title XIX (Medicaid) program.

The Department of Social Services is the single state agency which supervises the administration of the Title IVA (AFDC) and Title IVE (Foster Care/Adoption Assistance) programs.

Determination of Eligibility

County welfare departments are the local agencies that make eligibility determinations for Title XIX IVA and IVE under the supervision of the Department of Health Services and the Department of Social Services, respectively.

Under the supervision of the Department of Social Services, county welfare departments make Title XIX eligibility determinations for the following groups:

1. Persons approved for Title IVA and IVE cash assistance;

2. Persons who would be approved for Title IVA cash assistance if the IVA payment level in California were as high as the Minimum Basic Standard of Adequate Care set by California statute;

3. Persons deemed recipients of AFDC pursuant to 42 CFR 435.115;

4. Families eligible under 42 CFR 435.112;

5. Qualified pregnant women under Section 1902(a)(10)(A)(2)(III) of the Act who receive a State-only funded AFDC payment;

6. Persons whose Title IVA cash assistance has been suspended for administrative reasons only;

7. Persons under 21 who meet all of the Title IVA or IVE requirements except for deprivation or court ordered foster care placement. (These persons receive a State-only funded payment.)

In accordance with the state-federal agreement created under Section 1634 of Title XVI of the Social Security Act, the Social Security Administration certifies Medicaid eligibility for California residents on the basis of eligibility for cash assistance under Title XVI of the Act. Persons so certified are:

1. Persons receiving Supplementary Security Income (SSI);

2. Persons receiving a California State Supplemental Payment (SSP) (this includes those receiving a mandatory SSP made pursuant to Section 212 of Public Law 93-66);

3. Persons whose SSI and/or SSP has been suspended for administrative reasons only.

4. Persons eligible under 1619(b) of the Act.

All Other Medicaid eligibility determinations are made by local county welfare departments under the supervision of the Department of Health Services.

State: California

A State qualified HMO is an organization which:

(a) Is organized under the laws of the State of California,
(b) Is in good standing with the Office of the Secretary of State,
(c) Is operated primarily for the purpose of providing health care services as defined by 42 CFR 434.20 (c) (1), and is either:
(1) certified by the Commissioner of Insurance as a non-profit hospital service plan or is exempt therefrom under the provisions of Section 740 of the Insurance Code, or
(2) licensed by the Department of Corporations under the provisions of the Knox-Keene Health Care Service Plan Act or is exempt therefrom and;
(a) provides three or more of the six federally mandated Medicaid services on an at-risk basis,
(b) to the extent feasible, contracts for a comprehensive array of Medi-Cal services, not federally mandated, on an at-risk basis, and
(c) provides, directly or through subcontract, all covered Medi-Cal services not specifically excluded by the contract (excluded services are accessed through the fee-for-service system)
(d) Meets the requirements of Section 1903 (m) (2) (A) (i)-(vii) of Title XIX of the Social Security Act as demonstrated by a contract with the State of California,
(e) Ensures that all providers and facilities employed by it will be properly licensed or certified by the appropriate agency and will be in good standing with the Medi-Cal and Medicare programs where appropriate,
(f) Assures beneficiary access to care equal to that of nonenrolled Medicaid recipients in the HMO service area in conformance with 42 CFR 434.20 (c) (2), and
(g) Makes provision, satisfactory to the State Medicaid agency, against risk of insolvency in conformance with 42 CFR 434.20 (c) (3) which protects beneficiaries against liability.

Revision: HCFA-PM-86-20 (BERC)
September 1986

ATTACHMENT 2.2-A
Page 1
OMB No.:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citations(s)	Groups Covered

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy

1931(b) of the Social Security Act

1. Families who meet the provisions specified in section 1931(b) of the Act relating to the approved AFDC State plan in effect on July 16, 1996

The July 16, 1996 approved State AFDC plan includes:

x Families with unemployed parents.

x Pregnant women with no other eligible children.

x AFDC children age 18 who are full-time students in secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments under the July 16, 1996 approved AFDC State plan are listed in Supplement 1, Page 1a, of Attachment 2.6-A.

1931(b) of the Social Security Act

2. Deemed Recipients of the approved AFDC State plan in effect on July 16, 1996

a. Individuals who would have been denied a title IV-A cash payment solely because the amount would be less than $10.

b. Participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program.

*Agency that determines eligibility for coverage.

TN No. 96-015
Supersedes
TN No. 88-13

Approval Date DEC 26 1996

Effective Date OCT 01 1996

State: California

Agency*	Citations(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy - Categorically Needy and Other Required Special Groups (Continued)
DSS		2. Deemed Recipients of AFDC.
	1902(a)(10)(A)(i)(I) of the Act	b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.
	402(a)(22)(A) of the Act	c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.
	406(h), 408(a)(11), 1902(a)(10)(A)(i)(I), and 1931(c) of the Act	d. An assistance unit treated under Section 1931(b)(1)(A) as receiving AFDC (as in effect on July 16, 1996) for a period of four calendar months because the family would become ineligible for such assistance as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
	1902(a) of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) (as in effect as of June 1, 1995) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

* Agency that determines eligibility for coverage.

State: California

Agency*	Citations(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy - Categorically Needy and Other Required Special Groups (Continued)

407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act

3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

x Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

DHS 408(a)(11), 1902(a)(52), 1931(c), and 1925 of the Act

4. Families treated [under Section 1931(b)(1)(A)] as receiving AFDC (as in effect on July 16, 1996) that would become ineligible for such assistance solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998).

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.113
DHS

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

   a. Families denied AFDC solely because of income and resources deemed to be available from--

      (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;

      (2) Grandparents;

      (3) Legal guardians; and

      (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

   b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

   c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.114
DHS

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

X Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

X Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

X Not applicable with respect to intermediate care facilities; State did or does not cover this service.

DHS
1902(a)(10)(A)(i)(III) and 1905(n) of the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

1902(a)(10)(A)(i)(III) and 1905(n) of the Act

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

X Children born after June 30, 1977
specify optional earlier date)
who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

DRAFT--DRAFT--DRAFT--DRAFT--DRAFT--DRAFT--DRAFT

Revision: HCFA-PM- (MB) ATTACHMENT 2.2-A
February Page 4a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(I)(IV) and 1902(l)(1)(A) and (B) of the Act	8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(I)(IV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A. X The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
	9. Children:
1902(a)(10)(A)(I)(VI) 1902(l)(1)(C) of the Act	a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.
1902(a)(10)(A)(I)(VII) and 1902(l)(1)(D) of the Act	b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels. X Children born after September 30, 1977 (specify optional earlier date) who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.

TN No. 97-016
Supersedes 93-001 Approval Date 2/14/98 Effective Date 3/1/98

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	10. RESERVED
1902(e)(5) of the Act DHS	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(e)(4) of the Act DHS	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
42 CFR 435.120 SSA	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance
	X a. Individuals receiving SSI.
	This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.
	X Aged X Blind X Disabled

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE **Mandatory Coverage - Categorically Needy and Other Required Special Groups** (Continued)

435.121

13. /7 b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

1619(b)(1) of the Act

___ Aged
___ Blind
___ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
DHS	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 14. Qualified severely impaired blind and disabled individuals under age 65, who-- a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must-- (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled; (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits; (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

DHS

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)		Groups Covered

PAGE NOT APPLICABLE

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1619(b)(3) of the Act	/_/	The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
DHS	1634(c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--
		a. Are at least 18 years of age;
		b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.
		☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.
		☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
DHS	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.
SSA	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131
DHS

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

/_/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

___ Aged ___ Blind ___ Disabled

/X/ Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.132
DHS

19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--

a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

b. Remain institutionalized; and

c. Continue to need institutional care.

42 CFR 435.133
DHS

20. Blind and disabled individuals who--

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

b. Were eligible for Medicaid in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.134

DHS

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

/X/ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

/X/ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

/X/ Not applicable with respect to intermediate care facilities; the State did not cover this service.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135
DHS

22. Individuals who --

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1634 of the Act
DHS

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equalling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

State/Territory: CALIFORNIA

Agency*	Citation(s)	Groups Covered
DHS	1634(d) of the Act	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A. ____ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program. ____ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in § 1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard. ____ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A. ____ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in § 1634(d)(1)(A) in determining the income of the individual

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10(E)(i) and 1905(p) of the Act	25. Qualified Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
	1902(a)(10)(E)(ii), 1905(s) and 1905(p)(3)(A)(i) of the Act	26. Qualified disabled and working individuals-- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

*Agency that determines eligibility for coverage.

State: CALIFORNIA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10(E)(iii) and 1905(p)(3)(A)(ii) of the Act	27. Specified low-income Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income for calendar years 1993 and 1994 exceeds the income level in 25. b., but is less than 110 percent of the Federal poverty level, and whose income for calendar years beginning 1995 is less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

*Agency that determines eligibility for coverage.

State: California

Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634(e) of the Act	28. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) shall be treated, for purposes of title XIX, as receiving SSI benefits for the month.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy

42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act

☐ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

PAGE NOT APPLICABLE

☐ The plan covers all individuals as described above.

☐ The plan covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Caretaker relatives
___ Pregnant women

42 CFR 435.211

☐ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage.

State: California

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508(section 4732)

[ ] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

_X_ The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is _ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

State: California

Agency*	Citation(s)	Groups Covered
1932(a)(4) of Act	B.	Optional Groups Other Than Medically Needy (continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

___ Disenrollment rights are restricted for a period of _____ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

_X_ No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act P.L. 101-508 42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

_X_ The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

State/Territory: CALIFORNIA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
DHS	42 CFR 435.217	X 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A)(ii)(VII) of the Act

☑ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☐ The State covers all individuals as described above.

☑ The State covers only the following group or groups of individuals:

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.220

☐ 6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

☐ The State covers all individuals as described above.

1902(a)(10)(A)(ii) and 1905(a) of the Act

☐ The State covers only the following group or groups of individuals:

___ Individuals under the age of--
- ___ 21
- ___ 20
- ___ 19
- ___ 18

___ Caretaker relatives

___ Pregnant women

42 CFR 435.222
1902(a)(10)(A)(ii) and 1905(a)(i) of the Act

7. ☐ a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below.

- ___ 20
- ___ 19
- ___ 18

State: California

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.222

/ b. Reasonable classifications of individuals described in (a) above, as follows:

___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

___ (a) In foster homes (and are under the age of _____).

___ (b) In private institutions (and are under the age of _____).

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of _____).

___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

__X__ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 22). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

_____ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VIII) of the Act
DHS

/X/ 8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

a. Was eligible for Medicaid under the State's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--

_X_ 21
___ 20
___ 19
___ 18

Agency*	Citation (s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.223 /_/

9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:

1902(a)(10)(A)(ii) and 1905(a) of the Act

___ Individuals under the age of--
___21
___20
___19
___18
___ Caretaker relatives
___ Pregnant women

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230
SSA

X 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

X (1) All aged individuals.

X (2) All blind individuals.

X (3) All disabled individuals.

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy (Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

42 CFR 435.230 ___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes.

_X_ No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230
435.121
1902(a)(10)
(A)(ii)(XI)
of the Act

/ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

California

Agency*	Citation(s)	Groups Covered
	1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act, P.L. 99 (Sections 9401(a) and (b))	X 13. The following individuals specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and infant or child and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

___ (a) Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy) and infants under one year of age (effective April 1, 1987);

___ (b) Children who have attained one year of age but not attained two years of age (effective October 1, 1987);

___ (c) Children who have attained two years of age but not attained three years of age (effective October 1, 1988);

___ (d) Children who have attained three years of age but not attained four years of age (effective October 1, 1989);

___ (e) Children who have attained four years of age but not attained five years of age (effective October 1, 1990).

___ (f) Children who have attained one year of age but not six years of age (effective April 1, 1990).

Infants and children covered under items 13(a) through (f) above who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continue to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

The payment levels under the approved State AFDC plan are no lower than the AFDC payment levels in effect under the approved AFDC plan on April 17, 1986.

/X/ Yes.

/ / Not applicable. The State does not provide coverage of this optional categorically needy group.

1902(a)(10)(A)(ii)(X) and 1902(m)(1) and (3) of the Act, P.L. 99-509 (Section 9402(a) and (b))

___ 14. In addition to individuals covered under item B.13, individuals—

(a) Who are 65 years of age or older or are disabled--

___ As determined under section 1614(a)(3) of the Act; or

___ As determined under more restrictive categorical eligibility criteria specified under item A.9(b) of this Attachment.

(b) Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal nonfarm income poverty line) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

(c) Whose resources do not exceed the maximum amount allowed—

___ Under SSI;

___ Under the State's more restrictive financial criteria; or

___ Under the State's medically needy program as specified in ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered
	1902 a)(47) and 1920 of the Act, P.L. 99-509 (Section 9407)	___ 15. Pregnant women who meet the applicable income levels for the categorically needy specified in this plan under ATTACHMENT 2.6-A who are determined eligible by a qualified provider during a presumptive eligibility period in accordance with section 1920 of the Act.

C. Optional Coverage of the Medically Needy

* Title XIX — 435.301

This plan includes the medically needy.

___ No.

X Yes. This plan covers:

1. Pregnant women who, except for income and resources, would be eligible as categorically needy.

*Agency that determines eligibility for coverage. *Title XIX - added per tel F. Manfucci 12/2/87

Agency* Citation(s) Groups Covered

PAGE NOT APPLICABLE B. Optional Groups Other Than the Medically Needy
(Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes

___ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231 ☐
1902(a)(10)(A)(ii)(V) of the Act

12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☐ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

1902(a)(10)(A)(ii) and 1905(a) of the Act

___ Aged
___ Blind
___ Disabled
___ Individuals under the age of--
  ___ 21
  ___ 20
  ___ 19
  ___ 18
___ Caretaker relatives
___ Pregnant women

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

B. Optional Groups Other Than the Medically Needy (Continued)

1902(e)(3) of the Act ☐ 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act ☐ 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and

b. Infants under one year of age.

STATE California

Agency*	Citations(s)	Groups Covered
	1902(a)(10)(E), 1902(m)(3), and 1905(p) of the Act, P.L. 100-360 (Section 301), P.L. 100-647 (Section 8434)	E. Mandatory Coverage - Qualified Medicare Beneficiaries and Qualified Disabled Working Individuals (1). Qualified Medicare Beneficiary: An individual -- a. Who is entitled to hospital insurance benefits under Medicare Part A; and b. Whose income does not exceed the income level established at an amount up to 90% of the Federal income poverty line, to be increased to 100% in 1991; and c. Whose resources do not exceed twice the SSI standard.
	1905(p)(3) of the Act, P.L. 100-360 (Section 301), P.L. 100-647 (Section 8434)	Medical assistance for those individuals in this group who are not also otherwise eligible for Medicaid is limited to cost sharing as defined in Section 1905 (p)(3) of the Act.
	1905(s) of the Act, P.L. 101-239 [Section 6408(d)]	(2) Qualified Disabled Working Individual: An individual --

* Agency that determines eligibility for coverage

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a) (10)(A) (ii)(IX) and 1902(l)(1)(D) of the Act

** /_/

15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size.

Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained--

/_/ 7 years of age; or

/_/ 8 years of age.

**Not applicable/obsolete

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a) ☒ (ii) (X) and 1902(m) (1) and (3) of the Act	16. Individuals – a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
PAGE NOT APPLICABLE	B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(47) and 1920 of the Act	___ 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.

State/Territory: CALIFORNIA

Citation	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act DHS	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.
1902(a)(10)(F) and 1902(u)(1) of the Act DHS	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid extenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.
1902 (a) (10) (A) (ii) (XII)	20. Individuals who are TB infected whose income and resources do not exceed a specified maximum amount for a disabled individual but who are not described in Section 1902 (a) (10) (A) (i) of the Act but would receive limited TB-related services.

DRAFT--DRAFT--DRAFT--DRAFT--DRAFT--DRAFT

Citation	Groups Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(XIV) of the Act

___ ~~19.~~ 21. Optional Targeted Low Income Children who

a. are not eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spenddown liability);

Not Applicable

b. would not be eligible for Medicaid under the policies in the State's Medicaid plan as in effect on April 15, 1997 (other than because of the age expansion provided for in §1902(l)(2)(D));

c. are not covered under a group health plan or other group health insurance (as such terms are defined in §2791 of the Public Health Service Act coverage) other than under a health insurance program in operation before July 1, 1997 offered by a State which receives no Federal funds for the program;

d. have family income at or below:

200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or

A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income level" (as defined in §2110(b)(4) of the Act) but by no more than 50 percentage points.

The State covers:

___ All children described above who are under age _____(18, 19) with family income at or below_____percent of

TN No. 97-16
Supersedes NONE

Approval Date 2/19/98 Effective Date 3/1/

State/Territory: California

Citation		Groups Covered
		B. Optional Coverage Other Than the Medically Needy (Continued) the federal poverty level (FPL). The following reasonable classifications of children described above who are under age ___(18,19) with family income at or below the percent of the FPL specified for the classification: (ADD NARRATIVE DESCRIPTION(S) OF THE REASONABLE CLASSIFICATION(S) AND THE PERCENT OF THE FEDERAL POVERTY LEVEL USED TO ESTABLISH ELIGIBILITY FOR EACH CLASSIFICATION.)
1902(e)(12) of the Act	X	22. A child under age 19 (not to exceed age 19) who has been determined eligible is deemed to be eligible for a total of 12 months (not to exceed 12 months) regardless of changes in circumstances other than attainment of the maximum age stated above.
1920A of the Act	X	23. Children under age 19 who are determined by a "qualified entity" (as defined in 1920A(b)(3)(A)) based on preliminary information, to meet the highest applicable income criteria specified in this plan. The Single Point of Entry clearinghouse

Citation		Groups Covered
		B. Optional Coverage Other Than the Medically Needy (Continued) for mail-in applications, California schools participating in the National School Lunch Program Medicaid Expansion and Child Health and Disability Prevention providers are designated as the only "Qualified Entities" to determine presumptive eligibility for children under 19. The presumptive period begins on the day that the determination is made. If an application for Medicaid is filed on the child's behalf by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on the day that the State agency makes a determination of eligibility based on that application. If an application is not filed on the child's behalf by the last day of the month following the month the determination of presumptive eligibility was made, the presumptive period ends on that last day.
1902(a)(10)(A)(ii)(XIII) of the Act	X	24. Working disabled individuals who meet the requirement of Section 1902(a)(10)(A)(ii)(XIII) who: (a) have net countable family income below 250 percent of the FPL (b) are disabled according to federal standards, and (c) except for earnings, the disabled individual must be eligible for benefits under the Supplemental Security Income/State Supplemental Program (SSI/SSP). The FPL for one is used if the individual is a child; if the applicant is unmarried; or the applicant is married but there is no income counted

State/Territory: California

Citation	Groups Covered		
	B. Optional Coverage Other Than the Medically Needy (Continued)		
			under spousal deeming. The FPL for two is used for a married applicant when there is income counted under spousal deeming. See Attachment 2.6-A, Page 12c for more liberal income and resource methodologies than those in the SSI program.
1902(a)(10)(A)(ii)(XV) of the Act		X 25	(a) adolescents who were on foster care under the responsibility of the state on their 18th birthday are eligible for Medicaid until their 21st birthday without regard to their income and resources. This applies to all such children, regardless of living arrangements and with whom they reside.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement

B. Optional Coverage Other Than the Medically Needy (continued)

1902 (a) (10) (A) (ii) (XVIII) of the Act

X 26. Individuals who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
B. Optional Coverage Other Than the Medically Needy (continued)	
1920B of the Act __X__	27. Individual who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a individual described in 1902 (aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the individual's eligibility for Medicaid, or if the individual does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301
DHS

This plan includes the medically needy.

/ No.

X Yes. This plan covers:

DHS

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act
DHS

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of the Act
DHS

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of the Act
DHS

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

42 CFR 435.308
DHS

5. /X/ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--

- X 21
- ___ 20
- ___ 19
- ___ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

/_/ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

___ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

___ (a) In foster homes (and are under the age of _____).

___ (b) In private institutions (and are under the age of _____).

Agency*	Citation(s)	Groups Covered

PAGE NOT APPLICABLE

C. Optional Coverage of Medically Needy (Continued)

___ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___ ___).

___ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

___ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

___ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

___ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

Agency*	Citation(s)	Groups Covered

DHS is the Agency for all Groupd covered on this page.

C. Optional Coverage of Medically Needy (Continued)

42 CFR 435.310 /X/ 6. Caretaker relatives.

42 CFR 435.320 and 435.330 /X/ 7. Aged individuals.

42 CFR 435.322 and 435.330 /X/ 8. Blind individuals.

42 CFR 435.324 and 435.330 /X/ 9. Disabled individuals.

42 CFR 435.326 // 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.

435.340 11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

Citation(s)	Groups Covered
	C. Optional Coverage of Medically Needy (Continued)
1906 of the Act DHS	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: _____ California

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18

PAGE NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home

PAGE NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.402	3. Is residing in the United States and--
	a. Is a citizen;
Sec. 245A of the Immigration and Nationality Act	b. Is an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law, as defined in 42 CFR 435.408;
1902(a) and 1903(v) of the Act and 245A(h)(3)(B) of the Immigration & Nationality Act	c. Is an alien granted lawful temporary resident status under section 245A and 210A of the Immigration and Nationality Act if the individual is aged, blind, or disabled as defined in section 1614(a)(1) of the Act, under 18 years of age or a Cuban/Haitian entrant as defined in section 501(e)(1) and (2)(A) of P.L. 96-422;

Citation	Condition or Requirement
	d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or
	e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).
42 CFR 435.403 1902(b) of the Act	4. Is a resident of the State, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.
	/X/ State has interstate compact and placement of children agreement with all States, the Virgin Islands, District of Columbia with the exception of Washington D.C. and New Jersey.
	/_/ State has open agreement(s).
	/_/ Not applicable; no residency requirement.

CITATION			CONDITION OR REQUIREMENT
42 CFR 435.1008	5.	a.	Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008		b.	Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. __X__ Applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are provided under the plan.
42 CFR 433.145 1912 of the Act	6.		Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

Citation	Condition or Requirement
	An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. /X/ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number) -- except for aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Social Security Act (Section 1137 (f)).

Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

Citation	Condition or Requirement

435.725
435.733
435.832

B. Post-Eligibility Treatment of Institutionalized Individuals

The following amounts are deducted from gross income when computing the application of an individual's or couple's income to the cost of institutional care:

1. Personal Needs Allowance.

a. Aged, blind, disabled--

Individuals $ 35.00**

Couples $ 70.00**

For the following individuals with greater need-- for individuals (and couples) with therapeutic wages, $35 ($70 for couples) plus an additional amount equal to either a) 70% of the gross wages; or b) 70% of the medically needy income level allowed for a non-institutionalized household of the same size, whichever is less.*

b. AFDC related--

Children $ 35.00

Adults $ 35.00

c. Individuals under age 21 covered in this plan as specified in Item B.7. of ATTACHMENT 2.2-A.
$ 35.00

435.725
435.733
435.832

2. For maintenance of the non-institutionalized spouse only. The amount must be based on a reasonable assessment of need but must not exceed the highest of --

SSI level $
SSP level $
Medically needy level $ 550.00
Other as follows $

*See Attachment 2.6-A, Page 4a.
**The full MNIL will be allowed as the amount of the PNA for individuals institutionalized for part of a month.

B. Institutionalized Individuals (1.)(a)(1). (con't)

. Therapeutic wages are defined as monies paid for work that is performed by a long-term care (LTC) beneficiary and which has been prescribed by the beneficiary's doctor in order to improve a condition of disability. The work must be performed at the facility in which the beneficiary resides.

. If both members of an institutionalized couple are earning therapeutic wages, the deduction will be applied to the combined gross wages of the two. If only one spouse of the couple is earning therapeutic wages, the deduction will apply only to the therapeutic wages.

State: CALIFORNIA

Citation	Condition or Requirement

1924 of the Act

3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which a maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924(d)(3)(C). The maintenance needs standard consists of a poverty level component plus any excess shelter allowance.

_____ The poverty level component is calculated using the applicable percentage (set out in §1924(d)(3)(B) of the Act) of the official poverty level.

_____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to the maximum maintenance needs standard).

X The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

In determining any excess shelter allowance, utility expenses are calculated using:

* the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or

* the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

X one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage

*Not applicable under California's Section 1924(d)(3)(c) election for the community spouse's monthly income allocation.

Citation	Condition or Requirement
	specified in §1924(d)(3)(B)) exceeds the dependent family member's monthly income.
	_____ a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1):

California adheres to the definition of dependency provided by the Secretary.

State: CALIFORNIA

Citation	Condition or Requirement

3. For children, each family member.

   AFDC level $_____
   Medically needy level $*(see footnote below)
   Other as follows $_____

4. Amounts for incurred medical expenses not subject to payment by a third party.

   a. Health insurance premiums, deductibles and co-insurance charges

   b. Necessary medical or remedial care not covered under the Medicaid plan (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

5. An amount for maintenance of a single individual's home for not longer than 6 months, if a physician has certified he or she is likely to return home within that period.

   X Yes. Amount for maintenance of home $ 200.00

   __ No.

1902(l) of the Act

6. SSI benefits paid under section 1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital or NF.

*For maintenance of family members when there is no community spouse, an amount which, when added to the countable income of the family member(s), equals their Medi-Cal medically needy maintenance need levels.

Citation	Condition or Requirement

7. Maintenance standards for community spouses and other dependent family members used to calculate monthly income allowances under Section 1924 of the Act.

   a. Community spouses

   ___1. A standard based on the formula contained in Section 1924(d) is used.

   _X_2. The maximum standard contained in Section 1924(d)(3)(C).

   ___3. A fixed standard which is greater than the minimum standard described in Section 1924(d) plus actual shelter costs not to exceed the maximum standard contained in Section 1924(d)(3)(C).
   The standard used is $_____.

   b. Other family members who are dependent

   _X_1. A standard based on the formula contained in Section 1924(d)(1)(C) is used.

   ___2. A fixed standard greater than the amount which would be used if the formula described in Section 1924(d)(1)(C) were used. The standard used is $_____.

   *___ c. The standards described above are used for individuals receiving home and community-based waiver services in lieu of services provided in a medical or remedial care institution.

   d. Definition of dependency

   The definition of dependency below is used to define dependent children, parents and siblings for purposes of deducing allowances under Section 1924.

   "Dependency" is defined as IRS dependency for federal tax purposes.

* California does not apply the provisions of Section 1924 of the Act to any of its home and community-based service waiver programs, except for the Mentally Retarded and Developmentally Disabled program (#0129.91.01).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

State: CALIFORNIA

Citation	Condition or Requirement
___	Supplement 2 to ATTACHMENT 2.6-A specifies the resou levels for mandatory and optional categorically needy pove level related groups, and for medically needy groups.
___	Supplement 7 to ATTACHMENT 2.6-A specifies the income lev for categorically needy aged, blind and disabled persons are covered under requirements more restrictive than SS
___	Supplement 4 to ATTACHMENT 2.6-A specifies the methods determining income eligibility used by States that have mo restrictive methods than SSI, permitted under section 1902 of the Act.
___	Supplement 5 to ATTACHMENT 2.6-A specifies the methods f determining resource eligibility used by States that ha more restrictive methods than SSI, permitted under secti 1902(f) of the Act.
X	Supplement 8a to ATTACHMENT 2.6-A specifies the methods f determining income eligibility used by States that are mo liberal than the methods of the cash assistance program permitted under section 1902(r)(2) of the Act.
X	Supplement 8b to ATTACHMENT 2.6-A specifies the methods f determining resource eligibility used by States that are mo liberal than the methods of the cash assistance program permitted under section 1902(r)(2) of the Act.
X	Supplement 14 to ATTACHMENT 2.6-A specifies income leve used by States for determining eligibility of Tuberculosi infected individuals whose eligibility is determined und §1902(z)(1) of the Act.

Citation	Condition or Requirement
	c. In determining countable income for blind individuals, the following disregards are applied: X The disregards of the SSI program. __ The disregards of the State supplementary payment program, as follows: __ The disregards of the SSI program, except for the following restrictions applied under the provisions of section 1902(f) of the Act.
435.721 435.831 and 1902(m)(1)(B) and (m) (4) of the Act, P.L. 99-509 (Sec. 9402(a) and (b))	d. In determining countable income for disabled individuals, the following disregards are applied: X The disregards of the SSI program. For the Medically Needy, the Agency applies disregards as specified in Supplement 3 to Attachment 2.6-A, in addition to items 1b, c and d. For the A&D FPL Program under 1902(a)(10)(A)(ii)(X), rules more liberal than the SSI rules are listed on Supplement 8a to Attachment 2.6A, page 6.

Citation	Condition or Requirement
	____ The disregard of the State supplemental payment program, as follows:
	____ The disregard of the SSI program, except for the following restrictions applied under the provision of section 1902(f) of the Act.
	For the Medically Needy, the Agency applies disregards as specified in Supplement 3 to Attachment 2.6-A in addition to items 1 b, c and d.
1902(l)(3)(E) and 1902(r)(2) of the Act	e. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV, (VI), and (VII) and 1902(a)(10)(A)(ii)(IX) of the Act --
	(1) The following methods are used in determining countable income: the methods of the approved AFDC plan except those specified on page 3 of Supplement 8a for Attachment 2.6-A.
1902(e)(6) of the Act	(2) The agency continues to treat women eligible under the plan as an individual described in section 1902(a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to any changes in income of the family of which she is a member, until the end of the month in which the 60 day period (beginning on the last day of her pregnancy) ends.

Citation		Condition or Requirement
1905(p)(1)(C) and (m)(5)(B) of the Act, P.L. 99-509 (Secs. 9403(b) and (f)	f.	In determination countable income for qualified Medicare beneficiaries covered under section 1902(a)(10(E) of the Act, the following disregards are applied: __X__ The disregards of the SSI program; Unless a beneficiary is eligible by applying the same methods and standards used for any other ABD-MN. See Supplements 3 and 5 to Attachment 2.6.-A _____ The disregards of the State supplementary payment program, as follows: _____ The disregards of the SSI program except for the following restriction, applied under the provisions of section 1902(f) of the Act.

Supplement 1 to ATTACHMENT 2.6-A specifies for non-1902(f) and 1902(f) States the income levels for optional categorically needy groups of individuals with incomes up to the Federal nonfarm income poverty line--pregnant women and infants or children covered under section 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act--and for optional groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E) of the Act.

Supplement 7 to ATTACHMENT 2.6-A specifies for 1902(f) States the income levels for categorically needy, aged, blind and disabled persons who are covered under requirements more restrictive than SSI.

Citation	Condition or Requirement
1902(k) of the Act, P.L. 99-272 (Section 9506) and P.L. 99-509 (Section 9435(c))	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. ___ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act, P.L. 97-248 (Section 137)	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.
435.732 435.831	4. Handling of Excess Income - Spend-down for Medically Needy (All States) and Categorically Needy (1902(f) States) a. Medically Needy (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures

Citation	Condition or Requirement

available income for a period of 1 (one) month~~s~~ (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.

(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

(a) Health insurance premiums, deductibles and coinsurance charges.

(b) Expenses for necessary medical and remedial care not included in the plan.

(c) Expenses for necessary medical and remedial care included in the plan.

___ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

b. Categorically Needy - Section 1902 (f) States

435.732

___ The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:

(1) Any SSI benefit received.

(2) Any optional State supplement received.

(3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section.

Citation	Condition or Requirement

(4) Other deductions from income applied under the Medicaid plan.

(5) Required incurred medical and remedial services.

5. Resource Exemption - Categorically and Medically Needy

** a. Except as specified in item C.5.e. below, in determining countable resources for AFDC related individuals, the disregards and exemptions in the State's approved AFDC plan are applied.

1902(a)(10) and 1902(m)(1)(C) of the Act P.L. 97-248 (Section 137) and P.L. 99-509 (Section 9402) 1902(r)(2) of the Act

b. In determining countable resources for aged individuals, the following disregards are applied:

**X The disregards of the SSI program.

____ The disregards of the SSI program, except for the following restrictions applied under the provisions of Section 1902(f) of the Act:

c. In determining countable resources for blind individuals, the following disregards are applied:

1902(r)(2) of the Act

**X The disregards of the SSI program.

____ The disregards of the SSI program, except for the following restrictions applied under the provisions of Section 1902(f) of the Act:

**See SUPPLEMENT 8b TO ATTACHMENT 2.6-A for methodologies more liberal than SSI. and/or AFDC.

Citation		Condition or Requirement
		If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g.	(1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act		(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

* U.S. G.P.O.:1993-342-239:80032

Citation	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: _____ The disregards of the SSI program; _____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XIII) of the Act	(i) Working Disabled Who Buy In to Medicaid In determining countable income and resources for working disabled individuals who buy into Medicaid, the following methodologies are applied: ___ The methodologies of the SSI program. ___ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. X The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6A. pg 5. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6A pg 6. X The agency requires individuals to pay premiums or other cost-sharing charges. The premiums or other cost-sharing charges, and how they are applied, are described on Attachment 2.6-A Page 12d. Each individual eligible for the 250 Percent Working Disabled Program will pay a monthly sliding-scale premium based on countable income. A minimum payment of $20 and a maximum payment of $250 per eligible individual or $375 per eligible couple are required. The agency will be responsible for collection of such premiums.

State/Territory: _____

Citation	Condition or Requirement

1902(a)(10)(A)
(ii)(XIII) of the Act

Description of how premiums are applied:

Net Countable Income		Amount of Premium For One Eligible Individual	Amount of Premium For Two Eligible Individuals
From	To		
$1	$600 *	$20	$30
$601 (MNL for one + $1	$700	$25	$40
$701	$900	$50	$75
$901	$1,100	$75	$100
$1,101	$1,300	$100	$150
$1,301	$1,500	$125	$200
$1,501	$1,700	$150	$225
$1,701	$1,900	$175	$275
$1,901	$2,100	$200	$300
$2,101	250 Percent of the federal poverty level (FPL) for two (for year 2000 - $2,344)	$250	$375

* This amount is the maintenance need income level (MNL) for one under the Medically Needy (MN) program.

State: CALIFORNIA

Citation	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. _x_ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1917 of the Act	2a. Trusts established on or after August 11, 1993, shall be treated in accordance with Section 1917 of the Act.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only a. Medically Needy (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of 1 month(s) to determine the amount of excess countable income applicable to the cost of medical care and services. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. ___ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	4.a. Medically Needy (Continued)
1903(f)(2) of the Act	___ (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

PAGE NOT APPLICABLE

State/Territory California

Citation	Condition or Requirement
	Medically Needy (continued)
1902(a)(17) 435.831(g)(2) 436.831(g)(2)	States are permitted to exclude from incurred medical expenses those bills for services furnished more than three months before a Medicaid Application
	_X_ Yes, the State elects to exclude such expenses.
	____ No, the State does not elect to exclude such expenses.

Citation	Condition or Requirement
	4. b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732 PAGE NOT APPLICABLE	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	4.b. Categorically Needy - Section 1902(f) States Continued
1903(f)(2) of the Act	___ (6) Spenddown payments made to the State by the individual.
PAGE NOT APPLICABLE	NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

Citation	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

/X/ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation	Condition or Requirement

5. Methods for Determining Resources

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act

b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:

___ The methods of the SSI program.

X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ___ The methods of the SSI program. X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: CALIFORNIA

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the SSI program. X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act. The agency uses the following methods in the treatment of resources. ___ The methods of the SSI program only. ___ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

State: CALIFORNIA

Citation	Condition or Requirement
	___ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.
	The agency uses the following methods for the treatment of resources:
	___ The methods of the State's approved AFDC plan.
	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(l)(3)(C) of the Act	
1902(r)(2) of the Act	X Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	X Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g.	1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A. X Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A. ___ Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3)(C) of the Act		
1902(r)(2) of the Act		

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g.	2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan. 1902(l)(3)(C) the Act ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A. 1902(r)(2) of the Act X Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A. ___ Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State/Territory: CALIFORNIA

Citation	Condition or Requirement
1905(p)(1)(C) and (D) and 1902(r)(2) of the Act	5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. _Y_ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. ___ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

___ Same as SSI resource standards.

___ More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

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

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citations(s)	Condition or Requirement
1902(l)(3)(A) (B) and (C) of the Act.	c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan. X No. The agency does not apply a resource standard to these individuals
1902(l)(3)(A) and (C) of the Act	d. For children covered under the provisions of section 1902(a)(10)(A)(I)(VI) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard applied in t State's approved AFDC. X No. The agency does not apply a resource standard to these individuals
1902(l)(3)(A) and (D) of the Act	e. For children covered under the provisions of section 1902(a)(10)(A)(I)(VII) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFD X No. The agency does not apply a resource standard to these individuals.

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ___ Same as SSI resource standards. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

PAGE NOT APPLICABLE

State: CALIFORNIA

Citation	Condition or Requirement
	7. Resource Standard - Medically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(i) of the Act	b. A single standard is employed in determining resource eligibility for all groups.
	___ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--
	___ Aged ___ Blind ___ Disabled
	Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.
1905(p)(1)(D) and (p)(2)(B) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act and specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, the resource standard is twice the SSI standard.
1905(s) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

Citation		Condition or Requirement
1902(u) of the Act	9.1	For COBRA continuation beneficiaries, the resource standard is:
	___	Twice the SSI resource standard for an individual.
	___	More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only __X__ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

Citation	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

X Aged, blind, disabled.
X AFDC-related.
**

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied..

X Aged, blind, disabled.
X AFDC-related.
**

** ALL OTHER GROUPS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)		Condition or Requirement
1920(b)(1) of the Act	X	(3) For a presumptive eligibility period for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902(e)(8) and 1905(a) of the Act	X	b. For qualified Medicare beneficiaries defined in Section 1905(p)(1) of the Act; coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under Section 1905(p)(1). The eligibility determination is valid for-- X 12 months ___ 6 months ___ ___ months (no less than 6 months and no more than 12 months)

State/Territory CALIFORNIA

Citation	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	12. Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to ATTACHMENT 2.6-A.
1917 of the Act	12a. Transfer of assets (income and resources) occurring on or after August 11, 1993 shall be treated in accordance with Section 1917 of the Act.
1924 of the Act	13. The agency complies with the provisions of Section 1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources protected for community spouses in initial eligibility determinations, the State standard for community spouses is -- __X__ the maximum standard permitted under law; ____ the minimum standard permitted by law; or ____ a standard that is an amount between the minimum and the maximum. The amount is (specify amount or how it is calculated).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

Family Size	Need Standard	Payment Standard	Maximum Payment Amounts
Family Size	Need Standard	Payment Standard	Maximum Payment Amounts
1	$ 345	$ 307	$ 307
2	567	504	504
3	703	624	624
4	834	743	743
5	952	847	847
6	1070	952	952
7	1175	1045	1045
8	1281	1139	1139
9	1388	1230	1230
10	1508	1322	1322
More than 10	Add $14 for each additional person	1322	1322

2. For pregnant women and infants under Section 1902 (a)(10)(i)(IV) of the Act (infants under one year of age) the income eligibility level is 185 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

SUPPLEMENT 1 to
ATTACHMENT 2.6A
Page 1a

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

2.a Section 1931(b) Group

To determine eligibility under Section 1931(b), the income standards in the approved AFDC program in effect as of July 16, 1996 will be used.

TN No. 96-015
Supersedes
TN No.

Approval Date DEC 26 1996

Effective Date OCT 01 1996

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

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1977 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

PAGE NOT APPLICABLE

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(ii)(IX) and 1902(l)(2) of the Act are as follows:

Based on _____ percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).

Family Size	Income Level
1	$_____
2	$_____
3	$_____
4	$_____
5	$_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. Children Between Ages 6 and 8

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained 6 years of age but are under 8 years of age under the provisions of section 1902(l)(2) of the Act are as follows:

Based on _____ percent (no more than 100 percent) of the official Federal income poverty line.

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$
6	$
7	$
8	$
9	$
10	$

*THIS GROUP OBSOLETE.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA
INCOME ELIGIBILITY LEVELS (Continued)
Aged and Disabled individuals

1. The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of Section 1902(m)(3) of the Act are as follows:

   - Family size is defined for purposes of eligibility for the Aged and Disabled program as either one or two persons.
   - Income levels are established by family size in accordance with 100% of the Federal Poverty Income Guidelines published in the Federal Register.

FAMILY SIZE	INCOME LEVEL
1	$ XXXX
2	$ XXXX

If an individual receives a Title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a Title II COLA is not counted as income during a "transition period" beginning with January, when the Title II benefit for December is received, and ending the last day of the month following the month of publication of the revised annual federal poverty levels.

For individuals with Title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving Title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

C. OTHER OPTIONAL CATERGORICALLY NEEDY GROUPS

1. For TB-infected individuals described in Section 1902(z) of the Act, SSI break-even point will be used in determining income eligibility.

2. For the 250 Percent Working Disabled Program as defined in Section 1902(a)(10)(A)(iii)(XIII) of the Act, when determining whether net countable family income less than 250 percent of the federal poverty level (FPL), the FPL, as revised annually in the Federal Register is used.

OMB No.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

D. INCOME LEVELS – MEDICALLY NEEDY

X Applicable to all groups

_____ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level protected for maintenance ☐ urban only ☒ urban & rural	(3) Income Disregards (see Supplement 8a to Attachment 2.6A, page 7)	(4) Effective MNL for MN Program	(5)
1	$ 517	$ 83	$ 600.00	$
2	$ 642	$ 108	$ 750.00	$
2 Adults	$ 800**	$ 134	$ 934.00	$
3	$ 800	$ 134	$ 934.00	$
4	$ 950	$ 150	$ 1100.00	$
5	$ 1075	$ 184	$ 1259.00	$
6	$ 1209	$ 208	$ 1417.00	$
7	$ 1334	$ 216	$ 1550.00	$
8	$ 1450	$ 242	$ 1692.00	$
9	$ 1567	$ 258	$ 1825.00	$
10	$ 1684	$ 275	$ 1959.00	$
For each additional person, add:	$	$	$ 14.00	$

** This Maintenance Need Level applies only when at least one of the adults is aged, blind, or disabled.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

RESOURCE LEVELS FOR THE MEDICALLY NEEDY

X Applicable to all Groups , except Qualified Medicare Beneficiaries

____ Applicable to all groups except those specified below under the provisions of section 1902(f) of the Act.

FAMILY SIZE	RESOURCE LEVELS				
	1985	1986	1987	1988	1989 and later
1	1,600	1,700	1,800	1,900	2,000
2	2,400	2,550	2,700	2,850	3,000
3	2,550	2,700	2,850	3,000	3,150
4	2,700	2,850	3,000	3,150	3,300
5	2,850	3,000	3,150	3,300	3,450
6	3,000	3,150	3,300	3,450	3,600
7	3,150	3,300	3,450	3,600	3,750
8	3,300	3,450	3,600	3,750	3,900
9	3,450	3,600	3,750	3,900	4,050
10	3,600	3,750	3,900	4,050	4,200

* Applicable to Qualified Medicare Beneficiaries

Resource levels for qualified Medicare beneficiaries are twice the amounts stated above.

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

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOME RELATED TO FEDER POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

☐ Same as SSI resource levels.

☒ Resources are waived pursuant to Section 1902(l)(3).
See attachment 2.6a Page 21.

☐ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

b. Optional Groups

SECTION NOT APPLICABLE

☐ Same as SSI resource levels.

☐ Resources are waived pursuant to Section 1902(l)(3).
See attached 2.6a Page 21.

☐ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

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

2. Infants

a. Mandatory Group of Infants

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10 and above	

☒ Resources are waived pursuant to Section 1902(l)(3). See attachment 2.6a Page 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

PAGE NOT APPLICABLE

b. Optional Group of Infants

/_/ Same as resource levels in the State's approved AFDC plan.

/_/ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

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

2. Children

a. Mandatory Group of Children under Section 1902(a)(1)(I)(VI) of the Act. (Children have attained age 1 but have not attained age 6.)

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10 and above	

☒ Resources are waived pursuant to Section 1902(l)(3). See attachment 2.6a Page

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

b. Mandatory Group of Children under Section 1902(a)(1)(I)(VII) of the Act.
(Children born after September 30, 1977 who have attained age 6 but have not attained age 19.)

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10 and above	

☒ Resources are waived pursuant to Section 1902(l)(3). See attachment 2 6a Page 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

4. Aged and Disabled Individuals

PAGE NOT APPLICABLE

/_/ Same as SSI resource levels.

/_/ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

/_/ Same as medically needy resource levels (applicable only if State has a medically needy program)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

/_/ Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	$ 2,000
2	3,000
3	3,150
4	3,300
5	3,450
6	3,600
7	3,750
8	3,900
9	4,050
10 and above	4,200

Supplement 3 to Attachment 2.6A — Financial Eligibility - Income Disregards

Effective January 1, 1988

State of California

Aged, Blind and Disabled -- Medically Needy Individuals

The agency uses the same income disregards as used in SSI except as follows:

Income which must, by court order or by agreement with a district attorney (DA), be used to pay spousal or child support is held to be unavailable to meet the current needs of ABD-MN applicants and beneficiaries. In these cases the lower of 1) the amount ordered by the court or the DA agreement, or 2) the amount actually paid is deducted from the reported income.

TN No. 88-9
Supersedes
TN No. 85-8

Approval Date NOV 30 1988 Effective Date: JAN 01 1988

88-9

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

PAGE NOT APPLICABLE

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

PAGE NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

PAGE NOT APPLICABLE

Revision HCFA-AT-

SUPPLEMENT 6 TO
Attachment 2.6-A

State: California

Standards for Optional State Supplementary Payments

Payment Category (Reasonable Classification)	Administered by		Income Level				Income Disregarded Employed
			Gross		Net		
	Federal	State	1 person	Couple	1 person	Couple	
(1)	(2)		(3)		(4)		(5)
1. Aged/disabled independent living arrangement	X		1,020.00	2,040..	560.00	1,039.00	SSI
2. Blind independent living arrangement	X		1,020.00	2,040.00	627.00	1,221.00	SSI
3. Aged/disabled in household of another	X		680.01	1,360.02	446.67	869.00	SSI
4. Blind in household of another	X		680.01	1,360.02	513.67	1,051.00	SSI
5. Aged/disabled independent living arrangement without cooking facilities	X		1,020.00	2,040.00	620.00	1,160.00	SSI
6. Aged, blind, disabled in non-medical board and care	X		1,020.00	2,040.00	632.00	1,264.00	SSI
7. Disabled minor	X		1,020.00	N/A	444.00	N/A	SSI

TN # 87-02
Supersedes
TN # 86-04

Approval Date JUL 31 1987

Effective Date JAN 01 1987

California State Plan Amendment 82-16A

Attachment (Parental Responsibility) 2.6A (Supplement 7)

The effective date of this change is October 1, 1982 with all cases to be converted when a review of such cases can be completed.

82-16A 10-1-82
9-30-82
4/16/83 EFF

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

PAGE NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

PAGE NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME THAT DIFFER FROM THAT OF AFDC

As permitted under Section 1902(r)(2), the annual Title II Social Security cost of living increase will be disregarded until April 1 of the year it is effective for those pregnant women, infants, and children who receive benefits under 1902(a)(10)(A)(i)(IV,VI, and VII) and 1902(l)(1) of the Act.

As permitted under Section 1902(r)(2), in determining eligibility for those pregnant women and infants who receive benefits under 1902(a)(10)(A)(i)(IV) and 1902(l)(1) of the Act, an income deduction will be allowed which is the difference between 200 percent and 185 percent of the federal poverty level for the size of the family involved.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFERS FROM THOSE OF THE SSI AND AFDC PROGRAM
(Less Restrictive Than SSI and AFDC)

Covered Group: TB-infected individuals covered under Section 1902(a)(10)(A)(ii)(XII).

Income Methodology:

1. Net nonexempt income rather than gross income will be tested against the TB income standard addressed in 1902(a)(10)(A)(ii)(IX). Deductions allowed as ABD-Medically Needy individual will be applied.

2. Inkind support and maintenance as provided under the SSI program will not be included in the definition of income.

3. There will be no deeming from spouse to spouse. There will be deeming from parent to child.

Income Standards: This income standard, the SSI break-even point, represents the maximum amount of monthly income a TB-infected individual described in Section 1902(z) may have and still meet the financial requirements for Medicaid. This standard should then be compared to the net nonexempt income in determining eligibility. THERE IS NO INCOME STANDARD FOR A COUPLE. If both members are TB-infected, the prospective income of each will be compared to the income standard for an individual.

TN No. 94-012
Supersedes: NONE

Approval Date 4/25/96
Effective Date 10/1/94

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGY FOR TREATMENT OF INCOME
THAT DIFFERS FROM THOSE OF THE SSI AND AFDC PROGRAM
(Less Restrictive Than SSI and AFDC)

As permitted under Section 1902(r)(2), in determining eligibility for qualified children under Section 1902(a)(10)(A)(i)(III), an income deduction which is the difference between the child's foster care rate and the income requirement of the State Plan under Part A of Title IV (AFDC) will be allowed. This deduction applies to non-Title IV-E Foster Care children.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME THAT DIFFERS FROM THOSE OF THE SS/ AND AFDC PROGRAM
(Less Restrictive Than SSI and AFDC)

Citation	Condition or Requirement
1902(a)(10)(A)(i)(IV)	For pregnant women under the provisions of Section 1902(a)(10)(A)(i)(IV) (1) As permitted under Section 1902(r)(2), no income will be deemed to a pregnant woman from the pregnant woman's parents.

PD

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME THAT DIFFERS FROM THOSE OF THE SSI PROGRAM
(Less Restrictive Than SSI and AFDC)

1902(a)(10)(A)(ii)(XIII) of the Act	For the working disabled covered under the provisions of Section 1902(a)(10)(A)(ii)(XIII) of the Act.
	(1) As permitted under Section 1902 (r)(2); all disability income of the disabled individual is exempted (e.g., federal and state disability income and private disability income such as an indemnity payment from an insurance company based on the individual's disability).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI AND AFDC PROGRAM (Less Restrictive Than SSI and AFDC)

1902(a)(10)(A)(ii)(X) of the Act	Countable income, as determined in accordance with Section 1902(m) of the Act, does not exceed an income standard equal to 100 percent of federal poverty level for 1 or 2 persons. As permitted under Section 1902(r)(2) an income disregard of $230 for an individual or in a case of a couple a $310 income disregard. If such disregards are not sufficient to result in an effective income level equal to the SSI/SSP payment level for a disabled individual or, in the case of a couple, the SSI/SSP payment level for a disabled couple, then an income disregard sufficient to achieve that result. Including a deduction, equal to the Medically-Needy maintenance need level for the number of ineligible members in the family budget unit. Please refer to Supplement 1 to Attachment 2.6-A, page 6 for Medically Needy maintenance need levels.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE SSI OR AFDC PROGRAM
(More Liberal Than SSI or AFDC)

An income disregard applicable to the Medically Needy (MN) program (established pursuant to Sections 1902(a)(10)(C), 1902(r)(2), and 1905(a) of the Social Security Act) which is more liberal than those of the most closely related cash assistance program (the former AFDC program for AFDC-MN families and the SSI/SSP cash assistance program for ABD-MN individuals) is listed below. Included in this listing is a declaration as to whether the listed more-liberal income disregard replaces an existing AFDC or SSI program disregard.

1. A set of income disregards (see table below), dependent on family size, that, when added to the maximum income standard for the Medically Needy (MN) program permitted under Section 1903(f) of the Social Security Act (and based on 133 percent of the federally approved Maximum Aid Payment for the former AFDC program in place as of July 16, 1996) produces the effective income standards (listed on page 6 of Supplement 1 to Attachment 2.6-A) for the Medically Needy program. This set of income disregards does not replace any income disregard of the SSI program or of the former AFDC program.

MNL INCOME DISREGARD TABLE *
(MNL Disregard Amount Shown In Column 2)

Number of Family Members	**Size of MNL Income Disregard** (Authorized under 42 CFR 435.1007(e) & (f))	MN Income Std. Limit Per Sec. 1903(f)(3) of the SSA and 42 CFR 435.1007(b)-(d)	Effective MNL for MN Program
1	**83**	517	600
2	**108**	642	750
2 Adults	**134**	800	934
3	**134**	800	934
4	**150**	950	1100
5	**184**	1075	1259
6	**208**	1209	1417
7	**216**	1334	1550
8	**242**	1450	1692
9	**258**	1567	1825
10	**275**	1684	1959

* Effective MNLs for Medically Needy program enumerated on page 6, Supplement 1 to Attachment 2.6A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE SUPPLEMENTAL SECURITY INCOME (SSI)
PROGRAM OR THE AFDC PROGRAM
AS IT EXISTED ON JULY 16, 1996
(Less Restrictive Than SSI and AFDC)

In-home caregiver wages paid to a household member shall be exempt when both of the following conditions are met:

1) The caregiver is being paid for providing the in-home care to his/her spouse or minor child living in the home, and

2) The spouse or minor child is receiving those in-home services through any federal, state or local government program.

Payments made by the California Department of Social Services to an in-home care recipient for the purpose of purchasing in-home care services, including restaurant meals, shall be exempt.

These exemptions shall apply to the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- 1902(a)(10)(A)(i)(III)
- 1902(a)(10)(A)(i)(IV)
- 1902(a)(10)(A)(i)(VI)
- 1902(a)(10)(A)(i)(VII)
- 1902(a)(10)(A)(ii)
- 1902(a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM OR THE AFDC PROGRAM AS IT EXISTED ON JULY 16, 1996

(Less restrictive than SSI or AFDC)

As permitted under Section 1902(r)(2), in determining eligibility for the following coverage groups, State funded benefit payments under the State's Kinship Guardianship Assistance Payment Program (also known as Kinship Guardianship Assistance Payment Program – Enhanced) shall be exempt.

These coverage groups are:

1902(a)(10)(A)(i)(III)
1902(a)(10)(A)(i)(IV)
1902(a)(10)(A)(i)(VI)
1902(a)(10)(A)(i)(VII)
1902(a)(10)(A)(ii)
1902(a)(10)(C)(i)(III)
1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE SSI OR AFDC PROGRAM AS IT
EXISTED ON JULY 16, 1996

(More Liberal Than SSI or AFDC)

The following disregard is applicable to the Medi-Cal coverage groups listed below:

Income Disregard: All wages paid by the Census Bureau to an individual for his/her temporary employment related to 2008 Census Dress Rehearsal activities are disregarded as income to that individual.

Listed Coverage Groups:

1902(a)(10)(A)(i)(III)
1902(a)(10)(A)(i)(IV)
1902(a)(10)(A)(i)(VI)
1902(a)(10)(A)(i)(VII)
1902(a)(10)(A)(ii)
1902(a)(10)(C)(i)(III)
1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM
(More Liberal Than SSI)

A resource disregard is given to an individual who has purchased a precertified long-term care insurance policy or health care service plan contract which covers long-term care and has used such policy or plan to pay for services.

Services which the individual receives and are paid for by the precertified long-term care insurance policy or health care service plan contract, which covers long-term care, must not be delivered by a member of the individual's family, unless:

- The family member is a regular employee of an organization which is providing the services; and
- The organization receives the payment for the services: and
- The family member receives no compensation other than the normal compensation for employees in his or her job category.

The amount of the disregard is equal to the lesser of the following amounts:

- the amount of payments made for services by the insurance policy; or
- the actual charge for the services.

Such disregard is in effect for the lifetime of the individual. The disregard is also allowed if a Medicaid application is filed on behalf of a deceased individual for payment of costs for care and services received by the individual during his or her lifetime.

The disregard of resources is allowed for aged, blind and disabled individuals who are otherwise eligible and:

A. Medically Needy [1902(a)(10)(C)(i)(III)], or

B. Optional Categorically Needy [1902(a)(10)(A)(ii)], except those who are included in Section 1902 (a)(10)(A)(ii) (VIII), 1902(a)(10)(A)(ii)(XI) and 1902 (a)(10)(A)(ii)(IV) who are receiving Supplemental Security Income Payments under Title XVI or a State Supplemental Payment, or

C. Who are Qualified Medicare Beneficiaries [1905 (p)].

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI AND AFDC PROGRAM
(More Liberal Than SSI and AFDC As It Existed On July 16, 1996)

All of the following shall be disregarded in determining eligibility in their entirety and shall not be applied against a single $1500 limit:

(1) All of the following burial related funds:

(a) The first $1500 paid for clearly designated burial funds such as burial insurance policies with cash surrender values, revocable burial trusts, revocable burial contracts, or other revocable burial arrangements.

(b) Irrevocable burial trusts or irrevocable burial contracts, or other irrevocable burial arrangements.

(c) Burial insurance policies without cash surrender values.

(2) Life insurance policies on the life of any individual in the family shall be exempt if the combined face value of all of the policies on the insured individual is $1500 or less.

(3) All dividends and interest that accrue to and are not removed from the burial fund or policy described in (1) or (2).

The disregard of life insurance policies and burial related funds is allowed for all applicants and recipients who are otherwise eligible under California's State Plan and who are also a member of one of the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI)
- (a)(10)(A)(i)(VII)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

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

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI AND AFDC PROGRAM
(Less Restrictive Than SSI and AFDC)

The treatment of resources under the Medi-Cal Tuberculosis (TB) program shall be determined as follows:

The TB resource limit for an unmarried individual is $2,000.

If the TB beneficiary is an individual residing with a spouse, each individual would have a resource limit of $2,000. Consider each individual's separate property and half of community property. THERE IS NO RESOURCE LIMIT FOR A COUPLE.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES THAT DIFFERS FROM THOSE OF THE SSI AND AFDC PROGRAM
(Less Restrictive Than SSI and AFDC)

Citation	Condition or Requirement
1902(a)(10)(A)(i)(IV)	e. For pregnant women under the provisions of Section 1902(a)(10)(A)(i)(IV) (1) As permitted under Section 1902(r)(2), no resources will be deemed to a pregnant woman from the pregnant woman's parents.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI AND AFDC PROGRAM
(More Liberal Than SSI and AFDC)

A resource disregard would be allowed equal to the amount of incurred medical bills that are unpaid in the month where there are excess resources for the entire month,

- only when payment of those medical bills occurs in a later month, and
- verification of payment is provided.

This disregard would be allowed no earlier than the month of application (may not be one of the three months prior to the month of application).

The requirements listed above would have to be met before eligibility is granted for the month throughout which the excess resources existed.

This disregard would apply only to individuals who have excess resources for the entire month but who are otherwise eligible in that month under California's State Plan and who are also a member of one of the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI)
- (a)(10)(A)(i)(VII)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES THAT DIFFER FROM THOSE OF THE SSI AND AFDC PROGRAM
(More Liberal Than SSI and AFDC)

Japanese Reparation payments made by the Canadian government shall be exempt from consideration in determining eligibility for Medi-Cal.

Japanese Reparation payments, whether made by the United States or Canadian governments shall be exempt if received by the spouse or inherited from the spouse who was the original recipient, or both.

Where Japanese Reparation payments, whether made by the United States or Canadian governments, are converted to another form, amounts of otherwise excess, nonexempt resources sufficient to ensure that the amount of the exemption equals the amount of the reparation payments received by the individual or inherited by the spouse of the individual, or both, shall not be considered as resources in determining eligibility for Medi-Cal.

These exemptions shall apply to the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI)
- (a)(10)(A)(i)(VII)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES THAT DIFFERS FROM THOSE OF THE SSI PROGRAM
(Less Restrictive Than SSI and AFDC As it Existed on July 16, 1996)

Under the optional coverage group 1902(a)(10)(A)(ii)(XIII) of the Act, all retirement arrangements of the disabled individual are exempt (i.e., resoures in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI OR AFDC PROGRAM
(More Liberal Than SSI or AFDC)

In considering all of the various items of resources where the SSI program and the AFDC program have differing methodologies, the State shall follow the methodology of the least restrictive of either the SSI program or the AFDC program.

- The general rules contained in the paragraph above shall apply to determine the resource methodologies employed in consideration of all resource items unless a more specific methodology for a specific resource item is otherwise set forth and included in the State plan.

The above paragraphs apply to the resources of all applicants and recipients who are otherwise eligible under California's State Plan and who are also a member of one of the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI)
- (a)(10)(A)(i)(VII) (effective 7/1/91)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI OR AFDC PROGRAM
(More Liberal Than SSI or AFDC)

The principal residence shall not be considered as a resource if any of the following circumstances exist (this is in addition to the reasons specified by the SSI program and the AFDC program):

- if a child under the age of 21 lives on the property, or
- if a dependent relative lives on the property, (for this purpose only, a disabled child age 21 or over shall be considered a dependent relative),
- if a sibling or child age 21 or over of the applicant or beneficiary has continuously resided on the property for at least one year immediately prior to the date the applicant or beneficiary entered a skilled nursing facility or intermediate care facility and continues to reside there, or
- if the property cannot be readily converted to cash but a bona fide effort is being made to sell the property. A bona fide effort to sell means that the property is listed for sale with a licensed real estate broker for its fair market value established by a qualified real estate appraiser, a good faith effort is being made to sell the property, offers at fair market value are accepted, and the applicant or beneficiary has supplied proof of compliance with these conditions to the county.

The above paragraphs apply to all applicants and recipients who are otherwise eligible under California's State Plan and who are also a member of one of the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI)
- (a)(10)(A)(i)(VII) (effective 7/1/91)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI OR AFDC PROGRAM
(More Liberal Than SSI or AFDC)

The value of resources shall be disregarded when there is a bona fide, good faith effort being made to sell or liquidate the resource. The value of the resource shall be disregarded for as long as the bona fide good faith effort to sell or liquidate continues to be made. This methodology is essentially the same as the methodology applied to resources being sold or liquidated in the eligibility determinations of the SSI and AFDC program, however, since there is no conditional eligibility in the Medicaid program, the applicant/beneficiary shall not be required to sign, as a condition of eligibility, a statement agreeing to make repayment upon the sale of the property.

The above paragraph applies to all applicants and recipients who are otherwise eligible under California's State Plan and who are also a member of one of the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI) (effective 4/1/90)
- (a)(10)(A)(i)(VII) (effective 7/1/91)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI OR AFDC PROGRAM
(More Liberal Than SSI or AFDC)

One motor vehicle per budget unit shall be exempt regardless of value or use.

The above paragraph applies to all applicants and recipients who are otherwise eligible under California's State Plan and who are also a member of one of the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI) (effective 4/1/90)
- (a)(10)(A)(i)(VII) (effective 7/1/91)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITILE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SSI PROGRAM AND
THE AFDC PROGRAM AS IT EXISTED ON JULY 16, 1996
(More Liberal Than SSI or AFDC)

Excludable restitution payments made to a holocaust victim or his or her heirs or beneficiaries shall be considered an exempt resource for the purpose of determining eligibility to receive Medi-Cal benefits or the amounts of those benefits.

A "holocaust victim" is a person who was persecuted by Nazi Germany, any other Axis regime, or any other Nazi-controlled or Nazi-allied country:

(1) on the basis of race, religion, physical or mental disability, or sexual orientation;
(2) during any period before, during or after.

An "excludable restitution payment" is any payment or distribution, recovered or returned asset or property, received directly by a holocaust victim or heirs or beneficiaries of a holocaust victim:

(1) as compensation pursuant to the German Act Regulating Unresolved Property Claims, as amended (Gesetz zur Regelung offener Vermogensfragen);
(2) as a result of a settlement of claims against any entity or individual for any recovered asset. A "recovered asset" is any asset of any type, including any bank deposits, insurance proceeds, artwork, or interest earned on any of these assets, owned by a holocaust victim, withheld from that holocaust victim or his or her heirs or beneficiaries and recovered, returned or otherwise compensated to the holocaust victim or his or her heirs or beneficiaries;

(3) as a payment or restitution provided by law, or by a fund, established by any foreign country, the United States of America, or any other foreign or domestic entity, or as a result of a final resolution of a legal action;
(4) as a direct or indirect return of, or compensation or reparation for, assets stolen or hidden from, or otherwise lost to, the individual before, during or immediately after World War II, including any insurance proceeds under policies issued on the individual by European insurance companies immediately before and during World War II; or
(5) as interest, payable as part of any payment or distribution described in the paragraph.

These exemptions shall apply to the following coverage groups referenced in the Social Security Act at Section 1902r(2):

- (a)(10)(A)(i)(III)
- (a)(10)(A)(i)(IV)
- (a)(10)(A)(i)(VI)
- (a)(10)(A)(i)(VII) (effective 7/1/91)
- (a)(10)(A)(ii)
- (a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE SUPPLEMENTAL SECURITY INCOME (SSI)
PROGRAM OR THE AFDC PROGRAM
AS IT EXISTED ON JULY 16, 1996
(Less Restrictive Than SSI and AFDC)

In-home caregiver wages paid to a household member shall be exempt when both of the following conditions are met:

1) The caregiver is being paid for providing the in-home care to his/her spouse or minor child living in the home, and

2) The spouse or minor child is receiving those in-home services through any federal, state or local government program.

Payments made by the California Department of Social Services to an in-home care recipient for the purpose of purchasing in-home care services, including restaurant meals, shall be exempt.

These exemptions shall apply to the following coverage groups referenced in the Social Security Act at Section 1902(r)(2):

- 1902(a)(10)(A)(i)(III)
- 1902(a)(10)(A)(i)(IV)
- 1902(a)(10)(A)(i)(VI)
- 1902(a)(10)(A)(i)(VII)
- 1902(a)(10)(A)(ii)
- 1902(a)(10)(C)(i)(III)
- 1905(p)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in section 1917(c) of the Social Security Act (Act).

1. Transfer of resources by an institutionalized individual or spouse.

a. /x/ The agency follows the procedure as specified in Section 1917(c) of the Social Security Act which provides for a period of ineligibility for nursing facility services or a nursing facility level of care in a medical institution or home and community based waiver services for institutionalized individuals where resources were transferred for less than fair market value.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

b. /X/ The period of ineligibility is less than 30 months, as specified below:

When the period, as calculated in accordance with 1917(c) doesn't last the entire 30 months.

c. /X/ The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

2. Transfer of the home of an individual who is an inpatient in a medical institution or nursing facility.

/x/ A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for a maximum of 30 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 30 months of care in a nursing facility, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in a nursing facility) to the uncompensated value of the home as follows:

The uncompensated value is divided by the average private pay rate for nursing facilities in the State of California.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

b. /x/ Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 30 months of care in a nursing facility, the period of ineligibility is no more than 30 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in a nursing facility) to the uncompensated value of the home as follows:

The uncompensated value is divided by the average private pay rate of nursing facilities in the State of California. In accordance with 1917(c) of the Social Security Act, the period of ineligibility is limited to 30 months beginning with the date of transfer.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

No institutionalized individual is ineligible by reason of item A.2 if--any of the exceptions listed in 1917(c)(2)(A)-(D) of the Social Security Act apply.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that--

(A) the resources transferred were a home and title to the home was transferred to--

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual, or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the resources were transferred (i) to or from (or to another for the sole benefit of) the individual's spouse, or as defined in section 1924(h)(2),(ii) to the individual's child described in subparagraph (A)(ii)(II);

(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

(D) the State determines that denial of eligibility would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

3. 1902(f) States

___ Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

TRANSFER OF ASSETS (INCOME AND RESOURCES)

1917 of the Act

Transfers of assets occurring on or after August 11, 1993, shall be treated in accordance with Section 1917 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

CONSIDERATION OF MEDICAID QUALIFYING TRUSTS--UNDUE HARDSHIP

1902(k)(4) of the Act, P.L. 99-272 (Section 9506)

The following criteria will be used to determine whether the agency will not count the funds in a trust as specified in ATTACHMENT 2.6-A, section C.2., because it would work an undue hardship for categorically and medically needy individuals:

Delete this page from California's State Plan as it was erroneously submitted on approved SPA #91-02.

State/Territory: CALIFORNIA

Citation	Condition or Requirement

COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

1902(u) of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

___ The methodology as described in SMM section 3598.

___ Another cost-effective methodology as described below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under Section 1931 of the Act as follows:

California covers families and children who meet the "linkage" requirements of California's AFDC State Plan effective July, 16, 1996, or as described in this Plan; and who meet the financial eligibility requirements for the Section 1931 program, and who meet the other non-financial eligibility requirements of the Section 1931 program.

The following groups were included in the AFDC State Plan effective July 16, 1996:

__X__ Pregnant women with no other eligible children.

__X__ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational school or technical training.

__X__ Parents, and other caretaker relatives, of deprived children.

_____ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996. without modification.

__X__ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996. with the following modifications.

_____ The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

_____ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

_____ The agency applies lower resource standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

_____ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

__X__ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

See Supplement 12a to Attachment 2.6-A for less restrictive income methodologies.
See Supplement 12b to Attachment 2.6-A for less restrictive resource methodologies.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

See Supplement 12a and Supplement 12b to Attachment 2.6-A.

_____ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

__X__ The agency continues to apply the following waivers of provisions of Part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

The following Title IV-A waivers affecting Medi-Cal will be continued to be applied until further notice, as permitted under Public Law 104-1294.

1. 100-Hour Rule

This waiver was submitted as part of the California Department of Social Services California Work Pays Demonstration Project. This waiver continues the disregard of the 100-hour rule in determining deprivation based on unemployment for beneficiaries under Section 1931. This is a waiver of Section 402(a)(41) of the Social Security Act and Sections 233.100(a)(1)(i) and 233.1000(c)(1)(iii) of Tile 45, Code of Federal Regulations. This waiver is in effect statewide.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE AFDC PROGRAM AS IT EXISTED ON JULY 16, 1996
(More Liberal Than AFDC)

Effective January 1, 1998, in determining eligibility for Medicaid under Section 1931, Title XIX of the Social Security Act, the agency uses the AFDC income methodologies in effect as of July 16, 1996, except where the agency has adopted more liberal income methodologies. These more liberal methodologies are listed below (none of the methodologies listed below will result in an Section 1931 income exclusion which is more restrictive than its AFDC counterpart):

1. Applicants and Recipients: All income in excess of the AFDC 185% gross income test is disregarded for purposes of that test.*

2. Applicants and Recipients: An income disregard for families containing one or more members who receive cash assistance from the TANF or SSI/SSP which is equal to the amount of the difference between the cash assistance payment the family member(s) would have received if she/he were the only person in the family with income, and the cash assistance payment she/he receives.*

3. Applicants and Recipients: For purposes of determining net self-employment income, the individual gets a either a 40 percent deduction from their business revenue or the AFDC self-employment deductions, whichever is to their advantage.

4. Applicants and recipients: An exemption for the following payments made by California's TANF Program (CalWORKS): cash assistance payments, "diversion" payments, and payments for the "Special Needs" of the family.*

5. Recipients ~~only:~~ A disregard equal to the amount that California's TANF program's (CalWORKS) highest Minimum Basic Standard of Adequate Care (MBSAC) levels appropriate for the size of the family exceeds the July 16, 1996 AFDC Maximum Aid Payment (MAP) appropriate for the size of the family. Effective 8/99, until the current highest CalWORKS MAP is higher than the 7/99 highest CalWORKS MBSAC , the 7/99 highest CalWORKS MBSAC will be used in place of the current highest CalWORKS MBSAC in the preceding sentence. After that point, a disregard equal to the amount that highest CalWORKS MAP levels appropriate for the size of the family exceeds the July 16, 1996 MAP appropriate for the size of the family.**

6. Applicant and Recipients: a disregard of $240 against the disability-based unearned income of the Medi-Cal Family Budget Unit (MFBU).

7. Recipients: One of the following disregards, whichever is more advantageous.

   a. A disregard of any unused part of the $240 from paragraph #6 against the combined earnings of the two highest earners in the family; an additional $120 is disregarded from the earnings of each additional member of the family; then a disregard of 50% is deducted from each individual's remaining earnings. This disregard replaces the AFDC $30 and 1/3 deduction and the AFDC $90 deduction for recipients.

   Or

   b. In lieu of the income disregard in paragraph #5 and #7a, a disregard equal to the amount by which the federal poverty level (FPL) appropriate for the size of the family exceeds the July 16, 1996 MAP appropriate for the size of the family. (This disregard is added to the July 16, 1996 AFDC MAP to create an "effective" income limit equal to the Federal Poverty Level.)[1] ~~Recipients using this disregard also get the $90 AFDC earned income disregard.)~~ If more advantageous than the disregard in #5, a

8. Applicants: ~~A~~ disregard equal to the amount by which the federal poverty level (FPL) appropriate for the size of the family exceeds the July 16, 1996 MAP appropriate for the size of the family. (This disregard is added to the July 16, 1996 AFDC MAP to create an "effective" income limit equal to the Federal Poverty Level.)

9. Applicants and Recipients: Effective January 1, 2001, an income disregard for the months of January, February, and March, equal to the COLA increase in the Social Security RSDI payment to the individual. *

* Note: These income exclusions do not replace any AFDC income exclusions.

**This income deduction, when added to the July 16, 1996 AFDC income standard will produce an effective Section 1931 income limit, called the CalWORKs MBSAC-based income limit, equal to the highest CalWORKs MBSAC. After July 1999, the Section 1931 (CalWORKs MBSAC-based) income limit utilizing this disregard is "frozen". The Section 1931 CalWORKs MBSAC-based income limit will remain frozen until the CalWORKs MAP-based income limit is higher. Then the Section 1931 CalWORKs -based income limit will be based on the CalWORKs MAP. Prior to March 1, 2000, this disregard was also available to applicants.

[1] Effective March 1, 2000, recipients are income eligible for the Section 1931 program if they can pass either of two income tests. Under one test, a recipient is income eligible if his/her countable income, from which the $240 and ½ deduction (described in paragraph 7) has been subtracted, is less than the CalWORKs-based income limit. Under the other test, a recipient is income eligible if his/her countable income, from which the AFDC $90 earned income deduction (in lieu of the $240 and ½ deduction) has been subtracted, is less than the FPL income limit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON JULY 16, 1996

10. Income Disregard: All wages paid by the Census Bureau to an individual for his/her temporary employment related to 2008 Census Dress Rehearsal activities are disregarded as income to that individual.*

*Note: This income exclusion does not replace any AFDC income exclusion.

Supplement 12a to Attachment 2.6A, Page 4 is NOT included in the CA State Plan

Per CMS (KW 5/23/08)

METHODOLOGIES FOR TREATMENT OF INCOME THAT ARE LESS RESTRICTIVE THAN THOSE OF THE AFDC PROGRAM AS IT EXISTED ON JULY 16, 1996
(More Liberal Methodologies)

A. The Section 1931 program uses the income disregards of the AFDC program as of July 16, 1996 except as follows (cont.):

11. For the period starting the first of January of each year, and extending through the last day of March of such year, a disregard from the family's Social Security Retirement, Survivors, and Disability Income (RSDI) income equal to the amount of the increase in such income resulting from the application of the annual Social Security cost-of-living-adjustment (COLA) to the family's current RSDI income.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON JULY 16, 1996
(Less Restrictive Than AFDC)

In-home caregiver wages paid to a household member shall be exempt when both of the following conditions are met:

1) The caregiver is being paid for providing the in-home care to his/her spouse or minor child living in the home, and

2) The spouse or minor child is receiving those in-home services through any federal, state or local government program.

Payments made by the California Department of Social Services to an in-home care recipient for the purpose of purchasing in-home care services, including restaurant meals, shall be exempt.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF INCOME
THAT DIFFER FROM THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON JULY 16, 1996

State funded benefit payments under the State's Kinship Guardianship Assistance Payment Program (also known as Kinship Guardianship Assistance Payment Program – Enhanced) shall be exempt.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON ~~JUNE 16, 1996~~ July 16, 1996 PJD
(More Liberal Than AFDC)

Otherwise countable resources equal the difference between the amount permitted under the former AFDC program and $3,000 shall be exempt in determining eligibility for one individual. For larger sized families, this exemption shall equal the difference between the amount permitted under the former AFDC program and the amount listed by family size in the Appendix to Supplement 12b to Attachment 2.6-A, page 10.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT ARE NO MORE RESTRICTIVE THAN THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON ~~JUNE 16, 1996~~ July 16, 1996 PJO
(Same As or More Liberal Than AFDC)

The value of nonexempt personal property (other than real property), when determining eligibility for individuals or families who are applying for or are eligible under Section 1931 shall be fair market value minus encumbrances.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT ARE NO MORE RESTRICTIVE THAN THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON ~~JUNE 16, 1996~~ July 16, 1996 PJO
(The Same As Or More Liberal Than AFDC)

50491. Treatment of Property Under the Section 1931(b) Program. The property of Medi-Cal Family Budget Unit (MFBU) members applying for Medi-Cal under the Section 1931(b) program shall be treated in accordance with Article 9 as amended, (see Appendix 1 of Supplement 12b to Attachment 2.6A) with the following exceptions.

(a) Whenever determining or redetermining the eligibility of an MFBU under the Section 1931(b) program, counties shall complete the form "Property Reserve Work Sheet - Section 1931(b) Program" and retain a copy in the case record.

(b) The following sections of Article 9 shall not apply.

50402	50413	50421.5	50449	50463	50483
50408	50416	50423	50453	50465	50485
50409	50417	50425	50453.5	50467	50489
50410	50418	50426	50454.5	50469	50489.1
50411	50420.5	50427	50456	50471	50489.5
50412	50421	50428	50457	50473	50489.9
		50441	50461	50475	

(c) Notes, mortgages, deeds of trust, installment contracts and agreements (even where real property is held as security until the purchase price has been paid) shall be considered personal property. The portion of the payments which represent interest shall be considered to be income in the month of receipt and the portion of the payments which represent principal shall be considered property.

(d) The separate and community property share of real or personal property owned by a stepparent who is not an applicant or beneficiary shall be exempt.

(e) The exclusive personal property of a child who does not receive Medi-Cal under the Section 1931 program shall be exempt when determining eligibility for the MFBU under the Section 1931 program.

(f) The total value of all real or personal property in which an MFBU member has an ownership interest, (property which is either owned separately by the MFBU member or jointly with the SSI/SSP recipient), and which is considered in determining the eligibility of the SSI/SSP recipient shall be exempt.

(g) Real and personal property, including property held in trust, transferred to a trust, and income produced and retained by the trust, is considered to be available if a member of the MFBU has the legal right, power and authority to liquidate the property and to use the proceeds. Available property, unless otherwise exempt, shall be valued in accordance with this section and shall be included in the property reserve. Property which is not available shall not be included in the property reserve.

(1) Property, other than real property, owned jointly with someone outside of the MFBU shall be considered available in its entirety to the owner in the MFBU, unless it can be demonstrated that such property is inaccessible to the owner in the MFBU or that the source and amount of funds invested in the property or the facts around the inheritance, if it was acquired in this way, must be determined in order to arrive at the share which the applicant/beneficiary and/or his/her spouse actually owns. If the owner in the MFBU can demonstrate that he/she actually owns or has access to only a portion of the property, only the value of that portion of the property shall be included in the property reserve. The property shall be considered totally inaccessible to the owner in the MFBU if the property cannot practically be subdivided and the owner's access to the value of the property is dependent on the agreement of a joint owner who refuses to comply. Property cannot be practically subdivided if the financial value of the proportionate share would be significantly reduced by sale of only the subdivision.

(2) Personal property of a woman who is temporarily residing in a shelter for battered women and children shall be considered unavailable if:

(A) the property is jointly owned by the resident and member(s) of the former household from which the resident fled, and

(B) the resident's access to such property requires the consent of both the resident and the member(s) of the former household.

(3) Real property, not otherwise exempt, that the owner is making a good faith effort to sell shall be considered unavailable and shall not be included in the property reserve for one period per parcel of no more than nine months. If the owner elects not to sell the property at any time prior to the expiration of the nine months, the property shall no longer be considered unavailable and the net market value shall be included in the property reserve.

(A) For purposes of subsection (3) above, a good faith effort is made when, at a minimum, either:

(I) The owner lists the property for sale with a licensed real estate broker at the property's approximate fair market value and is willing to negotiate the terms of the sale with potential buyers, or

(II) The owner makes an individual effort to sell the property by doing all of the following:

(i) Advertising once a week in at least one publication of general circulation that the property is for sale.

(ii) Placing a sign on the property indicating that the property is for sale. Whenever possible, the sign shall be visible from the street.

(iii) Offering the property for sale at its approximate fair market value.

(iv) Is willing to negotiate the terms of the sale with potential buyers and respond to all reasonable inquiries about the property.

(B) For purposes of subsection (3) the fair market value of the property shall be the applicant's/beneficiary's choice of:

(I) The assessed value of the property or

(II) A valuation of the market value of the property obtained by the owner from a licensed real estate broker.

(III) In exceptional circumstances, such as when the property is located in a remote area and it is impossible or impractical to obtain a valuation, and the owner believes that the assessed value is too high or too low, the county and the owner may agree on the market value based upon other available information.

(C) The county shall inform the applicant/beneficiary at the time the property becomes unavailable that it is time-limited; and, at the end of nine months the net market value of the property shall be included in the property reserve.

(4) Personal property other than financial instruments or vehicles, which if sold or

otherwise disposed of would be unlikely to produce, after the costs of sale, "any significant amount of funds" or "significant return" for the support of the MFBU, shall be considered unavailable.

(A) "Any significant amount of funds" shall be funds amounting to one-half or more of the applicable property limit for the MFBU.

(B) "Significant return" shall be any return, after estimated costs of sale or disposition, and taking into account the ownership interest of the household, that is estimated to be one-half or more of the applicable property limit for the MFBU.

(h) The property reserve shall be equal to or less than $3,000 if the MFBU includes one or two individuals, or, for other MFBU sizes, shall be equal to or less than the amounts listed in Section 50420 at sometime during the month for which Medi-Cal is requested. (See Supplement 12b, Page 1 for information concerning the methodology employed to establish this limit.)

(i) A home, regardless of its value, occupied by the MFBU shall be exempt.

(1) Any house, mobile home, camper, trailer, houseboat or any other dwelling whether assessed as real or personal property by the county assessor is exempt if such an item of property is occupied by the MFBU as a home (place of residence). Property shall continue to be considered the home during temporary absence for reasons such as illness, seasonal employment, visits, extreme climatic conditions, etc., provided the recipient plans to, and it appears will be able to, return to the home when such circumstances no longer exists.

(2) The exempt home may be the unit of a multiple-dwelling unit that is occupied by the MFBU as a home. A home and a separate unit adjacent to the home shall be treated as a multiple dwelling unit.

(A) The unit(s) of the multiple dwelling that is (are) not occupied by the MFBU shall be treated as property and the value must be included in the property reserve.

(I) If the owner is making a good faith effort to sell the unit(s) that is (are) not occupied as a home as described in subsection (g)(3) above, then the unit(s) shall be considered unavailable for a period of time under the conditions specified in subsection (g)(3) above.

(II) If the unit(s) that is (are) not occupied as a home cannot be sold separately, the unit(s) shall be considered unavailable.

(3) The home which was the usual home of an owner who has entered into marital separation shall be treated as follows:

(A) The usual home shall be exempt in determining an applicant's eligibility for Medi-Cal during the month of application and for three consecutive months following the month of application.

(B) The usual home shall be exempt in determining a beneficiary's eligibility for Medi-Cal during the month of separation and for three consecutive months following the month in which the separation occurs.

(C) The applicant/beneficiary shall be informed when the exemption is granted that it is time-limited and that at the expiration of the three month period, the status of the home will be reconsidered and the net market value may be included in the property reserve.

(D) The status of the home shall be reconsidered at the end of the three month period to determine if it is exempt in accordance with subsection (e) or unavailable in accordance with subsection (g) above. If the home is no longer exempt or unavailable, the net market value shall be included in the property reserve.

(j) The net market value of real property, other than the exempt home or real property which is considered to be unavailable, shall be included in the property reserve. The net market value shall be determined by subtracting any encumbrances against the real property from its market value.

(1) The market value of real property shall be the lesser of the value established at the most recent appraisal of market value from a qualified real estate appraiser, the county assessor, recorder or tax collector.

(2) Encumbrances on real property include: mortgages, notes, deeds of trust, delinquent tax liens, court orders relating to judgements and mechanics liens, and assessments. Encumbrances may be written or oral.

(A) Evidence of written encumbrances shall be the documents which support the encumbrance.

(B) Evidence of unwritten encumbrances shall be the sworn statements of all parties, under penalty of perjury, to the following: initial and maturity date, extent of encumbrances, and value received.

(k) The net market value of nonexempt personal property [other than motor vehicles treated in accordance with subsection (l) below] shall be determined in accordance with this

subsection and included in the property reserve. The net market value is determined by subtracting any encumbrances against the property, penalties for early withdrawal or costs of sale (which are deducted before the proceeds are distributed to the seller of the property) from the market value.

(1) The market value of financial instruments or funds shall be the lowest face value, lowest balance (after subtracting any income which may have been deposited) or fair market value of the property during the month [as modified by subsection (k)(2) - (k)(4) below]. Fair market value of other personal property shall be established by any method; however, if the applicant/beneficiary disagrees with the fair market value established by the county, the applicant/beneficiary may provide another method. The county shall use the method which results in the lowest fair market value.

(2) The market value of IRAs, and available KEOGHs shall be the total fund value. Available KEOGHs are those which are established solely between MFBU members.

(3) The market value of bonds shall be the total bond value. If interest is being accrued, recorded and is available to the owner without having to liquidate the bond, then the interest accrued and recorded in the month shall be subtracted from the total bond value.

(4) The market value of stocks or mutual funds shall be the lowest price per share during the month or total fund value. If interest or dividends are accrued, recorded and are available to the owner without having to liquidate the stock or mutual fund, then the interest or dividends shall be subtracted from the lowest price per share or total fund value.

(l) Motor vehicles, including automobiles, vans, trucks, boats, mobile homes, motor homes, trailers, snowmobiles, jet skis, motorcycles, and tractors, shall be treated in accordance with the following, unless the item is exempt as a home. Whenever determining or redetermining eligibility of an MFBU and treating vehicles under this subsection, counties shall complete the form "Vehicle Determination Work Sheet for 1931 Group" and retain it in the case record.

(1) The entire value of any licensed vehicle (or an unlicensed vehicle used as a home or owned by a tribal member of an Indian reservation which does not require vehicles of tribal members to be licensed) shall be exempt if the vehicle meets any of the following conditions.

(A) The vehicle is for the purpose of producing income over 50 percent of the time the vehicle is in use, such as, but not limited to, a taxi, moving truck or fishing boat.

(B) The vehicle annually produces income, even if used only on a seasonal basis.

(C) The vehicle is necessary for long-distance travel, other than daily commuting, that is essential to the employment of an MFBU member; for example, the vehicle of a traveling sales person or a migrant farm worker moving from job to job.

(D) The exemptions in subsections (A) through (C) above, shall apply when the vehicle is not is use because of temporary unemployment.

(E) The vehicle was previously used by a self-employed MFBU member for farming but is no longer used over 50 percent of the time in farming because the MFBU member has terminated his/her self-employment. This exemption shall be limited to no more than one year from the date self-employment terminated.

(F) The vehicle is used as the home and, therefore, exempt under subsection (j) above.

(G) The vehicle is necessary to transport a disabled or incapacitated individual living in the home (as long as the home is not a boarding house or other licensed residence or facility, unless the disabled or incapacitated individual is the applicant/beneficiary or an ineligible member of the MFBU) regardless of the purpose of such transportation.

(I) If the disability or incapacity of the individual is not evident to the eligibility worker, verification shall be required.

(II) If verification is required, the individual shall be required to provide a statement from a physician certifying that the individual is disabled or incapacitated. The disability or incapacity may be temporary or permanent.

(III) There shall be a limit of one vehicle per disabled or incapacitated individual living in the home.

(IV) The vehicle need not have special equipment or be used primarily by or for the transportation of the disabled or incapacitated individual. However, a vehicle shall be considered necessary for the transportation of the disabled or incapacitated individual if the vehicle is specially equipped to meet the specific needs of the disabled or incapacitated person or if the vehicle is a special type

of vehicle that makes it possible to transport the disabled or incapacitated person.

(H) The vehicle is used to carry fuel for heating or water for home use, when such transported fuel or water is the primary source of fuel or water for the MFBU.

(2) All nonexempt licensed and unlicensed vehicles shall individually be evaluated for estimated fair market value.

(A) The estimated fair market value of two or more vehicles shall not be added together to reach a total fair market value in excess of the current vehicle exclusion limit.

(B) The estimated fair market value of vehicles customarily licensed by the Department of Motor Vehicles (DMV) may be determined in accordance with the methodology which utilizes the DMV License Fee Rate tables described in Section 50461 or by the value of those vehicles as listed in publications written for the purpose of providing guidance to automobile dealers and loan companies, customarily referred to as "blue books". If a blue book is used the county shall insure that the blue book used to determine the value of vehicles has been updated within the last six months.

(I) The county shall assign the wholesale value to vehicles. If the term "wholesale value" is not used in a particular blue book, the county shall assign the listed value which is comparable to the wholesale value.

(II) The county shall not increase the basic value of a vehicle by the value of low mileage or other factors such as optional equipment or special equipment for the handicapped.

(III) If a new vehicle is not yet listed in the blue book, the county shall determine the wholesale value through some other means, such as contacting a car dealer which sells that make of vehicle and asking how much the dealership would offer the household for the car.

(IV) To determine the most appropriate value of a vehicle, the county shall obtain from the owner or the vehicle's registration card, the vehicle's year, make, model, and number of doors. If the information for these four items is incomplete, the county shall use the lowest blue book value listed to the extent that the vehicle has been identified.

(C) If a vehicle is no longer listed in the blue book, the owner's estimate of the value of the vehicle shall be accepted, unless the county has reason to believe the estimate is incorrect. In that case, and if it appears that the vehicle's value will affect eligibility, the owner shall obtain an appraisal or produce other evidence of its value, such as a tax assessment or a newspaper advertisement which indicates the amount for which like vehicles are being sold.

(D) If the vehicle is in less than average condition, due to body damage or inoperability or the owner alleges that the blue book value does not apply to the vehicle, he/she shall be given the opportunity to obtain verification of the true value from a reliable source.

(E) Verification of the value of licensed antique, custom made, or classic vehicles shall be required if the county is unable to make an accurate appraisal.

(3) Counties shall individually determine the excess fair market value of nonexempt licensed vehicles by subtracting $4650 from the estimated fair market value determined in subsection (2) above.

(4) All nonexempt licensed or unlicensed vehicles shall individually be evaluated for equity value. Equity value shall be determined by subtracting any encumbrance against the vehicle from the estimated fair market value determined in subsection (2) above.

(5) Counties shall select the lesser of the excess fair market value determined in subsection (3) above or the equity value determined in subsection (4) above for each vehicle and include the amount determined to be the least in the property reserve, except as modified by subsection 6 below.

(6) Of the vehicles with equity values determined to be the least amount in subsection (5) above, the county shall subtract $1500 from the one vehicle with the greatest equity value and include that amount in the property reserve.

(m) The following items of personal property shall be exempt.

(1) Personal items and household goods to furnish and equip a home, including but not limited to jewelry, cameras, camcorders, tools and power tools, musical instruments, recreational equipment, cellphones, bicycles, computers, televisions, stereos, hobby items and collections shall be exempt.

(2) Personal property, to the extent that it is directly related to the maintenance or use

of a vehicle exempt under subsections (m) (1) (A), (B) or (D) above, shall be exempt.

(3) Stock in a water company not appurtenant to the land in the amount necessary for agricultural purposes shall be exempt.

(4) Loans shall be exempt when there is a written agreement signed and dated by the lender and the MFBU member as parties to the agreement that clearly specifies:

(A) the obligation of the MFBU member to repay the loan; and

(B) a repayment plan which provides for installments of specified amounts that continue on a regular basis until the loan is fully repaid.

(5) The cash surrender value of life insurance policies shall be exempt.

(6) The cash value of KEOGH plans which involve a contractual relationship with individuals who are not MFBU members, pension plans or pension funds shall be exempt.

(7) Real and personal property purchased with funds received under Title I or Title II of the Economic Opportunity Act when such funds were excluded from consideration as income or property. This exclusion does not extend to income or profits from such property.

(8) Personal property (except cash, nonbusiness financial institution accounts and other nonbusiness financial instruments where cash is available upon demand) which annually produces any income shall be exempt, even if only used on a seasonal basis. The full value of deeds of trust, promissory notes, mortgages, installment contracts or agreements shall be exempt if interest income is being produced.

(9) Personal property which is essential to the employment or self-employment of a MFBU member shall be exempt.

(A) Property may be, but is not limited to, tools of a tradesman or equipment of a farmer.

(B) Property of a business, such as funds in a checking or savings account, whether maintained exclusively for business purposes or commingled with nonexempt funds, shall be exempt.

(C) Counties shall accept the statement of the applicant/beneficiary whether the property, including financial reserves, are essential to the employment

or self-employment of the individual and are necessary to produce either current or future income.

(I) If an allegation is made that some or all of the funds contained in a personal account are those of the business of a self-employed MFBU member, then verification must be provided to demonstrate that some or all of the funds in the account are receipts of the business and verification must be provided that business expenses have been paid out of that account as well.

(D) When an MFBU member ceases to be self-employed in farming, property which was essential to this self-employment will continue to be exempt for a period of one year from the date of termination.

(10) Tools of trade, equipment and materials including stocks and inventories which will assist the MFBU member to implement and continue his/her approved plan of employment.

(A) The county shall determine if the items will assist the individual in his/her approved plan of employment.

(B) An approved plan of employment shall be the county's determination that:

(I) The MFBU member has training, education, or background in the chosen occupation; and

(II) There are no insurmountable physical barriers which render the individual incapable of returning to his/her chosen occupation.

(11) Any cash savings and interest accumulated pursuant to the Independent Living Program (ILP) written transitional independent living plan and retained by a child who is 16 years of age or older and is participating in the ILP. There is no limit to the amount that may be retained under this subsection.

(12) A Native American's interest in land held in trust by the United States Government is exempt.

(n) In addition to those payments that are exempt under Article 9 as amended, the following payments shall also be considered exempt.

(1) The amount of retroactive corrective aid is exempt for only the month of receipt and the following calendar month.

(2) Lump-sum retroactive SSI/SSP payments shall be exempt.

(3) Any federal, state or local Earned Income Tax Credit (EITC) payment received by any MFBU member shall be exempt for 12 months.

(A) If the pay stub does not indicate an EITC advance payment was received, no further verification is required.

(B) If the amount of the EITC advance payment is not clear from viewing the paystub, the county shall obtain clarification from the individual and contact the employer if necessary to obtain the amount.

(4) Income of students and self-employed individuals, which is received less frequently than monthly, shall be considered exempt property beginning with the month following the month of receipt. Those funds shall continue to be exempt for the period of time during which the funds are intended to be utilized by the individual, or until the month in which the next payment is received from the same source that is intended for the same purpose, whichever is shorter.

(5) Relocation assistance or real property acquisition benefits paid by a public agency to an individual who has been relocated as a result of a program of area redevelopment, urban renewal, freeway construction or any other public development, involving demolition or condemnation of existing house.

(6) Payments for lost, stolen, damaged, or destroyed property shall be exempt for the month of receipt and the month following the month of receipt.

(7) Payments made under PL 100-383, Section 105(f)(2), to U.S. citizens and permanent resident aliens of Japanese ancestry who were interned during World War II or their survivors; and payments received as restitution made to Aleut residents of the Pribilof and Aleutian Islands as a result of being relocated by the United States government and for injustices suffered while under United States control during World War II shall be exempt.

(8) Disaster and emergency assistance payments pursuant to the Disaster Relief Act of 1974 [as amended by PL 100-707, Section 105(i)], provided by federal, state, or local governments or disaster assistance organizations shall be exempt.

(9) Payments received from the Agent Orange Settlement Fund or any other fund established to settle liability claims by veterans or survivors of deceased veterans concerning Agent Orange under the Agent Orange Compensation Act of 1989 (PL 101-201, PL 101-239, and PL 101-329, Section 10405).

(10) Payments received under the Radiation Exposure Compensation Act shall be exempt pursuant to the Radiation Exposure Compensation Act of 1990 [PL 101-

426, Section 6(h)(2)].

(11) Payments to victims of Nazi persecution shall be exempt pursuant to PL 103-286, Section 1.

(12) Allowances, earnings and payments to individuals in programs specified under the Job Training Partnership Act of 1982 (PL 97-300) shall be exempt, with the following exception. Earnings from the JTPA on-the-job training program shall be exempt if the JTPA participant is a dependent child for purposes of Section 1931(b) program [PL 97-300, Section 142(b) and PL 99-198]. Earnings from all other on-the-job training programs shall not be exempt.

(13) Payments or allowances made under any federal laws, except benefits under a state program funded under Part A of Title IV of the Social Security Act, for the purpose of energy assistance, such as the Low Income Home Energy Assistance Act (LIHEAA), or from Housing and Urban Development (HUD) or the Farmers Home Administration (FmHA) programs shall be exempt. One-time assistance payments or allowances under federal or state laws for weatherization or emergency repair or replacement of heating or cooling devices are exempt.

(14) Financial assistance provided under any of the following shall be exempt:

(A) A program funded in whole or in part under Title IV of the Higher Education Act (PL 102-325).

(B) Bureau of Indian Affairs student Assistance program (PL 102-325).

(C) Title XIII, Indian Higher Education Programs, Tribal Development Student Assistance Revolving Loan Program (Tribal Development Student Assistance Act).

(D) To the extent the financial assistance provided under the Carl D. Perkins Vocational and Applied Technology Education Act Amendments of 1990 (20 U.S.C., Section 2301-2466d) is used or earmarked for future use to meet attendance costs for a student attending school on at least a half-time basis, as defined by the institution. Attendance costs are defined as tuition, fees, rental or purchase of required equipment, materials, supplies, books, transportation, dependent care and miscellaneous personal education expenses.

(15) Allowances, earnings, and payments made under Title I of the National and Community Service Act (NCSA) of 1990 shall be exempt (PL 101-610, Section 177(d)]. The NCSA includes programs under the Serve America, American Conservation and Youth Corps, and National and Community Service subtitles.

(A) Earnings of individuals, except dependent household members under 19 years of age participating in on-the-job training under Title I programs shall not be exempt, consistent with the provisions of subsection (m)(12) above.

(B) Examples of programs under Title I of the NCSA include: the Higher Education Service-Learning Program; the AmeriCorps umbrella program, including the National Civilian Community Corps and the Summer for Safety programs; and the School-to-Work Opportunities Program.

(16) Allowances paid under PL 104-204 to children of Vietnam Veterans who are born with spina bifida shall be exempt.

(17) Payments made from any fund established pursuant to the settlement in the case of Susan Walker v. Bayer Corporation (N.D. Ill.) shall be exempt.

(18) Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act are exempt to the extent they are kept identifiable. Austrian social insurance payments which are not based on wage credits granted under Paragraphs 500-506 are included in the property reserve in the month following the month of receipt.

(19) Court-ordered reimbursements made to Quilling v. Belshè class members shall be exempt property in the month of receipt and for three calendar following the month of receipt. The applicant/beneficiary shall provide any verification sufficient to establish that the payment or remaining funds are the result of a claim filed under Quilling v. Belshè. If verification is not available the county shall contact the Department of Alcohol and Drug Programs to verify the applicant's/beneficiary's statement that a Quilling reimbursement was made, and the date and amount of the reimbursement.

(o) In addition to the those payments that are exempt under Article 9 as amended, the following payments to Native Americans shall also be exempt. Counties shall exempt payments under whichever subsection provides the greatest advantage to the MFBU.

(1) Distributions from a Native corporation established pursuant to the Alaskan Native Claims Settlement Act paid to an MFBU, individual Native or descendent of a Native shall be exempt. Distributions include cash (including cash dividends on stock received from a Native corporation) to the extent it does not exceed $2,000 total per person per anum, stock, a partnership interest, land or interest in land, and interest in a settlement trust.

(2) Any funds distributed on a per capita basis or held in trust for members of any

Native American tribe under Public Law (PL) 92-254 or PL 94-540 shall be exempt.

(3) Funds of Native American tribes including interest earned from, investment income derived from and initial purchases made with such funds when the funds have been:

(A) Distributed by the Secretary of the Interior on a per capita basis; or

(B) Held in trust by the Secretary of the Interior; or

(C) Individually owned trusts or restricted lands.

(4) Funds or assets of, or payments to Native American tribal members or Alaska Natives shall be excluded as property if specifically exempt by any other federal law. These exemptions include, but are not limited to:

(A) Payments received under the Alaska Native Claims Settlement Act (PL 92-203, Section 29 and PL 100-23, Section 15 or the Sac and Fox Indian claims agreement (PL 94-189, Section 8);

(B) Payments received by Indian tribal members under PL 94-114, Section 6, regarding submarginal land held in trust by the United States. The following tribes may benefit from this provision.

(I) The Bad River Band of the Lake Superior Tribe of Chippewa Indians of Wisconsin;

(II) Blackfeet Tribe;

(III) Cherokee Nation of Oklahoma;

(IV) Cheyenne River Sioux Tribe;

(V) Crow Creek Sioux Tribe;

(VI) Lower Brule Sioux Tribe;

(VII) Devils Lake Sioux Tribe;

(VIII) Fort Belknap Indian Community;

(IX) Assiniboine and Sioux Tribes;

(X) Lac Corte Oreilles Bank of Lake Superior Chippewa Indians;

(XI) Kewcenaw Bay Indian Community;

(XII) Minnesota Chippewa Tribe;

(XIII) Navajo Tribe;

(XIV) Oglala Sioux Tribe;

(XV) Rosebud Sioux Tribe;

(XVI) Shoshone-Bannock Tribe; and the

(XVII) Standing Rock Sioux Tribe.

(C) Payments received from the disposition of funds to the Grand River Bank of Ottawa Indians shall be exempt pursuant to PL 94-540.

(D) Payments received by the Confederated Tribes and Bands of the Yakima Indian Nation and the Apache Tribe of the Mescalaro Reservation from the Indian Claims Commission (PL 95-433, Section 2) shall be exempt.

(E) Payments made to the Passamaquoddy Tribe, the Penobscot Nation, or the Houlton Band of Maliseet, or any Indian household or member thereof, pursuant to the Maine Indian Claims Settlement Act of 1980 shall be exempt pursuant to PL 96-420, Section 9(c).

(F) Payments of relocation assistance to members of the Navajo and Hopi Tribes shall be exempt pursuant to PL 93-531, Section 22.

(G) Funds that meet the criteria in subsection (I) below shall be exempt.

(I) The funds were appropriated to satisfy judgements of the Indian Claims Commission or Claims Court pursuant to PL 93-134, PL 97-458 and PL 98-64 which are any of the following:

(i) Distributed on a per capita basis, not exceeding $2,000, or held in trust according to an approved plan.

(ii) As of January 12, 1983, were to be distributed on a per capita basis, up to $2,000, or held in trust according to a plan approved by Congress prior to January 12, 1983.

(iii) Were distributed according to a plan approved by Congress after December 31, 1981, but prior to January 12, 1983, and any purchases made with such funds; or

(iv) Are per capita payments, not exceeding $2,000 from funds which are held in trust by the Secretary of the Interior (trust fund distribution).

(II) For purposes of subsection (G), the $2,000 limit on per capita shares applies to each payment made to each household member.

(III) Purchases made with payments described in subsection (G) which were distributed between January 1, 1982 and January 12, 1983 shall be exempt property to the extent exempt funds were used to make such purchases.

(H) Interest of individual Indians in trust or restricted lands shall be exempt property only, and any income from such interests shall be countable property in the month following the month of receipt pursuant to PL 93-134, PL 97-458 and PL 103-66, Section 13736.

(I) For purposes of subsection (H), interests include the individual's right to, or legal share of, the trust or restricted land and any resulting income.

(II) For purposes of this section, the exemption applies to each individual MFBU member who holds an interest or legal share.

(I) Assistance received under the Indian Child Welfare Act child and family service grant programs on or near reservations (PL 95-608). These programs include, but are not limited to: family assistance, day care, after school care, respite care, recreational activities, home improvement, employment of domestic relations and child welfare personnel, and education and training.

(J) Payments made to the following: Turtle Mountain Band of Chippewas, Arizona (PL 97-403); Blackfeet, Grosventre, Assiniboine tribes, Montana, and the Papago Tribe, Arizona (PL 97-408); Red Lake Band of Chippewa Indians (PL 98-123, Section 3); White Earth Band of Chippewa Indians, Minnesota, pursuant to the White Earth Reservation Land Settlement Act of 1985 (PL 99-264, Section 16); and Saginaw Chippewa Indian Tribe of Michigan [(PL 99-346, Section 6(b)(2)].

(K) Per capita and interest payments made to members of the Assiniboine

Tribe of the Fort Belknap Indian Community and the Fort Peck Indian Reservation, Montana (PL 98-124, Section 5).

(L) Funds paid to heirs of deceased Native American under the Old Age Assistance Claims Settlement Act, except for per capita share exceeding $2,000 (PL 98-500, Section 8).

(M) Funds distributed per capita of held in trust for the Chippewas of Lake Superior and the Chippewas of the Mississippi [PL 99-146, Section 6(b) and PL 99-377].

(O) Funds, assets or income from the trust fund established pursuant to the Puyallup Tribe of Indians Settlement Act of 1989 [PL 101-41, Sections 10(b) and (c)].

(P) Payments made to the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida and the independent Seminole Indians of Florida to satisfy the judgments of the Indians Claims Commission, except for per capita payments exceeding $2,000 (PL 101-277).

(Q) Payments, funds, distributions or income under the Seneca Nation Settlement Act of 1990 [PL 101-503, Section 8(b)].

(p) Exempt funds, that are otherwise exempt for a limited period of time, shall be exempt for an unlimited period of time when kept in a separate account and not commingled with other nonexempt funds.

(q) Funds which are to be apportioned over time shall be exempt property for the period of time over which they have been prorated as nonexempt income if the funds have been commingled with other nonexempt funds.

STATE PLAN UNDER TITILE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON JULY 16, 1996
(More Liberal Than AFDC)

Excludable restitution payments made to a holocaust victim or his or her heirs or beneficiaries shall be considered an exempt resource for the purpose of determining eligibility to receive Medi-Cal benefits or the amounts of those benefits.

A "holocaust victim" is a person who was persecuted by Nazi Germany, any other Axis regime, or any other Nazi-controlled or Nazi-allied country:

(1) on the basis of race, religion, physical or mental disability, or sexual orientation;
(2) during any period before, during or after.

An "excludable restitution payment" is any payment or distribution, recovered or returned asset or property, received directly by a holocaust victim or heirs or beneficiaries of a holocaust victim:

(1) as compensation pursuant to the Gerrnan Act Regulating Unresolved Property Claims, as amended (Gesetz zur Regelung offener Vermogensfragen);
(2) as a result of a settlement of claims against any entity or individual for any recovered asset. A "recovered asset" is any asset of any type, including any bank deposits, insurance proceeds, artwork, or interest earned on any of these assets, owned by a holocaust victim, withheld from that holocaust victim or his or her heirs or beneficiaries and recovered, returned or otherwise compensated to the holocaust victim or his or her heirs or beneficiaries;

(3) any payment or restitution provided by law, or by a fund, established by any foreign country, the United States of America, or any other foreign or domestic entity, or as a result of a final resolution of a legal action;
(4) any direct or indirect return of, or compensation or reparation for, assets stolen or hidden from, or otherwise lost to, the individual before, during or immediately after World War II, including any insurance proceeds under policies issued on the individual by European insurance companies immediately before and during World War II; or
(5) as interest, payable as part of any payment or distribution described in the paragraph.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT DIFFER FROM THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON JULY 16, 1996
(Less Restrictive Than AFDC)

In-home caregiver wages paid to a household member shall be exempt when both of the following conditions are met:

1) The caregiver is being paid for providing the in-home care to his/her spouse or minor child living in the home, and

2) The spouse or minor child is receiving those in-home services through any federal, state or local government program.

Payments made by the California Department of Social Services to an in-home care recipient for the purpose of purchasing in-home care services, including restaurant meals, shall be exempt.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

METHODOLOGIES FOR TREATMENT OF RESOURCES
THAT ARE NO MORE RESTRICTIVE THAN THOSE OF THE AFDC PROGRAM
AS IT EXISTED ON ~~JUNE 16, 1996~~ July 16, 1996 PJD
(The Same As Or More Liberal Than AFDC)

§50401. Property Evaluation.

(a) After determining the appropriate Medi-Cal program for the members of the MFBU, the county department shall evaluate the property holdings of the MFBU to determine:

(1) Property to be included in determining eligibility.

(2) The value of the included property.

(3) Whether the total value of the included property exceeds the property reserve limits specified in Section 50420.

(b) After determining the value of all property to be included in the property reserve of the MFBU, the value shall be waived for a pregnant woman and/or infant if those applicants or beneficiaries are found to be eligible under the 200 Percent program as provided in Section 50262(a).

(c) When determining eligibility under the Percent programs, as described under Sections 50262.5 and 50262.6, property shall be disregarded.

§50403. Treatment of Property: Separate and Community Property.

(a) The separate property and share of community property of any person included in the MFBU shall be considered in determining Medi-Cal eligibility.

(b) A spouse's share of community property is always one-half of the current total community property.

(c) For purposes of establishing eligibility, an interspousal agreement entered into pursuant to Welfare and Institutions Code Section 14006.2 shall:

(1) be written, dated and signed by both spouses or by a person who has the legal authority to enter into such agreements on behalf of either spouse;

(2) list each asset being transmuted;

(3) clearly designate the owner of each asset;

(4) list the value of each asset; and

(5) evidence an equal division of the nonexempt community property.

(d) If an interspousal agreement does not comply with (c)(4) of this section, the county shall request additional information from the applicant, or other party mentioned in (c)(1) to supplement the agreement and verify the methodology used to value assets. Such information may be necessary pursuant to verification requirements contained in Article 4 of this Division.

(e) If an interspousal agreement evidences an unequal division of the nonexempt community property, and the applicant received the smaller share of such property under the agreement, the county shall determine whether the transfer was for adequate consideration in accordance with Sections 50408 and 50409.

(1) If the county determines that the transfer was not for adequate consideration and was made in order to establish eligibility or to reduce the share of cost, the county shall give the applicant's spouse the option of reconveying to the applicant in accordance with Section 50411(d)(1) an amount of property sufficient to provide each spouse with equal shares of the total nonexempt community property identified in the interspousal agreement.

(2) If the applicant's spouse does not reconvey property pursuant to (e)(1) above, the county shall assess a period of ineligibility for the applicant in accordance with Section 50411.

§50404. Owner of Property.

(a) The owner of property, for Medi-Cal eligibility purposes, shall be the person who holds legal title to the property unless otherwise specified in these regulations.

(b) Ownership of property may be vested in one individual or shared with other individuals.

(c) Notwithstanding (a), a person shall be the owner of separate property designated in a written interspousal agreement.

§50405. Contracts of Sale.

(a) Property purchased under a signed contract of sale by the applicant or beneficiary shall be included in the property reserve of the applicant or beneficiary.

(b) Property being sold by the applicant or beneficiary under a signed contract of sale shall not be considered the property of the applicant or beneficiary. The interest payments received under the contract of sale shall be unearned income. The principal payments received under the contract of sale shall be property.

(c) Property being purchased or sold under a verbal or unsigned contract of sale shall be considered ie property of the seller until the sale is complete.

§50406. Conversion or Transfer of

Conversion or transfer of property may affect eligibility. Sections 50407 through 50411 describe methods of converting or transferring property, and the effect of each method on eligibility.

§50407. Conversion of Property--Treatment.

(a) Conversion of property in itself from one form to another has no effect on eligibility; however, the property obtained through a conversion may have an effect on eligibility and therefore shall be evaluated to determine its effect.

(b) Insurance or other third-party payments for the loss or damage of property shall be treated as converted property rather than income.

§50414. Share of Encumbrances Determination.

(a) The share of encumbrances shall be determined as follows:

(1) Determine the total market value of the property.

(2) Determine the market value of the portion of the property that is to be considered.

(3) Divide the amount determined in (2) by the amount determined in (1) to obtain the percentage that the portion of property is of the total property.

(4) Multiply the total encumbrances on the property by the percentage determined in (3) above. This is the share of encumbrances.

§50415. Net Market Value of Property.

(a) The net market value of real or personal property is the owner's equity in that property.

(b) The net market value shall be determined by subtracting the encumbrances of record from the market value.

(c) The net market value of real or personal property owned jointly with other persons shall be determined by subtracting the beneficiary's share of encumbrances from the beneficiary's interest in the property.

§50419. Property Reserve.

The property reserve is the net market value of the nonexempt property of those persons whose property is considered in determining the eligibility of the MFBU.

§50420. Property Limit.

(a) The property reserve shall not exceed the following limits.

Number of Persons Whose Property is Considered	*Property Limit 1985*	*Property Limit 1986*	*Property Limit 1987*	*Property Limit 1988*	*Property Limit 1989*
1 person	1,600	1,700	1,800	1,900	2,000
2 persons	2,400	2,550	2,700	2,850	3,000
3 persons	2,550	2,700	2,850	3,000	3,150
4 persons	2,700	2,850	3,000	3,150	3,300
5 persons	2,850	3,000	3,150	3,300	3,450
6 persons	3,000	3,150	3,300	3,450	3,600
7 persons	3,150	3,300	3,450	3,600	3,750
8 persons	3,300	3,450	3,600	3,750	3,900
9 persons	3,450	3,600	3,750	3,900	4,050
10 persons or more	3,600	3,750	3,900	4,050	4,200

(b) The members of the MFBU shall be ineligible for Medi-Cal if the condition specified in (a) above is not met at some time during the month in which application is made.

(c) If the property reserve has been in excess of the property limit from the first day of the month of application through the date of application the MFBU shall be eligible under the following conditions:

(1) The property reserve is brought within the property limit in any manner other than transfer without adequate consideration by the last day of the month of application.

(2) All other conditions of eligibility are met.

(d) The provisions of this regulation also apply to eligibility determinations or redeterminations made retroactively to January 1, 1985.

§50442. Life Estate.

(a) A life estate interest in real property shall be considered real property.

(b) A life estate interest in personal property shall be considered personal property.

(c) The value of a life estate shall be:

(1) The entire market value of the property on which the life estate is held if the applicant or beneficiary was the owner of the property prior to selling the property and he/she is retaining a life estate interest in the property, and the Life estate is revocable, or

(2) In all other instances, the value determined in accordance with the California State Gift Inheritance Tax Formula or, at the applicant's or beneficiary's option, a lesser value established by a person qualified to appraise such items as described in Section 50441 (c) (2).

§50443. American Indian's Interest in Land Held in Trust by United States Government.

The entire market value of an American Indian's interest in land held in trust by the United States Government shall be exempt.

§50445. Federal Payments to Indians and Alaskan Natives--Property.

(a) Payments received from the Federal Government under Public Law 90-507 shall be excluded from consideration as personal property when the total of nonexempt personal property, including such payments does not exceed $2,000 for each individual. Payments converted into other property shall be treated the same as the payments. However, if the property received through such a conversion is again converted, the property acquired is included in the property reserve unless otherwise exempt.

(b) Payments received from the Federal Government under Public Law 92-254 or Section 6 of Public Law 87-775 shall be exempt.

(c) Per capita payments distributed pursuant to any judgment of the Indian Claims Commission or the Court of Claims in favor of any Indian Tribe are exempt.

(d) Shares of stock and money payments made to Alaskan Natives under the Alaskan Native Claims Settlement Act are exempt as long as the payments or stock remain separately identifiable and not comingled with nonexempt resources. Any property obtained from stock investments under the Act is not exempt.

(e) Receipts derived from lands, as specified in Section 50537(e), shall be exempt providing all of the following conditions are met. The monies:

(1) Are retained by the original recipient.

(2) Are not commingled.

(3) Can be separately identified as a proportionate share of the applicant's or beneficiary's property.

§50446. Payments to Victims of the National Socialist Persecution.

(a) Payments received from the Federal Republic of Germany (German Reparations Payments) pursuant to the federal law on the Compensation of Victims of the National Socialist Persecution (Federal Compensation Law) shall be exempt from consideration as personal property provided these funds are not spent and are kept identifiable.

(b) If the funds referred to in subsection (a) have been spent, the property acquired with the funds shall be included in the property reserve unless otherwise exempt.

(c) If the exempt funds referred to in subsection (a) have been commingled with nonexempt funds, it is the applicant's or beneficiary's responsibility to be able to distinguish which are the exempt commingled funds. It is presumed that withdrawals from an account in which exempt and nonexempt funds have been commingled were made from the nonexempt fund first.

§50448. Payments to Victims of Crimes--Treatment as Property.

Payments made under the California Victims of Crimes program, which are exempt as income in the month of receipt in accordance with Section 50534, shall be exempt as property for the 9-month period beginning after the month in which the payment was received.

§50448.5. Relocation Assistance Benefits.

(a) Relocation assistance benefits are payments made by a public agency to a person who has been relocated as a result of a program of area redevelopment, urban renewal, freeway construction, or any other public development involving demolition or condemnation of existing housing.

(b) Relocation Assistance Benefits paid by a public agency shall be exempt provided these these funds are not spent and are kept identifiable.

(c) If the exempt funds referred to in subsection (b) have been commingled with nonexempt funds, it is the applicant's or beneficiary's responsibility to be able to distinguish which are the exempt commingled funds. It is presumed that withdrawals from an account in which exempt and nonexempt funds have been commingled were made from the nonexempt funds first.

§50451. Cash on Hand.

Cash on hand shall be included in the property reserve, unless it is income received in that month.

§50453.7. Long-Term Care Insurance Exemption.

(a) Property shall be exempt up to the amount of benefits that have been paid for Long-Term Care services countable towards the Medi-Cal property exemption as defined in Section 58023 in behalf of the Medi-Cal applicant or Medi-Cal beneficiary under a certified long-term care insurance policy or certificate certified by the State to provide this exemption.

(b) Property exempted under subsection (a) shall also be exempt from any recovery by the State of payments made for medical services.

(c) Income received from property exempt under subsection (a) shall be nonexempt and shall be treated in accordance with regulations contained in Article 10 of Chapter 8.

(d) The Medi-Cal applicant or Medi-Cal beneficiary shall provide verification from the insurance company of the amount of qualified benefits paid which entitle that applicant or beneficiary to an exemption under subsection (a). After notifying the Department in accordance with Probate Code, Sections 215 and 9202, the person handling the estate of a deceased Medi-Cal beneficiary shall also provide verification to the Department from the insurance company of the amount of qualified benefits paid which entitle that deceased beneficiary to an exemption under subsection (b).

(1) If the verification provided by the insurance company is found to be in error resulting in the ineligibility of the Medi-Cal applicant or Medi-Cal beneficiary, the County shall notify the Department to take appropriate actions against the insurance company under Section 58082(e).

(2) If the verification provided by the insurance company is found to be in such a condition that the County cannot determine whether the Medi-Cal applicant or Medi-Cal beneficiary is entitled to an exemption under subsection (a), the County shall determine that the Medi-Cal applicant or Medi-Cal beneficiary is not entitled to such an exemption and shall notify the Department to take appropriate actions against the insurance company under Section 58082(f) of the Partnership Regulations for Insurers.

(3) If the verification provided to the Department by the person handling the estate of a deceased beneficiary is found to be either in error, or in such a condition that the Department cannot determine whether the deceased beneficiary is entitled to an exemption under subsection (b), the Department shall take appropriate actions against the insurance company under Section 58082(e) and (f).

§50454. Income Tax Refunds.

Income tax refunds shall be included in the property reserve.

§50455. Lump Sum Payments.

(a) Nonrecurring lump sum social insurance payments, such as nonrecurring lump sum payments of any of the items specified in section 50507(a)(1) through (9), shall be included in the property reserve, except as provided in (b).

(b) Retroactive SSI and Title II benefit payments shall not be included in the property reserve for a period of six months after the month in which they are received.

(c) The provisions of this regulation also apply to eligibility determinations or redeterminations made retroactively to October 1, 1984.

§50476. Burial Insurance.

Burial insurance with no cash surrender value shall be exempt. Burial insurance with a cash surrender value shall be considered a revocable burial fund and shall be treated as provided for in section 50479.

§50477. Burial Plots, Vaults and Crypts.

(a) Any burial plot, vault or crypt retained by the applicant or beneficiary for use by any member of the family shall be exempt. For the purposes of this section only, the family shall include the applicant or beneficiary, his/her spouse, adult or minor children (including adopted and stepchildren), siblings, parents, adoptive parents, and the spouses of those individuals.

(b) The net market value of any burial plot not exempted above is other real property and shall be subject to all conditions placed on other real property in these regulations.

(c) The net market value of any burial vault or crypt not exempted above is personal property and shall be included in the property reserve.

(d) The net market value of a burial plot, vault or crypt shall be the net market value listed by the applicant or beneficiary on the Statement of Facts, unless the county department determines further verification is required. If verification is required:

(1) The applicant or beneficiary shall submit a statement of value from the organization from which the plot, vault or crypt was purchased. This statement of value shall be the market value.

(2) Subtract encumbrances of record from the market value. This is the net market value.

§50479. Burial Funds.

(a) All of the following burial funds for an individual shall be exempt.

(1) Money or securities placed in an irrevocable trust for funeral, cremation, or interment expenses with the following trustees: any banking institution or trust company empowered by the State of California to act as trustee in the handling of trust funds, cemetery authority which has established an endowment care fund, or not less than three persons one of whom may be in the employ of a funeral director.

(2) Money or securities placed in an irrevocable trust created by the deposit in an insured savings institution made by one person of his or her own money in his or her own name as trustee for a funeral director to provide payment for funeral services rendered by the funeral director upon the depositor's death.

(3) Life or burial insurance purchased specifically for funeral, cremation, or interment expense, which is placed in an irrevocable trust or which has no loan or surrender value available to the recipient.

(4) Securities issued by a licensed cemetery authority which by their terms are convertible only into payment for funeral, cremation, or interment expenses.

(b) The first $1,500 paid for designated burial funds for funeral, cremation or interment expenses for an individual shall be exempt when the fund is revocable.

(c) Designated burial funds include burial trusts, prepaid burial contracts, burial insurance, annuities or any separately identifiable assets which are clearly designated as set aside for the expenses connected with the individual's burial, cremation, or other funeral arrangements.

(d) Interest earned on or appreciation in value of either an exempt burial fund described in subsection (a), above or revocable designated burial fund described in subsections (b) and (c), above shall be exempt if it is left to accumulate and become part of the separately identifiable burial fund.

(e) The amount of designated burial funds which are not exempt shall be included in the property reserve.

§50481. Disaster and Emergency Assistance Payments.

Disaster and emergency assistance payments, regardless of the date of receipt, and any interest earned from such payments, shall be permanently exempt and shall not be included in the property reserve. This exemption applies only to such payments received from federal, state, or local government agencies, or disaster assistance organizations.

§50487. Stocks Held by Natives of Alaska.

Shares of stock in a regional or village corporation held by natives of Alaska for a 20 year period during which such stock cannot be conveyed, transferred or surrendered, shall be exempt.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

Section 1924(c)(3)(C) of the Act

1. Spousal Impoverishment

An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under Title XIX of the Social Security Act, per Section 1924(c)(3)(C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

For TB infected individuals under §1902(z)(1) of the Act, the income and resource eligibility levels are as follows:

Income Eligibility Level:

The income eligibility level is the SSI break-even point which represents the maximum amount of monthly income a TB-infected individual described in Section 1902(z) may have and still meet the financial requirements for Medicaid.

Resource Eligibility Level:

The TB resource limit for an unmarried individual is $2,000.

If the TB beneficiary is an individual residing with a spouse, each individual would have a resource limit of $2000.

(See Supplement 8a to Attachment 2.6A, Page 2 and Supplement 8b to Attachment 2.6A, Page 4 for less restrictive methodologies.)

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY:

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: [ ] No limitations [X] With limitations*

2. a. Outpatient hospital services.

   Provided: [ ] No limitations [X] With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

   [X] Provided: [ ] No limitations [X] With limitations*

   [ ] Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   [X] Provided: [ ] No limitations [X] With limitations*

   d. Ambulatory services offered by a health center receiving funds under Section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

   [X] Provided: [ ] No limitations [X] With limitations*

3. Other laboratory and X-ray services.

   Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

____ Provided ____ No limitations _X_ With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

____ Provided ____ No limitations _X_ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

____ Provided ____ No limitations _X_ With limitations*

5.a.1 Sign language interpreter services (in connection with physician's services).

_X_ Provided ____ No limitations _X_ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with secton 1905(a)(5)(B) of the Act).

____ Provided ____ No limitations _X_ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services

____ Provided ____ No limitations _X_ With limitations*

* Description provided on attachment.

State/Territory: CALIFORINA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/X/ Provided: / / No limitations /X/With limitations*

/ / Not provided.

c. Chiropractors' services.

/X/ Provided: / / No limitations /X/With limitations*

/ / Not provided.

d. Other practitioners' services.

/ / Provided: Identified on attached sheet with description of limitations, if any.

/ / Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: / /No limitations /X/With limitations*

b. Home health aide services provided by a home health agency.

Provided: / /No limitations /X/With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: / /No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

e. Private duty nursing services.

/_/ Provided: /_/ No limitations /_/With limitations*

/X/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/ / Provided: / / No limitations / / With limitations*

/X/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/__/ Provided: /__/ No limitations /__/ With limitations*

/X/ Not provided.

c. Preventive services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

d. Rehabilitative services; including rehabilitative mental health services and rehabilitative alcohol and drug treatment services for individuals diagnosed by physicians as having a substance-related disorder. (See Supplements 2 and 3 to Attachment 3.1-A):

/X/ Provided /__/ No limitations /X/ With limitations*

/__/ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

b. Skilled nursing facility services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

c. Intermediate care facility services.

/X/ Provided: /__/ No limitations /X/ With limitations*

/__/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)~~(13)~~31 CW-TN 91-13 10-24-91 (A) of the Act, to be in need of such care.

|XXX| Provided: |___| No limitations |XXX| With limitations*

|___| Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

|XXX| Provided: |___| No limitations |XXX| With limitations*

|___| Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

|XXX| Provided: |___| No limitations |XXX| With limitations*

|___| Not provided.

17. Nurse-midwife services.

|XXX| Provided: |___| No limitations |XXX| With limitations*

|___| Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

|XXX| Provided: |___| No limitations |XXX| With limitations*

|___| Not provided.

STATE/TERRITORY: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lanterman), and Supplements 1a-1f to ATTACHMENT 3.1-A for Case Management Services (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided __X__ With limitations* _____Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

__X__ Provided __X__ With limitations* _____Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

_____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

_____ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: _X_ No limitations ___ With limitations*

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

b. Services of Christian Science nurses.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

e. Emergency hospital services.

/XX/ Provided: /_/ No limitations /XX/ With limitations*

/_/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/ With limitations*

/XX/ Not provided.

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Local Education Agency (LEA) Services

|X| Provided: | | No limitations |X| With limitations*

| | Not provided.

*Description provided on attachment.

State: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided __X__ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or at work.

_X_ Provided: _X_ State Approved (Not Physician) Service Plan Allowed
_X_ Services Outside the Home Also Allowed

_X_ Limitations Described on Attachment

___ Not Provided.

State of California
PACE State Plan Amendment Pre-Print

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-A.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency California

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE **CATEGORICALLY NEEDY**

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency California

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)	Provision (s)
1927(d)(2) and 1935(d)(2)	1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D. **X** **The following excluded drugs are covered:** **X** **(a) agents when used for anorexia, weight loss, weight gain** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity. ☐ (b) agents when used to promote fertility (see specific drug categories below) ☐ (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below) **X** **(d) agents when used for the symptomatic relief of cough and colds** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity. **X** **(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride** **Medi-Cal will cover select prescription vitamins and minerals pursuant to prior authorization or utilization restrictions. Combination vitamin and mineral products are not a benefit. Vitamins or minerals used for dietary supplementation are not a benefit.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency California

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE **CATEGORICALLY NEEDY**

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	X	**(f) nonprescription drugs** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity.
	☐	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
	X	**(h) barbiturates (see specific drug categories below)** All drugs in this category are potential benefits, subject to medical necessity.
	X	**(i) benzodiazepines (see specific drug categories below)** All drugs in this category are potential benefits, subject to medical necessity.

__ **No excluded drugs are covered.**

Note: This chart is an overview only.)

Limitations on Att, 3,.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1 Inpatient hospital services	Inpatient services are covered as medically necessary except that services in an institution for mental diseases are covered only for persons under 21 years of age or for persons 65 years of age and over. Services in an institution for tuberculosis for persons under 65 are not covered. Services in the psychiatric unit or TB unit of a general hospital are covered for all age groups.	Prior authorization is required for all nonemergency hospitalization except for th first two days of obstetrical delivery or subsequent newborn care services. Certain procedures will only be authorized in an o patient setting unless medically contraind Emergency admissions require a physician's dentist's, or podiatrist's statement suppo the admission. Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subj to prior authorization by the Medi-Cal Consultant. Mental health services are identified in t Short-Doyle/Medi-Cal (SD/MC) agreement, al with the appropriate utilization controls that delivery system. Beneficiaries may e to receive service through either the regu Medi-Cal program or the SD/MC system.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH # 88-17

Eff. 7-1-88

Appr. MAR 21 1989

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services)	TC is covered for persons 18 years of age or older who are not receiving care in a small and rural hospital. Medical necessity includes, but is not limited to, one or more of the following: 1. Intravenous therapy, including but not limited to: • single or multiple medications • blood or blood products • total parenteral nutrition • pain management • hydration Note: The clinical record must document failure of other preventive measures, failure or inappropriateness of non-intravenous medications or the patient's inadequate response to oral hydration.	Prior authorization is required for TC level of care. The attending physician must determine that the patient has been clinically stable for the 24 hours preceding admission to TC level of care. A definitive and time-limited course of treatment must be developed prior to admission by the physician assuming TC treatment management. The attending physician must perform the initial medical visit within 24 hours of the patient's admission to TC level of care. For patients admitted from acute care hospitals, if the physician assuming the responsibility for treatment management in TC was also the attending physician in the acute care hospital, the initial physician visit must occur within 72 hours.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	2. Rehabilitative services, including physical therapy, occupational therapy, and speech therapy rendered to: A. The transitional rehabilitation patient, who, prior to admission to TC, meets all the following criteria: • Has been assessed by a physiatrist or physician otherwise skilled in rehabilitation medicine, who has provided an explicit, time-limited plan of treatment; • Has sufficient endurance to participate in a minimum of one hour a day, 5 days per week, of a single or combined rehabilitative therapy, as ordered by a physiatrist or physician otherwise skilled in rehabilitation medicine, provided by, or under the direct supervision of, a licensed or registered therapist; and	The attending physician must visit the TC patient at least twice weekly or more often as the patient's condition warrants while the patient is receiving TC level of care. A certified nurse practitioner, in collaboration with the attending physician, or physician's assistant, under the supervision of a physician, may provide non-duplicative services to TC patients. Leave of absence is covered for TC Rehabilitation patients only. TC patients require care by registered nurses on every shift.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	• Has potential to make significant functional gain in a reasonable period of time or has a caregiver available to participate in short-term training that will enable the patient to return safely to a residential environment with the caregiver's assistance. B. The transitional medical patient, who has a need for rehabilitation therapy as ordered by the physician.	Not covered by TC: • Obstetrical patients • Patients receiving anti-cancer intravenous cytotoxic drugs • Patients with highly complex multiple rehabilitation needs that include intensive social and/or psychological interventions in order to adjust to their disability or in order to be discharged safely to a residential setting • Patients with a primary psychiatric diagnosis, or any disorder resulting in behaviors that require an intensive, highly structured behavior management and/or cognitive retraining program

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1 1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	3. Wound care, including but not limited to, skin ulcers, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites requiring the implementation of a wound care plan every eight hours. Wounds that pre-existed at nursing facility-level B shall not qualify for TC level of care. Wound care management requires physician prescribed intervention by the licensed nurse and/or physical therapist beyond routine cleansing and dressing. 4. Respiratory treatments requiring medication administration by a licensed nurse or respiratory therapist at least every six hours. 5. Traction, requiring the assessment and intervention of a licensed nurse or licensed physical therapist at least every eight hours.	

Prior authorization is not required for emergency services.
* Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a	Hospital outpatient department services and organized outpatient clinic services	The following services are covered: 1. Physician 2. Optometric 3. Psychology 4. Podiatric 5. Physical therapy 6. Occupational therapy 7. Speech pathology 8. Audiology 9. Acupuncture 10. Laboratory and X-ray 11. Blood and blood derivatives 12. Chronic hemodialysis 13. Hearing aids 14. Prosthetic and orthotic appliances 15. Durable medical equipment 16. Medical supplies 17. Prescribed drugs 18. Use of hospital facilities for physicians' services 19. Family planning 20. Adult day health care	Prior authorization is always required for physical therapy; chronic hemodialysis; pur rental, or repair of hearing aids if cost e: $25; adult day health care; surgical proced considered to be elective; outpatient heroi detoxification; outpatient procedures such hyperbaric O_2 therapy, psoriasis day care, pheresis, and cardiac catheterization. Prior authorization is required for psychia visits in excess of 8 in 120 days and for allergy injections in excess of 8 in 120 da Speech pathology and audiology, occupationa therapy, acupuncture, and psychology servic are subject to the availability of MEDI lab Routine podiatry office visits are allowed out prior authorization. All other podiatr services are subject to prior authorization Prior authorization is required when the pu price of durable medical equipment or prost orthotic appliances exceeds $100. Prior authorization is required when cumul rental or repairs exceed $25.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

Eff 7-1-88

App. MAR 2 1 1989

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
			All services, including physicians' services are subject to the same requirements as when provided in a nonfacility setting. Mental health services are identified in the SD/MC agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program or the SD/MC system.
2b	Rural health clinic services and other ambulatory services courses under the state plan.	Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Home nursing services must be furnished in accordance with a written treatment plan established by a physician or nonphysician medical practitioner. The treatment plan must be approved and reviewed every 60 days by the supervising clinic physician. All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.
2c and 2d	Federally qualified health center (FQHC) services and other ambulatory services covered under the state plan.	Physician services and home nursing services provided by a FQHC.	All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.

* Prior authorization is not required for emergency service.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
3	Laboratory, radiological, and radioisotope services	As required on order of a licensed practitioner except laboratory services provided in renal dialysis centers and community hemodialysis units are payable only when billed by the center or unit.	Prior authorization is required for nonemergency portable X-ray services unless perfo in a skilled nursing facility (SNF) or intermediate care facility (ICF).
4a	Skilled nursing facility	Covered when patient has need for daily skilled nursing and/or daily special rehabilitation services which, as a practical matter, can only be provided on an inpatient basis. The patient must be visited by a physician at least monthly for the first three months and at least every two months thereafter.	Prior authorization is required. Attending physicians must recertify a patie level of care and plan every 60 days. For patients having Medicare as well as Med eligibility (crossover cases), authorizatio required at the time of Medicare denial or before the 20th day after admission.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHERS-17

Eff 7-1-88

App MAR 2 1 10[illegible]

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.1	Subacute care services (SNF)	This is a more intensive SNF level of care. Covered when patient has need for intensive licensed skilled nursing care. The patient must be visited by a physician at least twice weekly during the first month and a minimum of at least once every week thereafter. Subacute units must provide sufficient licensed nursing staff to provide a minimum daily average of 4.8 actual licensed nursing hours per patient day for nonventilator-dependent patients and 6.2 licensed nursing hours per patient day for ventilator-dependent patients.	Same as 4a above. Initial care may be authorized for up to two months. Prolonged care may be authorized for up to a maximum of four months.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPMH 88-17

Eff 7-1-88

App [illegible] 1988

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Minimal standards of medical necessity for the subacute level of care include: A. Physician visits medically required at least twice weekly during the first month and a minimum of at least once every week thereafter. B. Twenty-four hour access to services available in a general acute care hospital. C. Special equipment and supplies such as ventilators. D. Twenty-four hour nursing care by a registered nurse or licensed vocational nurse.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHAM 88-17

Eff 9-1-88

App. MAR 2 1 1989

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	E. Administration of three or more of the following treatment procedures: 1. Traction and pin care for fractures (this does not include Bucks Traction). 2. Total parenternal nutrition. 3. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week. 4. Tube feeding (NG or gastrostomy). 5. Tracheostomy care with suctioning. 6. Oxygen therapy and/or inhalation therapy treatments during every shift and a minimum of four times per 24-hour period.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH 91-88 17

EFF 7-1-80

App MAR 2 1 1990

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	7. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or frequent IV drug administration via a peripheral and/or central line without continuous infusion such as via Heparin lock.	
	8. Medically necessary isolation precautions as recommended by the Centers for Disease Control. (Infection control measures for the care of decubitus ulcers do not apply in this category).	
	9. Debridement, packing, and medicated irrigation with or without whirlpool treatment.	
	10. Continuous mechanical ventilation for at least 50 percent of each day.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.2 Pediatric subacute services (NF)	Pediatric subacute care services are the services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function. Covered when medical necessity is substantiated as follows: Patient requires any one of the following items in 1-4 below: 1. A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day; 2. Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the four treatment procedures listed in B through E below:	Same as 4a above. A Treatment Authorization Request shall be required for each admission to a subacute unit caring for pediatric patients, and may be granted for a period of up to six months and reauthorized for a period of up to six months.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	A. Dependence on intermittent suctioning at least every eight hours, and room air mist or oxygen as needed;	
	B. Dependence on continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion;	
	C. Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours;	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	D. Dependence on tube feeding, naso-gastric or gastrostomy tube;	
	E. Dependence on other medical technologies required continuously, which in the opinion of the attending physician and the Medi-Cal consultant require the services of a professional nurse.	
	3. Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the five treatment procedures listed in (b)(2)(A) through (E) above;	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	4. Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in (b)(2)(A) through (E) above; Medical necessity shall be further substantiated by all of the following conditions: 1. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the patient's health care needs, and not be any less than the nursing staff ratios specified in Section 51215.8 (g) and (i);	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	2. The patient's medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, are not medically necessary; 3. The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed. Patients shall be visited by their physician at least twice weekly during the first month of stay, and a minimum of once each week thereafter.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.3 Transitional Inpatient Care (TC) (Nursing Facility)	TC is covered when provided in qualified SNFs that have a TC contract with the Department of Health Services. See 1.1.	Prior authorization is required for TC level of care. The physician must conduct a comprehensive medical assessment and determine the patient has been clinically stable for the 24 hours preceding admission to the TC level of care in a SNF. Preadmission screening must be conducted for all patients admitted to TC level of care in a SNF by an appropriate facility clinician. Bed hold is covered for nursing facility level A or level B patients who are authorized for TC level of care. See 1.1.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found.	Covered for Medi-Cal eligibles under 21 years of age. Includes rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, day care intensive, day care habilitation offered in local and mental health clinics or in the community. Includes Local Education Agency (LEA) Medi-Cal Billing Option Program services (LEA services). LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

MAR 14 2005

Approval Date _____

Authorization and Other Requirements*

Prior authorization is not required.

Medical necessity is the only limitation.

Service Limitations

LEA services are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services per 12-month period from the beneficiary's:

- Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student,
- California Children Services Program,
- Short-Doyle Program,
- Medi-Cal field office authorization (TAR),
- Prepaid health plan authorization (including Primary Care Case Management).

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	LEA services are defined as: Non-IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 13d). Health and mental health evaluation and education includes parts of the EPSDT assessment such as assessment of nutritional status and nutritional education, vision assessment, hearing assessment, developmental assessment, assessment of psychosocial status, health education and anticipatory guidance appropriate to age and health status which includes wellness counseling.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

LEA services are covered when provided to, or directed exclusively toward the treatment of, a Medicaid eligible student under 21 years of age.

Provider Qualifications

Services must be performed by providers who meet the applicable qualification requirements as described in 42 C.F.R. Part 440 who render services, within their scope of practice, as established in state law. Rendering providers of LEA services are licensed physicians/psychiatrists, licensed physician's assistants, licensed optometrists, licensed registered nurses, licensed credentialed school nurses, certified public health nurses, certified nurse practitioners, licensed vocational nurses, trained health care aides, registered school audiometrists, licensed clinical social workers, licensed psychologists, licensed educational psychologists, licensed marriage and family therapists (formerly licensed marriage, family and child counselors), credentialed school psychologists, credentialed school social workers, credentialed pupil service workers, licensed speech pathologists, licensed audiologists, credentialed language, speech and hearing specialists, licensed physical therapists, registered occupational therapists, and registered dieticians.

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 13d) includes psychosocial and developmental assessments to determine a student's eligibility for services under the Individuals with Disabilities Education Act (IDEA) or to obtain information on the student to identify and modify the health related services in the IEP/IFSP. These assessments, referred to as IEP/IFSP assessments, include psychological, speech language, occupational therapy, physical therapy, audiological and health evaluations.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

In addition, the following limitations apply:

- Credentialed school psychologists may provide psychosocial assessments, health education and anticipatory guidance, and psychological treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Section 2909 and Education Code Sections 49422 and 49424 to Medicaid eligible students.
- Credentialed school social workers may provide psychosocial assessments, health education and anticipatory guidance, and psychosocial treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 4996, 4996.9, 4996.14 and 4996.15 and Education Code Section 44874 to Medicaid eligible students.

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	Treatment Services • Physical therapy, (as covered in Subsection 11(a); • Occupational therapy (as covered in Subsection 11(b); • Speech/audiology (as covered in Subsection 11(c); • Physician services (as covered in Subsection 5(a); • Psychology (as covered in Subsections 6(d) and 13(d); • Nursing services (as covered in Subsection 13(c); • School health aide services (as covered in Subsections 13(d) and 24(a); • Medical transportation (as covered in Subsection 24(a).

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

- Credentialed language, speech and hearing specialists may provide audiological and communication disorders assessments and treatment services, for which a student has been referred by a physician or other licensed practitioner of the healing arts, under the direction of licensed speech pathologists or licensed audiologists only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students.

  The definition of "under the direction of" a licensed practitioner is that the licensed practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed language, speech and hearing specialists that he or she agrees to direct. The licensed practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun.

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	
4c Family planning services and supplies for individuals of child bearing age.	Covered as physician and pharmaceutical services.
5a Physician's Services	As medically necessary, subject to limitations; however, experimental services are not covered.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

TN No. 03-024
Supercedes
TN No. 00-026

Approval Date MAR 14 2005

Authorization and Other Requirements*

- Credentialed pupil service workers may provide psychosocial assessments only;
- Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only;
- School health aides may provide trained health aide services only under the direct supervision of a physician, registered nurse or nurse practitioner or licensed vocational nurse and only to the extent authorized under federal law and the California Business and Professions Code.

LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.

Prior authorization is not required, and informed consent must be properly obtained for all sterilizations. Sterilization of persons under 21 years of age is not covered.

Physician services do not require prior authorization except as noted below:

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Procedures generally considered to be elective must meet criteria established by the Director. Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.)	Outpatient medical procedures such as hyperbaric 0^2 therapy, psoriasis day care, apheresis, cardiac catheterization, and selected surgical procedures (generally considered to be elective) are subject to prior authorization. Prior authorization is required for the correction of cosmetic defects. Inhalation therapy when not personally rendered by a physician requires prior authorization. All sterilizations require informed consent.
	Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered to be physician services for purposes of program coverage.	Prior authorization is required for psychiatric services in excess of 8 services in each 120-day period and injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies in excess of 8 in any 120-day period.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5b Medical and surgical services furnished by a dentist, to the extent mandated by 42 U.S.C. Section 1396(a)(5)(B), are covered.	In accordance with 42 U.S.C. Section 1396d (a)(5)(B) and 42 C.F.R. Section 40.50(b), medical and surgical services furnished by a dentist are limited to those services, including maxillofacial surgical services, oral surgery services, and associated diagnostic services, to the extent that these services may be performed under California law either by a doctor of medicine or doctor of dental surgery or dental medicine and would be described as physicians' services if performed by a physician.	Medical and surgical services furnished by a dentist, as described, administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion and oversight, and applicable federal and state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for the above services performed by an enrolled dental provider. Prior authorization of a defined subset of the above services is required.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
Medical care and any other type of remedial care recognized under State law.		
6a. Podiatrists' services.	Routine nail trimming is not covered. Inpatient services are covered only on written order of the physician or podiatrist who admits the patient to the hospital, and only when the period of hospital stay is covered by the program. Podiatry services are limited to treatment of disorders of the feet which complicate, or are secondary to, chronic medical diseases or which significantly impair the ability to walk.	Routine office visits do not require prior authorization. All other podiatry services are subject to prior authorization, except emergencies. All services provided in SNFs and ICFs are subject to prior authorization.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6b	Optometry services	As medically necessary except that orthoptics and pleoptics are not covered. Routine eye examinations with refraction are limited to one service in a 24-month period.	Prior authorization is necessary for low vi aids when the billed amount is over $100 an for contact lenses if they are the extended type or the contacts are to correct anisomet or when facial pathology or deformity precl the use of eyeglasses. Payment for some procedures may require additional justificat
6c	Chiropractic services	Limited to manual manipulation of the spine.	Prior authorization is not required; howeve services are limited to a total of two servi or any combination of two services in any on month from among the following: chiropracti acupuncture, psychology, occupational therap speech pathology, and audiology.
6d.1	Psychology	Psychology services are covered subject to the availability of MEDI labels.	
6d.2	Nurse anesthetist services	Nurse anesthetists may administer all types of anesthesia within their scope of licensure.	Since rendered as an adjunct to a physician, clinic, or hospital service, separate authorization is not required.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA HS 87 17 Eff 7-1-88 App [illegible] 1988

STATE PLAN CHART

(Note: This chart is an overview only.) Limitations on Attachment 3.1-A

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d3	Acupuncture services	Covered to prevent, modify, or alleviate the perception of severe, persistent, chronic pain resulting from a generally recognized medical condition.	Same as 6c.
6d.4	Licensed midwife services	All services permitted under scope of licensure.	Limited to the care of mothers and newborns during the maternity cycle, which consists of pregnancy, labor, birth, and a six-week postpartum period; and when performed under the supervision of a licensed physician and surgeon. Prior authorization for some services is required when applicable.
7.	Home Health Services Home health agency services, including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.		
7a. 7b.	Home health nursing and aide services	Covered when prescribed by a physician in the home of a beneficiary in accordance with a written treatment plan. The patient's condition must require skilled nursing care or other therapeutic services.	One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.

* Prior authorization is not required for emergency service.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1	Medical supplies	As prescribed by a licensed practitioner within the scope of his or her practice. Common household items, supplies not primarily medical in nature, and articles of clothing are not covered. Medical supplies provided in renal dialysis centers are included in the all-inclusive rate and are not separately billable. Medical supplies commonly used in providing SNF and ICF level of care are not separately billable.	Prior authorization is required for supplie listed in the Medical Supplies Formulary. Certain items require authorization unless for the conditions specified in the Medical Supplies Formulary.
		Blood and blood derivatives are covered when ordered by a physician or dentist.	Prior authorization is not required. Certification that voluntary blood donations cannot be obtained is required from blood b supplying the blood or facility where transf is given.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH 4828 (1)

Eff 7-1-88

Approved MAR 1 1989

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
7c.2	Durable medical equipment	Covered when prescribed by a licensed practitioner. DME commonly used in providing SNF and ICF level of care is not separately billable. Common household items are not covered.	Prior authorization is required when the purchase exceeds $100. Prior authorization is required when price, repairs, maintenance, or cumulative rental of listed items exceeds $25, except that the provision of more than two "H" oxygen tanks in any one month requires prior authorization. Purchase or rental of "By Report" (unlisted) items are subject to prior authorization regardless of purchase price. Authorization shall be granted only for the lowest cost item that meets medical needs of the patient.
7c.3	Hearing aids	Covered only when supplied by a hearing aid dispenser upon the prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available. Loaner aids, during repair periods covered under guarantee, are not covered. Replacement batteries are not covered.	Prior authorization is required for the purchase or trial period rental of hearing aids and for hearing aid repairs which exceed a cost of $25. Cords, receivers, ear molds, and hearing aid garments are covered without prior authorization. Authorization for hearing aids may be granted only when tests reveal an average loss of 35 dB or greater, or if the difference between the level of 1,000 Hertz and 2, 000 Hertz is 20 dB or more. The hearing loss need only b 30 dB, and speech communication is effectively improved or the need for personal safety is met.
7c.4	Enteral Formulae	Covered only when supplied by a pharmacy provider upon the prescription of a licensed practitioner within the scope of his or her practice. Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable. Common household items (food) are not covered.	Prior authorization is required for all products. Authorization is given when the enteral formulae is used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. Dietary supplements or products that cannot be used as a complete source of nutrition are considered non-benefits, except that the program may deem such a product a benefit when it determines that the use of the product is neither investigational nor experimental when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN 03-12
Supersedes
TN 88-017

Approval date JAN - 2 2004

Effective date: January 1, 2003

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7d	Physical and occupational therapy, speech pathology and audiology services provided by a home health agency.	See 11.	See 11.
8	Special duty nursing services.	Not covered.	
9	Clinic services	See 2a.	See 2a.
10	Dental services	Pursuant to 42 U.S.C. Section 1396d(a)(10), emergency and essential diagnostic and restorative dental services are covered, subject to limitations contained in applicable state statutes, regulations, manual of criteria, and utilization controls. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not benefits. For beneficiaries 21 years of age and older, there is an $1,800 annual benefit maximum, with the following exceptions: • Emergency dental services • Services that are federally mandated under Part 440 (commencing with Section 440.1) of Title 42 of the Code of Federal Regulations, including pregnancy-related services and for other conditions that might complicate the pregnancy.	Dental services are administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI), subject to state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for covered dental services performed by an enrolled dental provider. Prior authorization of a defined subset of dental services is required.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	• Dentures • Maxillofacial and complex oral surgery • Maxillofacial services, including dental implants and implant-retained prostheses. • Services provided in long-term care facilities. For beneficiaries under 21 years of age, medically necessary dental services mandated by Sections 1905(a)(4)(B) and (r) of the Social Security Act (42 U.S.C. Sections 1396d(a)(4)(B) and (r), early and periodic screening, diagnostic, and treatment services are covered.	

* Prior Authorization is not required for emergency service.
** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11	Physical therapy and related services	Physical therapy and occupational therapy are covered only when prescribed by a physician, dentist, or podiatrist. Speech pathology and audiology may be provided only upon the written prescription of a physician or dentist. Outpatient physical therapy, occupational therapy, speech therapy, and audiology provided in a certified rehabilitation center are payable only when billed by the rehabilitation center. Maintenance therapy services are not covered.	All physical therapy services are subject to prior authorization. Occupational therapy, speech pathology, and audiology services rendered by independent practitioners are subject to the availability of MEDI labels, except that these services, when rendered to patients in SNFs or ICFs are subject to prior authorization. In a certified rehabilitation center, one visi in a six-month period for evaluation of the patient and preparation of an extended treatme plan may be provided without prior authorizati Additional services including other evaluation can be provided in accordance with an approved treatment plan signed by a physician, subject prior authorization.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

App MAR 2 1 1989

SPH 88-17

Eff 7-1-88

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12a Pharmaceutical services and prescribed drugs	Covered when prescribed by a licensed practitioner. Drugs for the treatment of hospital inpatients are covered as encompassed in the formulary of the hospital. Drugs administered for chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units are covered, but payable only when included in the all-inclusive rate.	Prior authorization is not required for drugs listed in the Drug Formulary except that certain Formulary drugs are subject to prior authorization unless used as specified therein. Except for hospital inpatients, prescriptions shall not exceed a 100-calendar-day supply. Hospital inpatient drugs, as encompassed in the Formulary of the hospital, do not require prior authorization. Hospital discharge medications may not exceed a ten-day supply. Certain Formulary drugs are subject to minimum or maximum quantities to be supplied. Drugs not on the Drug Formulary are subject to prior authorization, except that certain drugs are excluded from Medi-Cal program coverage. Six- prescription-per-month-limit. Additional prescriptions will be available through the "prior authorization" process. The limit shall not apply to patients receiving care in a nursing facility or to drugs for family planning.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

(Note: **This chart is an overview only.**) Limitations on Attachment 3.1-A

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b	Dentures	See 10.	See 10.
12c	**Prosthetic and orthotic appliances**	Covered when prescribed by a physician or podiatrist. Stock shoes (conventional or orthopedic) are covered when at least one of the shoes is to be attached to a prosthesis or brace. Orthopedic modifications to stock shoes are also covered.	Prior authorization is required when the purchase price is more than $100. Prior authorization is required for rental, or repair when the total cost is more than $50. Custom-made orthopedic shoes may be authorized when there is a clearly established medical need that cannot be satisfied by the modification of stock orthopedic shoes.
12d	**Eyeglasses, prosthetic eyes, and other eye appliances**	Covered as medically necessary on the written prescription of a physician or optometrist.	Prior authorization is required for some vision aids and contact lenses.
13a	Diagnostic services	See 4b	
13b	Screening services	See 4b	
13c	Preventive services	See 4b EPSDT program coverage. Covered services for pregnant/ postpartum Medi-Cal recipients etc.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

STATE P[illegible] CHART

(Note: [illegible]s chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13d.1	Adult day health care	Covered when requested by a physician for elderly persons or other adults with mental or physical impairments which handicap daily living activities, require treatment, or rehabilitative services but which are not of such a serious nature as to require 24-hour nursing care.	Prior authorization is required. Requests for authorization must be accompanied by a multidisciplinary team assessment which ascertains the individual's pathological diagnosis, physical disabilities, functions, abilities, psychological status, and social and physical environment.
13d.2	Chronic dialysis services	Covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs, and laboratory tests. Home dialysis and continuous ambulatory peritoneal dialysis are covered.	Prior authorization is required for the facility but not the physician. Initial authorization may be granted up to three months. Reauthorization may be granted up to 12 months. Inpatient hospitalization for patients under going dialysis requires prior authorization.
13d.3	Outpatient heroin detoxification services.	Daily treatment is covered through the 21st day.	Prior authorization is required. Additional charges may be billed for services medically necessary to diagnose and treat diseases which the physician believes are concurrent with, but not part of, the outpatient heroin detoxification services.
13d.4	Rehabilitative mental health services for seriously emotionally disturbed children.	See 4b EPSDT program coverage.	Medical necessity is the only limitation.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

AUG 0 5 1992

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-A

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.4 Rehabilitative mental health services (continued)	Short-Doyle/Medi-Cal rehabilitative mental health services are provided in the least restrictive setting appropriate for maximum reduction of psychiatric impairment, restoration of functioning consistent with requirements for learning and development, and/or independent living and enhanced self-sufficiency.	Services are based on medical necessity and in accordance with a coordinated client plan signed by a licensed practitioner of the healing arts.
13.d.5 Substance Abuse Treatment Services	Narcotic treatment program services, including outpatient methadone maintenance and/or levoalphacetylmethadol (LAAM), are covered under Drug Medi-Cal (DMC) when prescribed by a physician as medically necessary to alleviate the symptoms of withdrawal from opioids.	Prior authorization is not required. Post-service periodic reviews are conducted by the Department of Alcohol and Drug Programs (ADP) pursuant to an interagency agreement with the Department of Health Services (DHS), the Single State Agency. Reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Naltrexone provided as an outpatient treatment service directed at serving detoxified opioid addicts is covered under DMC when prescribed by a physician as medically necessary. Pregnant beneficiaries are precluded from receiving these services.	Same as above.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TN No. 00-016
Supercedes TN No. 97-005

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-A

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Abuse Treatment Services (continued)	Outpatient drug free treatment services to stabilize and rehabilitate patients who have a substance-related disorder diagnosis are covered under DMC when prescribed by a physician as medically necessary.	Same as above, except in those cases where additional EPSDT services (beyond those available under ADP regulations) are needed for individuals under 21, services are available subject to prior authorization by DHS.
	Day care rehabilitative treatment services provided to patients a minimum of three hours per day, three days a week, are covered under DMC when prescribed by a physician as medically necessary.	Prior authorization is not required. Post-service periodic reviews are conducted by ADP pursuant to an interagency agreement with DHS, the Single State Agency. Reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	See Supplement 2 to Attachment 3.1-A and Enclosure 1 for a description of substance abuse treatment services for pregnant and postpartum women.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TN No. 00-016
Supercedes TN No. 97-005

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-A

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
14.a. Services for individuals age 65 or older in institutions for tuberculosis	See 1, 4a, 15	See 1, 4a, 15.
14.b. Services for individual age 65 or older in institutions for mental diseases	See 1, 4a, 15.	See 1, 4a, 15.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TN No. 00-016
Supercedes TN No. ~~97-005~~ N/A
PJD

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
15	ICF services	Covered when patient is under the care of a physician and requires out-of-home protective living arrangements with 24-hour supervision and skilled nursing care on an ongoing intermittent basis. The patient must be visited by a physician at least every 60 days.	Prior authorization is required. The patient' physician must recertify patient's need for continued care every 60 days.
15a	ICF services for the developmentally disabled, developmentally disabled habilitative, or developmentally disabled nursing	Covered only for developmentally disabled persons who require 24-hour care in a protected setting and who require and will benefit from the services provided. The developmentally disabled nursing services are for those who are more medically fragile.	Prior authorization is required. The patient' physician must recertify patient's need for continued care on the same schedule as require for ICFs.
16	Inpatient psychiatric facility services for individuals under 22 years of age	See 1.	See 1.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA #88-17

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
17. Nurse Midwife Services	All services permitted under scope of licensure.	Services do not require prior authorization.
18. Hospice Services	Covered when provided by a Medicare certified hospice in the same scope and duration as Medicare. Services are limited to individuals who have been certified by a physician as having a life expectancy of six months or less.	Prior authorization is required for each of the four levels of hospice care described in regulation: routine home care, continuous home care, inpatient respite care, and general inpatient care. Special physicians services do not require prior authorization. Persons electing hospice care agree to waive their right to receive curative services related to their terminal illness.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
19. Case Management Services (Pertains to Supplements 1a-1f to Attachment 3.1-A)	Services are limited to individuals who meet the target population criteria.	Prior authorization is not required. Case Management services do not include: • Program activities of the agency itself which do not meet the definition of targeted case management • Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management • Diagnostic and/or treatment services • Services which are an integral part of another service already reimbursed by Medicaid • Restricting or limiting access to services, such as through prior authorization • Activities that are an essential part of Medicaid administration such as outreach, intake processing, eligibility determination or claims processing

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

	TYPES OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
19b	Special Outpatient Tuberculosis-Related	Services designed to encourage the completion of regimens of prescribed drugs by outpatients, including services to directly observe the intake of prescribed drugs (directly observed therapy (DOT)). Dot includes; delivery of prescribed medications; assisting with the means to ingest medications; monitoring for signs of nonadherence or adverse side effects; documenting that medications have been ingested; and reporting compliance and/or other problems.	Prior authorization is not required.

* Prior authorization is not required for emergency services
**Coverage is limited to medically necessary services

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	Preventive Services provided in the home, by Comprehensive Perinatal Services Providers, which are clinics and hospital outpatient departments, as medically necessary for pregnancy-related conditions only. Services are covered throughout pregnancy and through the end of the month in which the 60th day period following termination of pregnancy ends.	Prior authorization is required when services are provided in excess of the basic allowances. Basic allowances are described in Title 22, Sections 51348 and 51504.
21	Ambulatory prenatal care to pregnant women provided during a single limited period of presumptive eligibility. The scope of benefits is limited to specified outpatient pregnancy related services and does not include abortion or labor and delivery services.	Prior authorization is not required.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
24a.	Medical transportation services	Covered when transport by ordinary means is medically contraindicated and the transportation is required for covered medical care, subject to limitation. Only the lowest cost type of medical transportation adequate for the patient's needs is covered.	All nonemergency transportation requires prior authorization and a physician's, dentist's or podiatrist's written prescription. Emergency claims must be accompanied by justification.
24b.	Christian Science practitioners	Limited to the extent allowed under Title XVIII of the Social Security Act.	Services are subject to the two services per month limitation. See 6c.
24c.	Christian Science sanitoria care and services	See 4a.	See 4a.
24d.	SNF services provided for patients under 21 years of age	See 4a.	See 4a.
24d.1	Transitional Inpatient Care (TC) (Nursing Facility)	See 4a.3.	See 4a.3.
24e.	Emergency hospital services	See 1.	See 1.
24f.	Personal care services	Not covered.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
24g Local Education Agency (LEA) Services	LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus. LEA services are defined as: <u>Non-IEP/IFSP Assessments</u> • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and 13d). Health and mental health evaluation and education includes parts of the EPSDT assessment such as assessment of nutritional status and nutritional education, vision assessment, hearing assessment, developmental assessment, assessment of psychosocial status, health education and anticipatory guidance appropriate to age and health status which includes wellness counseling.	<u>Service Limitations</u> LEA services are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services 12-month period from the beneficiary's: • Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student, • California Children Services Program, • Short-Doyle Program, • Medi-Cal field office authorization (TAR), • Prepaid health plan authorization (including Primary Care Case Management). All Medi-Cal recipients have access to enrolled LEA providers for the services they provide.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Type of Service	Program Coverage**
24g Local Education Agency (LEA) Services (cont.)	IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and 13d) includes psychosocial and developmental assessments to determine a student's eligibility for services under the Individuals with Disabilities Education Act (IDEA) or to obtain information on the student to identify and modify the health related services in the IEP/IFSP. These assessments, referred to as IEP/IFSP assessments, include psychological, speech language, occupational therapy, physical therapy, audiological and health evaluations.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

Provider Qualifications

Services must be performed by providers who meet the applicable qualification requirements as defined in 42 C.F.R. Part 440 who render services, within their scope of practice, as established in state law. Rendering providers of LEA services are licensed physicians/psychiatrists, licensed physician's assistants, licensed optometrists, licensed registered nurses, licensed credentialed school nurses, certified public health nurses, certified nurse practitioners, licensed vocational nurses, trained health care aides, registered school audiometrists, licensed clinical social workers, licensed psychologists, licensed educational psychologists, licensed marriage and family therapists (formerly licensed marriage, family and child counselors), credentialed school psychologists, credentialed school social workers, credentialed pupil service workers, licensed speech pathologists, licensed audiologists, credentialed language, speech and hearing specialists, licensed physical therapists, registered occupational therapists, and registered dieticians.

In addition, the following limitations apply:

- Credentialed school psychologists may provide psychosocial assessments, health education and anticipatory guidance, and psychological treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Section 2909 and Education Code Sections 49422 and 49424 to Medicaid eligible students.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
24g Local Education Agency (LEA) Services (cont.)	Treatment Services • Physical therapy, (as covered in Subsection 11(a); • Occupational therapy (as covered in Subsection 11(b); • Speech/audiology (as covered in Subsection 11(c); • Physician services (as covered in Subsection 5(a); • Psychology (as covered in Subsections 6(d) and 13(d); • Nursing services (as covered in Subsection 4 (b) and 13(c); • School health aide services (as covered in Subsections 13(d) and 24(a); • Medical transportation (as covered in Subsection 24(a).	• Credentialed school social workers may provide psychosocial assessments, health education and anticipatory guidance, and psychosocial treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 4996, 4996.9, 4996.14 and 4996.15 and Education Code Section 44874 to Medicaid eligible students. • Credentialed language, speech and hearing specialists may provide audiological and communication disorders assessments and treatment services, for which a student has been referred by a physician or other licensed practitioner of the healing arts, under the direction of licensed speech pathologists or licensed audiologists only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students. The definition of "under the direction of" a licensed practitioner is that the licensed practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed language, speech and hearing specialists that he or she agrees to direct. The licensed practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Type of Service	Program Coverage**
24g Local Education Agency (LEA) Services (cont.)	

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

- Credentialed pupil service workers may provide psychosocial assessments only;
- Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only;
- School health aides may provide trained health aide services only under the direct supervision of a physician, registered nurse or nurse practitioner or licensed vocational nurse and only to the extent authorized under federal law and the California Business and Professions Code.

LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
25. Personal Care	Personal Care Services authorized by the county worker are based on an assessment of the recipient. Qualified providers shall perform services in the recipient's home or at place of employment. Services may include one or more activities such as assisting with the administration of medications, providing needed assistance or supervision with basic personal hygiene, eating, grooming and toileting. Other incidental services may also be provided as long as they are subordinate to personal care services.	Personal Care Services shall be available to all categorically needy eligibles covered under the state plan and in accordance with state law. Services will be provided to the recipients who have an illness that has been diagnosed to be chronic and/or permanent (lasting at least one year) and who are unable to remain safely at home or are unable to obtain, retain or return to work without this assistance. Personal Care Service hours shall be capped at a maximum of 283 hours per month. Service hours for recipients shall be based on medical necessity as determined by the Statewide Uniform Assessment. Services in support of work are only available to the extent that service hours utilized at work are included in the total personal care service hours authorized for the recipient based on the recipient's need for services in the home. Authorized personal care services utilized by a recipient for work shall be services that are relevant and necessary in supporting and maintaining employment and shall not supplant any reasonable accommodation required of an employer under the Americans with Disabilities Act or other legal entitlements or third-party obligations. Services shall not be available to residents of a facility licensed by the California State Department of Health Services nor to residents of a community care facility or a residential care facility licensed by the California State Department of Social Services Community Care Licensing Division.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
27. Program for All-Inclusive Care for the Elderly (PACE)	PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE services package includes all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team essential for the care of the enrollee. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees and shall provide enrollees access to necessary and covered items and services 24 hours per day, every day of the year.	PACE services shall be available to eligible individuals who meet the age criteria of 55 years old or older, reside in the service area of the PACE program, are certified as eligible for nursing home care by the California Department of Health Services, and meet other eligibility conditions as may be imposed under the PACE program agreement.

**Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

19. CASE MANAGEMENT SERVICES

A. Target Group: See Supplement 1 to Attachment 3.1-A.

A-1 Mentally Disabled (Short-Doyle), Page 3
A-2 Developmentally Disabled (Lanterman), Page 4

B. Areas of State in which services will be provided:

|X| Entire State.

|_| Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

|_| Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

|X| Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services: See Supplement 1 to Attachment 3.1-A.

D-1 Mentally Disabled, Page 4
D-2 Developmentally Disabled, Page 6

E. Qualification of Providers: See Supplement 1 to Attachment 3.1-A.

E-1 Mentally Disabled, Page 10
E-2 Developmentally Disabled, Page 11

State/Territory: California

F. Assurances: See Supplement 1 to Attachment 3.1-A.

F-1 Mentally Disabled, Page 12
F-2 Developmentally Disabled, Page 14

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

A. Target Group

A-1 Mentally Disabled

Short-Doyle mental health programs will provide case management services according to locally established priorities for mental health services and in a manner consistent with existing administration and service delivery structure. Services will be provided concurrently to clients who are Medi-Cal beneficiaries and to those who are not; services provided to clients who are not Medi-Cal eligible will be funded with State General Funds exclusively. Services provided to clients of the target population who are Medi-Cal beneficiaries will be reimbursed through SD/MC* Program. The target population for case management services include:

1. Individuals who are or have been hospitalized for psychiatric care in a state or local inpatient facility, including a psychiatric health facility, or admitted to a skilled nursing facility, and for whom a different level of care is appropriate.

2. Individuals who are perceived to be at risk of being admitted for psychiatric care to a state or local inpatient facility, psychiatric health facility, or a skilled nursing facility, but for whom care in a nonmedical facility is appropriate.

3. Mentally disabled individuals living with their families, significant others, or in independent or semi-independent living arrangements who need support services to maintain stability at this level.

4. Mentally disabled individuals who require care and supervision in a licensed nonmedical community care facility.

5. Severely emotional disabled children and adolescents who are at risk of needing out-of-home placement.

6. Mentally disabled children and youth who do not fall into the target groups previously cited but who are perceived to be in need of guidance and assistance to secure appropriate treatment and care.

---

* SD/MC means the Short/Doyle/Medi-Cal Program, which is that portion of the statewide mental health program which serves Medicaid-eligible persons.

7. Mentally disabled homeless individuals.

A-2 Developmentally Disabled

The target population for which federal financial participation is requested is composed of those developmentally disabled persons who meet the following definition of developmental disability.

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. This term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include handicapping conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

Persons residing in those facilities designated as Intermediate Care Facilities/Mentally Retarded (ICF/MR) shall be excluded from the target group.

D. Definition of Services

D-1 Mentally Disabled

Client-specific services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services. Defined services activities are:

1. Evaluation

Purpose: To determine the individual's strengths, needs, and resources. this activity would typically include assessment and periodic reassessment of the level of psychosocial impairment.

physical health problems, self-care potential, support network availability, adequacy of living arrangements, financial status, employment status, and potential and training needs. The case manager will review all available medical, psych-social, and other records; meet with the client as necessary; and consult with treatment staff and other agencies. Contacts may be face-to-face or by telephone with the client, family, or significant others.

2. Plan Development

Purpose: To develop a written, comprehensive, individual service plan (ISP), which specifies the treatment, services activities, and assistance needed to accomplish the objectives negotiated between the client and case manager. The service plan must describe the nature, frequency, and duration of services to be offered. Contacts may be face-to-face or by telephone with the client, family, or significant others.

3. Emergency Intervention

Purpose: To intervene with the client/others at the onset of a crisis to provide support and assistance in problem resolution and to coordinate or arrange for the provision of other needed services. Contacts may be face-to-face or by telephone with the client, family, or significant others.

4. Placement Services

Purpose: To assess the adequacy and appropriateness of the client's living arrangements and to assist in securing alternative living arrangements when needed. Services would typically include locating and coordinating the resources necessary to facilitate a successful and appropriate out-of-home placement, monitoring the client's progress, and consulting, as required, with the care provider. Contacts may be face-to-face or by telephone with the client's family, significant other, or service provider.

5. Assistance in Daily Living

Purpose: To monitor, support, and assist the client on a regular basis in developing or maintaining the skills needed to implement and achieve the goals of the ISP. Services would typically include support in the use of psychiatric, medical, and dental services; guidance in money management; and the use of educational, socialization, rehabilitation, and other social services.

6. Linkage and Consultation

Purpose: to identify, assess, and mobilize resources to meet the client's needs. Services would typically include consultation and intervention on behalf of the client with Social Security, welfare and health departments, and other community agencies, as appropriate. Although contact with the client, family, or significant others is not required, contacts must be on behalf of a specific client.

Client case records shall specify which case management service(s) has been provided, the date of the service(s), and the time spent providing the service(s).

D. Definition of Service

D-2 Developmentally Disabled

Regional center case management, as provided to eligible developmentally disabled clients, via contract with the Department of Developmental Services (DDS) and authorized by the Lanterman Act, are those individual services that will assist beneficiaries in gaining access to needed medical, social, educational, and other services.

1. Background

California's developmental disabilities service system is administered by DDS which, as of January 1988, was serving 88,314 Clients and has expenditures of $911 million. DDS directly administers 7 state developmental centers (formerly called state hospitals) and contracts on an annual basis with 21 boards of directors of private, nonprofit corporations to operate regional centers (case management provider agency). It is through these contacts that DDS ensures program and financial accountability for regional center case management services.

The regional center system is governed by the Lanterman Developmental Disabilities Services Act of 1977 (Division 4.5 of the California Welfare and Institutions Code). Under the Act, DDS is responsible for coordinating the services of many state departments and community agencies to ensure that no gaps occur in communication or the provision of services to persons with developmental disabilities.

The catchment area boundaries for the regional centers conform to county boundaries or groups of counties, except for Los Angeles County which is divided into 7 areas, each served by a regional center.

2. Core Elements of Case Management

For purposes of the Medicaid Targeted Case Management Services program, the provision of services will be limited to case management services provided by the regional centers (case management provider agency). Case management is the process of needs assessment, setting of objectives related to needs, service scheduling, program planning, and evaluating program effectiveness.

The regional center provides services which ensure that the changing needs of the person and the family are recognized on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

a. Assessment

Assessment includes those case management services available to the developmentally disabled client in order to provide data necessary to develop a plan for current and future client services. This involves acquainting and educating the client, parent, or legal guardian with sources of services in the community; providing procedures for obtaining services through the regional center; analyzing each client's medical, social, and psychological evaluations, and any other evaluations necessary to determine appropriate resources to meet each client's needs and completing a treatment plan. (While physical and psychological examinations and evaluations are essential components of case management, these services fall within the scope of regular Medi-Cal benefits. As such, these services will not be billed as Targeted Case Management Services). Specific client objectives are discussed and strategies for achieving the stated objectives are identified.

b. Individual Program Plan (IPP)

An IPP is created for each client who is determined, through the above described assessment, to be in need of such a plan. This is a process in which a client's abilities and needs are identified and goals, objectives and plans are formulated by the case manager to meet the unique needs of the clients. The regional center case manager, the Client Service Coordinator (CSC), is responsible for the development of the IPP. The IPP includes an assessment of the client's specific capabilities and problems; time-limited objectives for improving capabilities and resolving problems; a schedule of services to meet objectives; and a schedule of regular, periodic review and reassessment to ascertain that planned services have been provided and that objectives have been reached within times specified.

The IPP represents the cooperative effort and agreement of an interdisciplinary team which is composed of the regional center CSC, the client and/or legal representative, and other parties involved, as appropriate.

c. Annual/Periodic Review

At least on an annual basis, CSC will complete a summation of client progress in achieving IPP objectives and an assessment of the client's current status. Based on this assessment, the regional center CSC and the person with developmental disabilities, or the conservator shall determine if reasonable progress has been made and shall be free to choose whether current services should be continued, modified, or discontinued. Periodic reviews will be conducted when it is determined that the implementation of the client's IPP needs to be reviewed more frequently than once a year or where state/federal law requires more frequent reviews.

d. Discharge Planning

Discharge planning to assist the individual in transitioning from inpatient to outpatient status, and arranging for appropriate services for the person being discharged. This work needs to begin prior to the actual date of discharge, and for this reason, targeted case management services for discharge planning activities performed by the regional center for up to 180 days prior to an individual's actual discharge from an institutional setting are included.

Individuals requesting case management services may receive these services from the regional center responsible for the catchment area in which the individual resides. Catchment area boundaries have been established in order to assure individuals access to services within a reasonable distance for their residence. The individual's freedom of choice of providers is not, however, restricted to any particular regional center in that the individual may seek case management services from any regional center in the state.

The Lanterman Act requires that the performance of the CSC be reviewed at least annually by the regional center, the client, and the client's parents or guardian or conservator. The CSC may not continue to serve as a case manager for the client unless there is agreement by all parties that the CSC should do so. All parties shall be free to choose whether the CSC's services should be continued, modified, or discontinued. If the client is dissatisfied with a particular CSC, the regional center works with the client and the CSC in an attempt to resolve the problem. If the situation cannot be resolved, the client may transfer to another case manager.

Clients are not required to accept case management services. Should a client refuse to accept these services, this refusal shall not be used as a basis to restrict the client's access to other Medicaid-funded services. Further, the provision of case management services will in no way restrict the individual's free choice of providers of other Medicaid-funded services.

A fair hearing opportunity will be provided in compliance with Article 3 of the Lanterman Act for beneficiaries who believe they were not given the choice of case management services or who believe they are denied the service of their choice by the regional center.

A process of client fair hearings is described in the California Administrative Code, Title 17, Section 50540.

E. Qualification of Providers

E-1 Mentally Disabled

SD/MC reimbursement for hospital and clinic services is provider-specific, based upon costs (to a maximum) that are unique to that provider. The provider, moreover, must be certified by DHS to be eligible for the SD/MC Program, and certification is dependent upon compliance with established staffing standards. For case management services, the same basic principles will apply. County mental health programs will have two options:

1. Case management services may be added as a mode of service to be provided by certified SD/MC clinics. This option may be the more appropriate and cost-effective one for small county programs with a limited number of staff and/or service providers and relatively few clients who require case management services. The designated case manager(s) may be required to perform other duties in addition to case management services, but a clear audit trail for case management services will be assured by requiring counties to maintain a unique cost center for case management services and to document case management activities separately; i.e., a separate case record or a separate section of the clinical record.

2. A distinct program unit, or more than one, may be established by the county and certified by DHS to provide and be reimbursed FFP for the case management mode of service. The identified unit(s) will be required (1) to have a unique provider number, (2) to meet staffing standard requirements, and (3) to have ain place a utilization review system.

Case management services, whether provided by a certified SD/MC clinic or by a distinct program unit which provide case management services exclusively, shall be provided by or under the direction of Title 9, CCR, Sections 623, 624, 625, 627, 628, and 629 (minimum qualifications which apply to the head or chief of a particular service).

Case managers who will function under the supervision of the licensed professional noted above will include staff who are social workers (licensed and nonlicensed), nurses, marriage, family and child counselors, and, in some instances, staff with mental health experience but varied backgrounds who have been hired into job classifications of a generic nature, i.e., mental health specialists.

The State will require that supervisor/supervisees ratios for case management services be commensurate to the professionalism and experience of the case management staff. The local mental health director is held responsible to assure the quality of services provided subject to DMH and DHS oversight.

E. Qualification of Providers

The CSC, employed by the regional center, will be designated as the provider of TCM services. The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis. Case aides will do basic duties such as working by telephone with consumers and families. They assist in screening calls for services and frequently resolve requests for services. The case aides are employed by the regional center and work under the direct supervision of the CSC.

F. Additional Assurances

F-1 Mentally Disabled

County mental health programs which claim SD/MC reimbursement for case management services shall be required to provide and abide by the following assurances. DMH and DHS, as the single state agency, shall monitor to assure that:

1. Reimbursement

SD/MC reimbursement for case management services provided to residents of an inpatient hospital or skilled nursing/intermediate care (SNF/ICF) facility will be claimed only for evaluation and placement services. Those case management services, as defined in Attachment to Supplement 1 to Attachment 3.1-A, will not be allowed as a substitute for or as a part of the screening and other requirements of Public Law 100-203 (Nursing Home Reform).

FFP for case management evaluation and placement services provided to residents of an inpatient hospital or an SNF/ICF will be limited to a period of 30 days immediately prior to the eligible individual's discharge from the facility to noninstitutional care. Moreover, while acknowledging that, for a variety of possible reasons, discharge may not always materialize as planned; the State, nevertheless, will limit reimbursement for such case management services to a maximum of 3 nonconsecutive episodes of 30 days or less per institutional stay.

2. Record Keeping/Utilization Review

Record keeping/utilization review requirements are fully implemented.

DMH utilization review standards for case management services will be similar to those which have been developed and implemented for hospital impatient and outpatient clinic services. DMH will develop an appropriate utilization review protocol which will be submitted to DHS for review and concurrence prior to implementation.

DMH shall require local mental health programs and providers of case management services to utilize existing systems, or establish necessary additional systems, to review the quality and appropriateness of case management services funded by Medi-Cal and shall audit for compliance. County or provider utilization review committees should anticipate that DMH utilization review audits shall:

a. Verify that providers of case management services have a continuous operational program of utilization review in effect under which the admission of each client for case management services is reviewed for approval.

b. Verify that the client meets the criteria established for the target population.

c. Verify that the county/provider has established criteria, and applied that criteria, to evaluate the need for case management services and for termination of case management services.

d. Verify that the need for case management services has been established and clearly documented. The initial review by the county or provider's utilization review committee shall be within 60 days of the client's admission for case management service; subsequent reviews shall be scheduled, at a minimum, every 6 months.

e. Verify that the case management service plan (goals, objectives, time frame) are appropriate to the identified need(s) and that the interventions of the case manager are appropriate to the goals, objectives, and projected time frame.

f. Identify and recoup inappropriate payments of FFP.

g. Provide an administrative mechanism for providers who wish to appeal a review finding.

F. Additional Assurances

F-2 Developmentally Disabled

No assurances.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

CASE MANAGEMENT SERVICES

A. Target Group:

Title XIX eligible, high-risk persons identified as having a need for public health case management services including the following individuals:

- Women, infants, children and young adults to age 21
- Persons with HIV/AIDS
- Persons with reportable communicable diseases
- Pregnant women
- Persons who are technology dependent
- Persons who are medically fragile
- Persons with multiple diagnoses

"High-risk persons" are those who have failed to take advantage of necessary health care services, or do not comply with their medical regimen or who need coordination of multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, substance abuse or because they are victims of abuse, neglect, or violence.

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

__ Entire State

X Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide): Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, Fresno, Humboldt, Imperial, Kern, Kings, Lake, Lassen, Los Angeles, Madera, Marin, Mendocino, Merced, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Trinity, Tulare, Tuolumne, Ventura, and Yuba counties, City of Berkeley, City of Long Beach, and the City of Pasadena.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

C. Comparability of Services

___ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted case management services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

1. Assessment

Analyzing each client's need for medical, social, educational and other services to determine appropriate resources and to develop a service plan.

2. Plan Development

Plan development includes the development of a written, comprehensive, individual service plan based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency and duration of the activities and assistance which meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with sources of services in the community and providing information for obtaining services through community programs.

3. Linkage and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services, as well as follow-up to ensure services are received by the client.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational and other services.

5. Crisis Assistance Planning

The evaluation, coordination and arranging of immediate services or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

Case Management services do not include:

- Program activities of the agency itself which do not meet the definition of targeted case management
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management
- Diagnostic and/or treatment services
- Services which are an integral part of another service already reimbursed by Medicaid
- Restricting or limiting access to services, such as through prior authorization
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing

E. Qualification of Providers:

1. Case Management Agencies:

a. Must be a public health agency employing staff with case manager qualifications; and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

b. Have the ability to evaluate the effectiveness, accessibility and quality of targeted case management services on a community-wide basis; and

c. Have established referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and

d. Have a minimum of five years experience in assisting high-risk, low income persons to obtain medical, social, educational and/or other services; and

e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and

f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

h. Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

2. Case Managers employed by the case management agency must meet the following requirements for education and/or experience as defined below:

a. A certified Public Health Nurse or a Registered Nurse, or a Licensed Vocational Nurse under the direct supervision of a skilled professional medical person, or an individual, specified in (b) through (d) below, who is under the direct supervision of a skilled professional medical person.

b. An individual with a Bachelor's degree from an accredited college or university, and completion of agency-approved case management training; or

c. An individual with an AA degree from an accredited college, and completion of agency-approved case management training and two years experience performing case management duties in a health or human services field; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

d. An individual who has completed an agency-approved case management training course with four years experience performing case management duties in a health or human services field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

G. Implementation of Targeted Case Management as described in this State Plan Amendment is subject to retroactive changes in state law necessary to implement this amendment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURTIY ACT

State/Territory: California

CASE MANAGEMENT SERVICES

A. Target Group:

Medi-Cal eligible persons who are in need of outpatient clinic medical services and who need case management services in connection with their treatment because they are unable to access or appropriately utilize services themselves, including the following individuals:

- Persons who have demonstrated non compliance with their medical regimen
- Persons who are unable to understand medical directions because of language or other comprehension barriers
- Persons with no community support system to assist in follow-up care at home
- Persons who require services from multiple health/social service providers in order to maximize health outcomes

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

__ Entire State.

X Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide): Alameda, Fresno, Kings, Lake, Los Angeles, Monterey, Placer, Riverside, San Diego, San Francisco, San Joaquin, San Mateo, Shasta, Solano, and Tuolumne counties, City of Long Beach, and the City of Pasadena.

C. Comparability of Services:

__ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

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

D. Definition of Services:

Targeted case management services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

1. Assessment

Analyzing each client's need for medical, social, educational and other services to determine appropriate resources and to develop a service plan.

2. Plan Development

Plan development includes the development of a written, comprehensive, individual service plan based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency and duration of the activities and assistance which meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with sources of services in the community and providing information for obtaining services through community programs.

3. Linkage and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services, as well as follow-up to ensure services are received by the client.

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational and other services.

5. Crisis Assistance Planning

The evaluation, coordination and arranging of immediate non-medical services or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

Case Management services do not include:

- Program activities of the agency itself which do not meet the definition of targeted case management
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management
- Diagnostic and/or treatment services
- Services which are an integral part of another service already reimbursed by Medicaid
- Restricting or limiting access to services, such as through prior authorization
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing

E. Qualification of Providers:

1. Case Management Agencies:

a. Must be a public health agency employing staff with case manager qualifications; and

b. Ensure 24-hour availability of case management services and continuity of those services; and

c. Have five years experience in serving the target population; and

d. Have the capacity to communicate with persons who have little or no proficiency in the English language; and

e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

h. Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

2. Case Managers employed by the case management agency must meet the following requirements for education and/or experience as defined below:

a. A Registered Nurse; or an individual, specified in (b) through (d) below, who is under the direct supervision of a skilled professional medical person.

b. An individual with a Bachelor's degree from an accredited college or university, and completion of agency-approved case management training; or

c. An individual with an AA degree from an accredited college, and completion of agency-approved case management training and two years experience performing case management duties in a health or human services field; or

d. An individual who has completed an agency-approved case management training course with four years experience performing case management duties in a health or human services field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

G. Implementation of Targeted Case Management as described in this State Plan Amendment is subject to retroactive changes in state law necessary to implement this amendment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

CASE MANAGEMENT SERVICES

A. Target Group:

Title XIX eligible individuals:

Children with an Individualized Education Plan (IEP), an Individualized Family Service Plan (IFSP) or an Individualized Health and Support Plan (IHSP).

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

__X__ Entire State.

_____ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide.

C. Comparability of Services

_____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

__X__ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted case management services include needs assessment, setting objectives related to needs, individual service planning, service scheduling, and periodically evaluating service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

1. Assessment

Analyzing each client's need for medical, social, educational and other services to determine appropriate resources and to develop a service plan.

2. Service Plan Development

Plan development includes the development of a written, comprehensive, individual service plan based on the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency and duration of the activities and assistance which meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with sources of services in the community and providing information for obtaining services through community programs.

3. Linkage, Consultation and Coordination

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services, as well as follow-up to ensure services are received by the client.

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational and other services.

5. Crisis Assistance Planning

The evaluation, coordination and arranging of immediate non-medical services or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving service plan objectives. Based on this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

Case Management services do not include:

- Program activities of the agency itself which do not meet the definition of targeted case management
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management
- Diagnostic and/or treatment services
- Services which are an integral part of another service already reimbursed by Medicaid
- Restricting or limiting access to services, such as through prior authorization
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing

E. Qualifications of Providers:

1. Case Management Agencies:

   a. Agencies with five years experience in developing and implementing IEPs, IFSPs, or IHSPs; and

   b. Must have demonstrated the ability to collaborate with public and private service providers; and

   c. Employ qualified Case Managers as identified in E.2. below; and

   d. Must have demonstrated direct experience in the coordination of educational support services (e.g. EPSDT, Social Services, Counseling Services, Psychological Services, Student Assistance, Special Education and Nutritional Service); and

   e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and

   f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

   g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

   h. Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

2. Case Managers employed by the case management agency must meet the following requirements for education and experience:

   a. Must meet the qualifications under Part B or Part H of Public Law 99-457; and

b. Have related experience working with children with special health care needs, developmental delay, or handicapping conditions; and

c. Be licensed or credentialed by a California state agency, or trained and supervised by a licensed or credentialed individual to provide case management services.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

G. Implementation of Targeted Case Management as described in this State Plan Amendment is subject to retroactive changes in state law necessary to implement this amendment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

CASE MANAGEMENT SERVICES

A. Target Group:

Title XIX eligible individuals:

Individuals, 18 years or older, who have exhibited an inability to handle personal, medical, or other affairs, who are under conservatorships of person and/or estate or a representative payee.

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

__ Entire State.

_X_ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide): Amador, Butte, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Lake, Lassen, Los Angeles, Mendocino, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Shasta, Solano, Stanislaus, Trinity, Tulare, Tuolumne, Yolo, and Yuba counties.

C. Comparability of Services

__ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted case management services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

1. Assessment

Analyzing each client's need for medical, social, educational and other services to determine appropriate resources and to develop a service plan.

2. Plan Development

Plan development includes the development of a written, comprehensive, individual service plan based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency and duration of the activities and assistance which meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with sources of services in the community and providing information for obtaining services through community programs.

3. Linkage and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services, as well as follow-up to ensure services are received by the client.

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational and other services.

5. Crisis Assistance Planning

The evaluation, coordination and arranging of immediate services or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management services do not include:

- Program activities of the agency itself which do not meet the definition of targeted case management
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management
- Diagnostic and/or treatment services
- Services which are an integral part of another service already reimbursed by Medicaid
- Restricting or limiting access to services, such as through prior authorization
- Activities that are an essential part of Medicaid administration such as outreach, intake processing, eligibility determinations and claims processing
- Activities related money management, property management or the legal requirements for annual renewal of conservatorship.

E. Qualification of Providers:

1. Case Management Agencies:

   a. Must be an agency employing staff with case manager qualifications; and

   b. Have established referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and

   c. Have a minimum of five years experience in providing case management services to the targeted population; and

   d. Ensure 24-hour availability of case management services and continuity of those services; and

   e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and

   f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

   g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

   h. Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

2. Case Managers employed by the case management agency must meet the following requirements for education and experience as defined below:

   a. An individual with a Bachelor's degree from an accredited college or university, and completion of agency-approved case management training; or

   b. An individual with an AA degree from an accredited college or university, and completion of agency-approved case management training and two years expereince performing case management duties in a health or human services field; or

   c. An individual who has completed an agency-approved case management training course with four years experience performing case management duties in a health or human services field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

   1. Eligible recipients will have free choice of the providers of case management services.

   2. Eligible recipients will have free choice of the providers of other medical care under the plan.

   3. Eligible clients will have the option to participate in the services offered under this plan.

G. Implementation of Targeted Case Management as described in this State Plan Amendment is subject to retroactive changes in state law necessary to implement this amendment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

CASE MANAGEMENT SERVICES

A. Target Group:

Title XIX eligible individuals, 18 years and older, in frail health and in need of assistance to access services in order to prevent institutionalization.

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

__ Entire State.

X Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide): Alameda, Amador, Butte, Calaveras, Contra Costa, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern, Kings, Los Angeles, Mendocino, Merced, Nevada, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Tulare, Tuolumne, and Yolo counties, and the City of Berkeley.

C. Comparability of Services

__ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted case management services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

1. Assessment

Analyzing each client's need for medical, social, educational and other services to determine appropriate resources and to develop a service plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

2. Plan Development

Plan development includes the development of a written, comprehensive, individual service plan based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency and duration of the activities and assistance which meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with sources of services in the community and providing information for obtaining services through community programs.

3. Linkage and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services, as well as follow-up to ensure services are received by the client.

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational and other services.

5. Crisis Assistance Planning

The evaluation, coordination and arranging of immediate services or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management services do not include:

- Program activities of the agency itself which do not meet the definition of targeted case management.
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management
- Diagnostic and/or treatment services
- Services which are an integral part of another service already reimbursed by Medicaid
- Restricting or limiting access to services, such as through prior authorization
- Activities that are an essential part of Medicaid administration such as outreach, intake processing, eligibility determinations or claims processing

E. Qualification of Providers:

1. Case Management Agencies:

a. Must have demonstrated programmatic and administrative experience in providing long-term care services and the ability to increase their service capability to provide their services to adults of all ages; and

b. Demonstrate they have an advisory group which includes representatives of the target group; and

c. Have established referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and

d. Have five years experience providing case management services to the targeted population; and

e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and

f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

h. Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

2. Case Managers employed by the case management agency must meet the following requirements for education and experience as defined below:

a. A Registered Nurse; or

b. An individual with a Bachelor's Degree from an accredited college or university, and completion of agency-approved case management training.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

c. An individual with an AA degree from an accredited college, and completion of agency-approved case management training and two years expereince performing case management duties in a health or human services field; or

d. An individual who has completed an agency-approved case management training course with four years experience performing case management duties in a health or human services field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

G. Implementation of Targeted Case Management as described in this State Plan Amendment is subject to retroactive changes in state law necessary to implement this amendment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

CASE MANAGEMENT SERVICES

A. Target Group:

Medi-Cal eligible persons who are 18 years of age and older who are on probation and have a medical and/or mental condition and are in need of assistance in accessing and coordination of medical, social and other services.

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

__ Entire State.

_X_ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than Statewide): Alameda, Amador, Butte, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Kings, Lake, Lassen, Los Angeles, Marin, Modoc, Monterey, Napa, Orange, Placer, Plumas, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Trinity, Tulare, Ventura, and Yolo counties.

C. Comparability of Services

__ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted case management services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

1. Assessment

Analyzing each client's need for medical, social, educational and other services to determine appropriate resources and to develop a service plan.

2. Plan Development

Plan development includes the development of a written, comprehensive, individual service plan based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency and duration of the activities and assistance which meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with sources of services in the community and providing information for obtaining services through community programs.

3. Linkage and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services, as well as follow-up to ensure services are received by the client.

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational and other services.

5. Crisis Assistance Planning

The evaluation, coordination and arranging of immediate services or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management services do not include:

- Program activities of the agency itself which do not meet the definition of targeted case management
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management
- Diagnostic and/or treatment services
- Services which are an integral part of another service already reimbursed by Medicaid
- Restricting or limiting access to services, such as through prior authorization
- Activities that are an essential part of Medicaid administration such as outreach, intake processing, eligibility determinations and claims processing

E. Qualification of Providers:

1. Case Management Agencies:

a. Must have a minimum of five years experience providing case management services to the targeted population; and

b. Have established referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and

c. Ensure 24-hour availability of case management services and continuity of those services; and

d. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and

e. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

f. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

g. Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

2. Case Managers employed by the case management agency must meet the following requirements for education and experience as defined below:

a. An individual with a Bachelor's Degree from an accredited college or university, and completion of agency-approved case management training which includes training on the medical aspects of case management; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

b. An individual with an AA degree from an accredited college, and completion of agency-approved case management training and two years experience performing case management duties in a health or human services field; or

c. An individual who has completed an agency-approved case management training course with four years experience performing case management duties in a health or human services field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

G. Implementation of Targeted Case Management as described in this State Plan Amendment is subject to retroactive changes in state law necessary to implement this amendment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

A. **Target Group**

Title XIX eligible children from birth to 21 years of age, who are eligible for medical assistance in accordance with Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act and who have laboratory test results documenting:

1. **One venous blood lead level equal to or greater than 20 micrograms of lead per deciliter of blood (mcg/dL) or**
2. **Two blood lead levels equal to or greater than 15 mcg/dL, which are drawn at least 30 and no more than 600 calendar days apart. The first specimen is not required to be venous, but the second must be venous.**

Individuals identified as lead poisoned require case management by public health nurses in order to access medical services to reduce elevated blood lead levels and to reduce and eliminate lead toxicity.

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

__X__ Entire State
_____ Only in the following geographic areas.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

C. Comparability of Services

___ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

_X_ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Medi-Cal Lead Poisoning Case Management Services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management of lead poisoned individuals includes the following:

1. Assessment

Analyzing each lead poisoned client's need for medical, social, educational, and other services to determine appropriate resources and to develop a service plan.

2. Plan Development

Plan development includes the development of a written, comprehensive, individual service plan based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with the sources of services in the community and providing information for obtaining services through community programs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

3. Linkages and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services as well as follow-up to ensure services including, but not limited to blood lead tests prescribed by providers, are received by the client.

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational, and other services.

5. Crisis Assistance Planning

The evaluation, coordination, and arranging of immediate services or treatment needed in those situations that appear to be emergent in nature or that require immediate attention or resolution in order to avoid, eliminate, or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

Medi-Cal Lead Poisoning Case Management services do not include:

- Program activities of the agency itself that do not meet the definition of case management defined by Medicaid.
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to case management services.
- Diagnostic and/or treatment services.
- Services that are an integral part of another service already reimbursed by Medicaid.
- Restricting or limiting access to services, such as through prior authorization.
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.

E. Qualification of Providers:

1. Case Management Agencies:

a. Must be a public health agency employing staff with case manager qualifications; and
b. Have the ability to evaluate the effectiveness, accessibility and quality of case management services on a community-wide basis; and
c. Have established referral systems and demonstrated linkages and referral ability with essential social and health services agencies; and
d. Have a minimum of five years experience in assisting high-risk, or low income persons to obtain medical, social, educational, and/or other services; and
e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and
f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

h. Have demonstrated the ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

2. Case managers employed by the case management agency must meet the following requirements for education and/or experience as defined below:

a. A certified Public Health Nurse with a Bachelor's degree from an accredited college or university, and completion of agency-approved case management training.

F. The State assures that the provision of Medi-Cal Lead Poisoning Case Management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

CASE MANAGEMENT SERVICES

A. Target Group:

Title XIX eligible individuals:

Medi-Cal eligible adults and children at risk of abuse and unfavorable developmental, behavioral, psychological, or social outcomes including the following individuals:

- Persons abusing alcohol or drugs, or both
- Persons at risk of physical, sexual, or emotional abuse
- Persons at risk of neglect

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915(g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

There shall be a county-wide system to ensure coordination among providers of case management services provided to beneficiaries who are eligible to receive case management services from two or more programs.

B. Areas of State in which services will be provided:

_____ Entire State.

__X__ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide): Alameda, Butte, Calaveras, Contra Costa, El Dorado, Fresno, Glenn, Kern, Kings, Lassen, Los Angeles, Marin, Mendocino, Mono, Monterey , Orange, Placer, San Benito, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Shasta, Solano, Sonoma, and Tuolumne counties, and the City of Long Beach.

C. Comparability of Services:

_____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

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

CASE MANAGEMENT SERVICES

__X__ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Targeted case management services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

1. Assessment

Analyzing each client's need for medical services to determine appropriate resources and to develop a service plan.

2. Plan Development

Plan development includes the developrnent of a written, comprehensive, individual service plan based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency and duration of the activities and assistance which meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with sources of services in the community and providing information for obtaining services through community programs.

3. Linkages and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical services, as well as follow-up to ensure services are received by the client.

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

CASE MANAGEMENT SERVICES

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, education and other services.

5. Crisis Assistance Planning

The evaluation, coordination and arranging of immediate services or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are still appropriate.

Case Management Services do not include:

- Program activities of the agency itself which do not meet the definition of targeted case management;
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management;
- Diagnostic and/or treatment services;
- Services which are an integral part of another service already reimbursed by Medicaid;
- Restricting or limiting access to services, such as through prior authorization; or
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination or claims processing.

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

CASE MANAGEMENT SERVICES

E. Qualification of Providers:

1) Case Management Agencies:

a. Must be a health care agency affiliated with a Local Governmental Agency, employing staff with case manager qualifications; and

b. Have the ability to evaluate the effectiveness, accessibility and quality of targeted case management services on a community-wide basis; and

c. Have established referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and

d. Have a minimum of five years' experience in assisting high-risk, low income persons to obtain medical services; and

e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and

f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and

g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

h. Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

2) Case Managers employed by the case management agency must meet the following requirements for education and/or experience as defined below:

a. An individual with a Bachelor's degree from an accredited college or university, and completion of agency-approved case management training; or

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

CASE MANAGEMENT SERVICES

b. An individual with an AA degree from an accredited college or university, and completion of agency-approved case management training and two years experience performing case management duties in a health or human services field; or

c. An Individual who has completed an agency-approved case management training course with four years experience performing case management duties in a health or human services field.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902 (a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

State/Territory: California

20. Extended Services For Pregnant Women

a. Pregnancy-related and postpartum services for 60 days after pregnancy ends.

PROVIDED: Pregnancy-related and postpartum services include all antepartum (prenatal) care, care during labor and delivery, postpartum care, and family planning. Pregnancy-related services include all care normally provided during pregnancy (examinations, routine urine analyses, evaluations, counseling, and treatment) and labor and delivery (initial and ongoing assessment of maternal and fetal well-being and progress of labor, management of analgesia and local or pudendal anesthesia, vaginal delivery with or without episiotomy, initial assessment and, when necessary, resuscitation of the newborn infant). Postpartum care includes those services (hospital and scheduled office visits during the puerperium, assessment of uterine involution and, as appropriate, contraceptive counseling) provided for 60 days after pregnancy ends. Family planning services include contraceptive counseling and tubal ligation.

Pregnancy-related and postpartum services may also include alcohol and other drug treatment services that ameliorate conditions that complicate pregnancy because the developing fetus is vulnerable to the mother's alcohol or drug dependence. Those services include women-specific treatment and recovery services (therapeutic interventions addressing issues such as relationships, sexual and physical abuse, and parenting), therapeutic child care, parenting skills training, child development education, and transportation services.

Day care rehabilitative services provided to pregnant and postpartum women a minimum of three hours per day, three days a week, are covered under the Drug Medi-Cal program when prescribed by a physician as medically necessary.

Perinatal residential services provided in a 24-hour structured environment are covered for pregnant and postpartum women under the Drug Medi-Cal program when prescribed by a physician as medically necessary. The costs of room and board are not reimbursable under the Medi-Cal program.

b. Services for any other medical conditions that may complicate pregnancy.

PROVIDED Treatment for obstetrical complications (including preexisting or developing maternal or fetal conditions) which create a high-risk pregnancy and which may or may not be pregnancy-related is also covered.

State: California

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATION ON SERVICES

13. d. Rehabilitative Mental Health Services

Rehabilitative Mental Health Services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for the maximum reduction of mental disability and restoration of a recipient to his best possible functional level, when provided by local public community mental health agencies and other mental health service providers licensed or certified by the State of California. Services are provided based on medical necessity and in accordance with a coordinated client plan or service plan approved by a licensed physician or other licensed practitioner of the healing arts, excluding crisis services for which a service plan is not required. Rehabilitative mental health services are provided in the least restrictive setting appropriate for reduction of psychiatric impairment, restoration of functioning consistent with the requirements for learning and development, and/or independent living and enhanced self-sufficiency. Services include:

Individual mental health services
Group mental health services
Crisis intervention
Crisis stabilization
Medication management
Day treatment, adult
Day treatment, children and youth
Day rehabilitation
Short term crisis residential treatment
Residential treatment

Provider Qualifications:

Rehabilitative mental health services are provided by qualified mental health organizations, agencies or mental health professionals who agree to abide by the definitions, rules, and requirements for rehabilitative mental health services established by the Department of Mental Health in conjunction with the Department of Health Services and who sign a provider agreement to serve all persons for whom these services are medically necessary, irrespective of ability to pay, subject to caseload capacity.

Services are provided by or under the supervision of a Qualified Mental Health Professional functioning within their scope of practice. A Qualified Mental

State: California

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Health Professional means any provider qualified under the Medi-Cal program that has specialized training as required by state law and Medi-Cal regulations.

Assurances:

The state assures that rehabilitative mental health services shall be available to all children found to be eligible under the provisions of Social Security Act (SSA) Sec. 1905(r)(5).

The state assures that services will not be available to residents of an institution for mental disease as defined in SSA Sec. 1905(j) and 42 CFR 435.1009.

The state assures that the Single State Agency shall not delegate to any other state agency the authority and responsibilities described in 42 CFR 431.10(e).

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATION ON SERVICES

13.d.5 Substance Abuse Treatment Services

Substance abuse treatment services are to stabilize and rehabilitate Medi-Cal beneficiaries who are diagnosed by physicians or other licensed practitioners of the healing arts, within the scope of their practices, as having a substance-related disorder. Substance abuse treatment services are provided by certified substance abuse treatment clinics, their certified satellite sites, or certified perinatal residential substance abuse programs; are based on medical necessity; and are provided in accordance with a coordinated patient, treatment or service plan approved by a licensed physician, excluding crisis services for which a service plan is not required. Services include:

- Day Care Rehabilitative Treatment
- Naltrexone Treatment
- Narcotic Treatment Program
- Outpatient Drug Free Treatment
- Perinatal Residential Substance Abuse Services
- Substance Abuse Treatment Services Provided to Pregnant and Postpartum Women as Described in Supplement 2 to Attachment 3.1-A and Enclosure 1.

Provider Qualifications

Stabilization and rehabilitation services are provided by qualified certified substance abuse treatment clinics, their certified satellite sites, or certified perinatal residential substance abuse programs that agree to abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Alcohol and Drug Programs in conjunction with the Department of Health Services, and that sign a provider agreement to serve all persons for whom these services are medically necessary.

Services are provided by or under the supervision of a qualified substance abuse treatment professional functioning within the scope of his/her practice. A qualified substance abuse treatment professional means any provider

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

qualified under the Medi-Cal program that has specialized training as required by State law and Medi-Cal regulations.

Assurances

The State assures that substance abuse treatment services shall be available to all children found to be eligible under the provisions of Social Security Act section 1905(r)(5).

The State assures that the Single State Agency shall not delegate to any other State Agency the authority and responsibilities described in 42 CFR section 431.10(e).

The State assures that all Medicaid program requirements regarding free choice of providers as defined in 42 CFR 431.51 shall be adhered to.

The State assures that Perinatal Residential Substance Abuse Services are not provided in facilities that are Institutes for Mental Diseases.

State of California
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

The State will set an enrollment limit of 5,850 Medicaid PACE recipients to be funded under the Medicaid program.

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: See Supplement 4, Attachment 3.1-A, Page 1.1.

(If this option is elected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program).

C. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

State of California
PACE State Plan Amendment Pre-Print

Medicaid Eligibility Groups Subject to Institutional Eligibility Rules

Individuals receiving services under the PACE Program are eligible under the following eligibility groups(s) in the California State plan. The State will apply all applicable FFP limits under the plan.

1. X The home and community-based group described under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need PACE services in order to remain in the community, and who are covered under PACE).

   Spousal impoverishment rules are used in determining eligibility for the home and community-based group described at 42 CFR 435.217 but who are receiving services under PACE.

   X A. Yes ____ B. No

   a. X The PACE Program covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need PACE Services in order to remain in the community. The enrollment of beneficiaries for PACE services under this method of determining eligibility will be capped for each fiscal year (see Supplement 4, Attachment 3.1-A, Page 1).

State of California
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

1. _X_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a). Sec.435.726 – States which do not use more restrictive eligibility requirements than SSI.

   1. Allowances for the needs of the:
      (A) Individual (check one) community rules apply
      1.___ The following standard included under the State plan (check one):
      (a) ___ SSI
      (b) ___ Medical Needy
      (c) ___ The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level_____%
      (e) _X_ Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902 (a)(10)(A)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.
      2.____The following dollar amount: $_____
      Note:If this amount changes, this item will be revised.
      3.____The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

1.____ SSI Standard

State of California
PACE State Plan Amendment Pre-Print

2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard this is not greater than the standards above:_____% of _____ standard.
6.____ The amount is determined using the following formula:
7._X__ Not Applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of ____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7._X__ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.726

State of California
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

2.____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735 – States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
   1.____ The following standard included under the State plan (check one):
   (a) ____ SSI
   (b) ____ Medically Needy
   (c) ____ The special income level for the institutionalized
   (d) ____ Percent of the Federal Poverty Level:_____%
   (e) ____ Other (specify):_____
2. ____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3. ____ The following formula is used to determine the needs allowance.

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
1.____ The following standard under 42 CFR 435.121:

_____

2.____ The Medically needy income standard

_____

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

State of California
PACE State Plan Amendment Pre-Print

4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____
5.____ The amount is determined using the following formula:

_____

_____

6.____ Not applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____ standard.
5.____ The amount is determined using the following formula:

_____

_____

6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3._X__ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under

State of California
PACE State Plan Amendment Pre-Print

Section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:
1. Individual (check one):
(A) _X_ The following standard included under the State plan (check one):
1.____ SSI
2.____ Medically Needy
3.____ The special income level for the institutionalized
4.____ Percent of the Federal Poverty Level:_____%
5._X_ Other (specify):An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.

(B) ____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) ____ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

Because this is the same amount that may be retained by individuals in the community to meet their needs.

State of California
PACE State Plan Amendment Pre-Print

II. Rates and Payments

A.. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon one of the following methodologies. Please attach a description of the negotiate rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See Supplement 4, Attachment 3.1-A, Page 7a.

1. X Rates are set at a percent of fee-for-service costs
2. ____ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3. ____ Adjusted Community Rate (please describe)
4. ____ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Gary McCollum, ASA, MAAA	Capitation Rate Unit, DHS
Robert Ruderman, ASA, MAAA	Capitation Rate Unit, DHS
Arlene Livingston, FSA, MAAA	Capitation Rate Unit, DHS

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

State of California
PACE State Plan Amendment Pre-Print

Rate Setting Methodology for PACE

Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the State of providing those same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. The Program of All-Inclusive Care for the Elderly (PACE) is a capitated program for individuals who are eligible for placement in a Long-Term Care facility.

Capitation rates for contracts the State has with PACE contractors in a number of different counties are set using a fee-for-service equivalent (FFSE) methodology. The FFSE is calculated for each plan, and then the capitation rate is set at a percentage of the FFSE, not to exceed 100 percent.

The calculation of the FFSE starts with a statewide base cost from a prior period, expressed as a cost per eligible per month. Adjustments are then made which adjust the base cost for the specific plan rate being calculated. The adjustments are for the following items:

1. Demographics – This adjusts for the specific age/sex demographics of a plan.
2. Contract Adjustments – Since plans do not cover all available services in fee-for-service, reductions for those services not covered are accounted for on this line. The specific type of services not covered would include the following: AIDS Waiver Services, In-Home Waiver Services, Nursing Facility Waiver Services, and other items not covered related to children who would not be enrolled under this program.
3. Medicare Adjustments – Because Medicare pays a significant portion of the medical expenses for individuals over 65, the capitation rate is different for individuals who have Medicare coverage and for those who do not. This adjusts for the plan population relative to the statewide base.

This adjusted base cost then needs to be projected into the future. There are two considerations here; legislative changes and trend.

1. Legislative Changes – This evaluates the financial impact of legislation that has been passed or is expected to be enacted.

State of California
PACE State Plan Amendment Pre-Print

2. Trend – This adjustment predicts the affect of all other changes that may take place in the Medi-Cal population and in the medical services arena. Because the Base Costs are for fiscal year 1996/97, it is necessary to project these forward to the rate year. Trend adjustments for AIDS are the same as trend adjustments for Long Term Care. The calculation of trends is made in two parts; number of units used per eligible and cost per unit.

The rate setting methodology for PACE is the FFSE cost per person per month. The capitation rate paid to a PACE Program is 85, 90, or 95 percent of the FFSE costs. The percentage used is mutually agreed to by the State and the PACE Program.

Historically, the start up of California PACE Demonstrations Programs capitation rates were set at 95 percent of the FFSE costs for two years in order to gain experience as a PACE Program prior to applying for a federal waiver and then recalculated at 85 percent of FFSE costs in subsequent years as a PACE Program became more stable and financially self-sufficient.

AltaMed Senior BuenaCare's (SBC) percent of FFS continues to remain at 95 percent since they have not been able to achieve self sufficiency. DHS will consider to reduce SBC's percent of FFS to 85 percent in the future.

Over the last several years, On Lok had experienced increased difficulties in recruiting new in-home care workers. In July 1999, On Lok had to increase its home care worker wages by 25 percent over the salary scale just to match the wages of the In-Home Supportive Services (IHSS) workers in San Francisco who perform tasks comparable to On Lok's in-home care workers. The high cost of these services in San Francisco justified On Lok receiving an increase from 85 percent to 90 percent of the cost of a comparable population. On Lok continues to increase its wages just to remain competitive with the IHSS wages.

State of California
PACE State Plan Amendment Pre-Print

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

...on: HCFA-PM-86-20 (BERC)
...EMBER 1986

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

*Description provided on attachment.

Supplement to Attach 3.1
RHS/1

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   [X] Provided: [ ] No limitations [X] With limitations*

2. a. Outpatient hospital services.

   [X] Provided: [ ] No limitations [X] With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

   [X] Provided: [ ] No limitations [X] With limitations*

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   [X] Provided: [ ] No limitations [X] With limitations*

   d. Ambulatory services offered by a health center receiving funds under Section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

   [X] Provided: [ ] No limitations [X] With limitations*

3. Other laboratory and X-ray services.

   [X] Provided: [ ] No limitations [X] With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

   [X] Provided: [ ] No limitations [X] With limitations*

   b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

   [X] Provided: [ ] No limitations [X] With limitations*

   c. Family planning services and supplies for individuals of childbearing age.

   [X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): _____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

_____ Provided ____ No limitations _X_ With limitations*

5.a.1 Sign language interpreter services (in connection with physician's services).

_X_ Provided ____ No limitations _X_ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

____ Provided ____ No limitations _X_ With limitations*

* Description provided on attachment.

...on: HCFA-PM-86-20 (BERC)
...TEMBER 1986

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Chiropractors' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Other Practitioners' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

MEDI-CAL BENEFITS CHAPT...

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

8. Private duty nursing services.

/ / Provided: / / No limitations / / With limitations*

9. Clinic services.

/X/ Provided: / / No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: / / No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: / / No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: / / No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: / / No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

c. Prosthetic devices.

/X/ Provided: /__/ No limitations /X/ With limitations*

d. Eyeglasses.

/X/ Provided: /__/ No limitations /X/ With limitations*

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

/__/ Provided: /__/ No limitations /__/ With limitations*

b. Screening services.

/__/ Provided: /__/ No limitations /__/ With limitations*

c. Preventive services.

/__/ Provided: /__/ No limitations /__/ With limitations*

d. Rehabilitative services; including rehabilitative mental health services and rehabilitative alcohol and drug treatment services for individuals diagnosed by physicians as having a substance-related disorder. (See Supplements 1, 2, and 3 to Attachment 3.1-B):

/X/ Provided /__/ No limitations /X/ With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/X/ Provided: /__/ No limitations /X/ With limitations*

b. Skilled nursing facility services.

/X/ Provided: /__/ No limitations /X/ With limitations*

*Description provided on attachment.

State/Territory: California

AMOUNT DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

c. Intermediate care facility services.

|XXX| Provided: |___| No limitations |XXX| With limitations*

15.a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

|XXX| Provided: |___| No limitations |XXX| With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

|XXX| Provided: |___| No limitations |XXX| With limitations*

16. Including psychiatric facility services for individuals under 22 years of age.

|XXX| Provided: |___| No limitations |XXX| With limitations*

17. Nurse-midwife services.

|XXX| Provided: |___| No limitations |XXX| With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

|XXX| Provided: |___| No limitations |XXX| With limitations*

STATE/TERRITORY: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
TO THE MEDICALLY NEEDY GROUP(S): _____

19. Case management services and Tuberculosis related activities

a. Case management services as defined in, and to the group specified in, Supplemental 1 to ATTACHMENT 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lanterman), and Supplements 1a-1f to ATTACHMENT 3.1-A for County-Funded Case Management Services (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

__X__ Provided __X__ With limitations* _____Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

__X__ Provided __X__ With limitations* _____Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

__X__ Provided: + _____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

__X__ Provided: + _____ Additional coverage ++ _____Not provided.

21. Certified pediatric or family nurse practitioners' services.

__X__ Provided: _____ No limitation _____ With limitations*
_____ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Services of Christian Science nurses.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Care and services provided in Christian Science sanitoria.

☒ Provided: ☐ No limitations ☒ With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No limitations ☐ With limitations*

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

g. Local Education Agency (LEA) Services
X Provided: ___ No Limitations X With Limitations*
___ Not Provided

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

25. Personal Care Services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or at work. PJD

X Provided: X State Approved (Not Physician) Service Plan Allowed
X Services Outside the Home Also Allowed
X Limitations Described on Attachment
PJD

__ Not Provided:

* Decription provided on attachment.

State of California
PACE State Plan Amendment Pre-Print

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE SERVICES PROVIDED TO THE MEDICALLY NEEDY

26. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-B.

__X__ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

_____ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency California

MEDICAID PROGRAM: REQUIREMENTS RELATING TO
COVERED OUTPATIENT DRUGS FOR THE **MEDICALLY NEEDY**

Citation (s)	Provision (s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency California

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	1.	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit -Part D.
	X	**The following excluded drugs are covered:**
	X	**(a) agents when used for anorexia, weight loss, weight gain** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity.
	☐	(b) agents when used to promote fertility (see specific drug categories below)
	☐	(c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
	X	**(d) agents when used for the symptomatic relief cough and colds** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity.
	X	**(e) prescription vitamins and mineral products, except prenatal vitamins and fluoride** **Medi-Cal will cover select prescription vitamins and minerals pursuant to prior authorization or utilization restrictions. Combination vitamin and mineral products are not a benefit. Vitamins or minerals used for dietary supplementation are not a benefit.**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency California

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	X	**(f) nonprescription drugs** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity.
	☐	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
	X	**(h) barbiturates** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity.
	X	**(i) benzodiazepines** (see specific drug categories below) All drugs in this category are potential benefits, subject to medical necessity.

__ **No excluded drugs are covered.**

(Note: This chart is an overview only.)

Limitations on Att. 3.1
3.1-B

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1	Inpatient hospital services	Inpatient services are covered as medically necessary except that services in an institution for mental diseases are covered only for persons under 21 years of age or for persons 65 years of age and over. Services in an institution for tuberculosis for persons under 65 are not covered. Services in the psychiatric unit or TB unit of a general hospital are covered for all age groups.	Prior authorization is required for all nonemergency hospitalization except for the first two days of obstetrical delivery or subsequent newborn care services. Certain procedures will only be authorized in an outpatient setting unless medically contraindi Emergency admissions require a physician's, dentist's, or podiatrist's statement suppor the admission. Emergency admissions are exempt from prior authorization, but the continuation of the hospital stay beyond the admission is subje to prior authorization by the Medi-Cal Consultant. Mental health services are identified in th Short-Doyle/Medi-Cal (SD/MC) agreement, alo with the appropriate utilization controls f that delivery system. Beneficiaries may el to receive service through either the regul Medi-Cal program or the SD/MC system.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA # 88-17

Eff 7-1-88

Appr. MAR 21 1989

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services)	TC is covered for persons 18 years of age or older who are not receiving care in a small and rural hospital. Medical necessity includes, but is not limited to, one or more of the following: 1. Intravenous therapy, including but not limited to: • single or multiple medications • blood or blood products • total parenteral nutrition • pain management • hydration Note: The clinical record must document failure of other preventive measures, failure or inappropriateness of non-intravenous medications or the patient's inadequate response to oral hydration.	Prior authorization is required for TC level of care. The attending physician must determine that the patient has been clinically stable for the 24 hours preceding admission to TC level of care. A definitive and time-limited course of treatment must be developed prior to admission by the physician assuming TC treatment management. The attending physician must perform the initial medical visit within 24 hours of the patient's admission to TC level of care. For patients admitted from acute care hospitals, if the physician assuming the responsibility for treatmen management in TC was also the attending physician in the acute care hospital, the initial physician visit must occur within 72 hours.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1 1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	2. Rehabilitative services, including physical therapy, occupational therapy, and speech therapy rendered to: A. The transitional rehabilitation patient, who, prior to admission to TC, meets all the following criteria: • Has been assessed by a physiatrist or physician otherwise skilled in rehabilitation medicine, who has provided an explicit, time-limited plan of treatment; • Has sufficient endurance to participate in a minimum of one hour a day, 5 days per week, of a single or combined rehabilitative therapy, as ordered by a physiatrist or physician otherwise skilled in rehabilitation medicine, provided by, or under the direct supervision of, a licensed or registered therapist; and	The attending physician must visit the TC patient at least twice weekly or more often as the patient's condition warrants while the patient is receiving TC level of care. A certified nurse practitioner, in collaboration with the attending physician, or physician's assistant, under the supervision of a physician, may provide non-duplicative services to TC patients. Leave of absence is covered for TC Rehabilitation patients only. TC patients require care by registered nurses on every shift.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1	Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	• Has potential to make significant functional gain in a reasonable period of time or has a caregiver available to participate in short-term training that will enable the patient to return safely to a residential environment with the caregiver's assistance. B. The transitional medical patient, who has a need for rehabilitation therapy as ordered by the physician.	Not covered by TC: • Obstetrical patients • Patients receiving anti-cancer intravenous cytotoxic drugs • Patients with highly complex multiple rehabilitation needs that include intensive social and/or psychological interventions in order to adjust to their disability or in order to be discharged safely to a residential setting • Patients with a primary psychiatric diagnosis, or any disorder resulting in behaviors that require an intensive, highly structured behavior management and/or cognitive retraining program

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE		PROGRAM COVERAGE**		PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1 1	Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	3.	Wound care, including but not limited to, skin ulcers, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites requiring the implementation of a wound care plan every eight hours. Wounds that pre-existed at nursing facility-level B shall not qualify for TC level of care. Wound care management requires physician prescribed intervention by the licensed nurse and/or physical therapist beyond routine cleansing and dressing.	
		4.	Respiratory treatments requiring medication administration by a licensed nurse or respiratory therapist at least every six hours.	
		5.	Traction, requiring the assessment and intervention of a licensed nurse or licensed physical therapist at least every eight hours.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a	Hospital outpatient department services and organized outpatient clinic services	The following services are covered: 1. Physician 2. Optometric 3. Psychology 4. Podiatric 5. Physical therapy 6. Occupational therapy 7. Speech pathology 8. Audiology 9. Acupuncture 10. Laboratory and X-ray 11. Blood and blood derivatives 12. Chronic hemodialysis 13. Hearing aids 14. Prosthetic and orthotic appliances 15. Durable medical equipment 16. Medical supplies 17. Prescribed drugs 18. Use of hospital facilities for physicians' services 19. Family planning 20. Adult day health care	Prior authorization is always required for physical therapy; chronic hemodialysis; purc rental, or repair of hearing aids if cost ex $25; adult day health care; surgical procedu considered to be elective; outpatient heroir detoxification; outpatient procedures such a hyperbaric O_2 therapy, psoriasis day care, pheresis, and cardiac catheterization. Prior authorization is required for psychiat visits in excess of 8 in 120 days and for allergy injections in excess of 8 in 120 day Speech pathology and audiology, occupational therapy, acupuncture, and psychology service are subject to the availability of MEDI labo Routine podiatry office visits are allowed w out prior authorization. All other podiatry services are subject to prior authorization. Prior authorization is required when the pur price of durable medical equipment or prosth orthotic appliances exceeds $100. Prior authorization is required when cumula rental or repairs exceed $25.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPLAN 88-17

Eff 7-1-88

App. MAR 21 1989

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
			All services, including physicians' services are subject to the same requirements as when provided in a nonfacility setting. Mental health services are identified in the SD/MC agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program or the SD/MC system.
2b	Rural health clinic services and other ambulatory services courses under the state plan.	Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Home nursing services must be furnished in accordance with a written treatment plan established by a physician or nonphysician medical practitioner. The treatment plan must be approved and reviewed every 60 days by the supervising clinic physician. All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.
2c and 2d	Federally qualified health center (FQHC) services and other ambulatory services covered under the state plan.	Physician services and home nursing services provided by a FQHC.	All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.

* Prior authorization is not required for emergency service.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
3	Laboratory, radiological, and radioisotope services	As required on order of a licensed practitioner except laboratory services provided in renal dialysis centers and community hemodialysis units are payable only when billed by the center or unit.	Prior authorization is required for nonemergency portable X-ray services unless perfor in a skilled nursing facility (SNF) or intermediate care facility (ICF).
4a	Skilled nursing facility	Covered when patient has need for daily skilled nursing and/or daily special rehabilitation services which, as a practical matter, can only be provided on an inpatient basis. The patient must be visited by a physician at least monthly for the first three months and at least every two months thereafter.	Prior authorization is required. Attending physicians must recertify a patie level of care and plan every 60 days. For patients having Medicare as well as Med. eligibility (crossover cases), authorizatio required at the time of Medicare denial or before the 20th day after admission.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPMAY-17

Eff 7-1-88

App MAR 3 1 19

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.1	Subacute care services (SNF)	This is a more intensive SNF level of care. Covered when patient has need for intensive licensed skilled nursing care. The patient must be visited by a physician at least twice weekly during the first month and a minimum of at least once every week thereafter. Subacute units must provide sufficient licensed nursing staff to provide a minimum daily average of 4.8 actual licensed nursing hours per patient day for nonventilator-dependent patients and 6.2 licensed nursing hours per patient day for ventilator-dependent patients.	Same as 4a above. Initial care may be authorized for up to tw months. Prolonged care may be authorized for up to maximum of four months.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPMU 88-17

Eff 7-1-88

App 1989

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Minimal standards of medical necessity for the subacute level of care include: A. Physician visits medically required at least twice weekly during the first month and a minimum of at least once every week thereafter. B. Twenty-four hour access to services available in a general acute care hospital. C. Special equipment and supplies such as ventilators. D. Twenty-four hour nursing care by a registered nurse or licensed vocational nurse.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH 88-17

Eff 1-1-88

App. MAR 2 1 1989

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
E. Administration of three or more of the following treatment procedures: 1. Traction and pin care for fractures (this does not include Bucks Traction). 2. Total parenternal nutrition. 3. Inpatient physical, occupational, and/or speech therapy, at least two hours per day, five days per week. 4. Tube feeding (NG or gastrostomy). 5. Tracheostomy care with suctioning. 6. Oxygen therapy and/or inhalation therapy treatments during every shift and a minimum of four times per 24-hour period.		

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPH 4168 17

Eff 7-1-80

App MAR 21 1989

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	7. Continuous IV therapy involving administration of therapeutic agents or IV therapy necessary for hydration or frequent IV drug administration via a peripheral and/or central line without continuous infusion such as via Heparin lock.	
	8. Medically necessary isolation precautions as recommended by the Centers for Disease Control. (Infection control measures for the care of decubitus ulcers do not apply in this category).	
	9. Debridement, packing, and medicated irrigation with or without whirlpool treatment.	
	10. Continuous mechanical ventilation for at least 50 percent of each day.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.2 Pediatric subacute services (NF)	Pediatric subacute care services are the services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function. Covered when medical necessity is substantiated as follows: Patient requires any one of the following items in 1-4 below: 1. A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day; 2. Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the four treatment procedures listed in B through E below:	Same as 4a above. A Treatment Authorization Request shall be required for each admission to a subacute unit caring for pediatric patients, and may be granted for a period of up to six months and reauthorized for a period of up to six months.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	A. Dependence on intermittent suctioning at least every eight hours, and room air mist or oxygen as needed; B. Dependence on continuous intravenous therapy including administration of therapeutic agents necessary for hydration or of intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion; C. Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours;	

** Prior authorization is not required for emergency services.
* Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	D. Dependence on tube feeding, naso-gastric or gastrostomy tube;	
	E. Dependence on other medical technologies required continuously, which in the opinion of the attending physician and the Medi-Cal consultant require the services of a professional nurse.	
	3. Dependence on total parenteral nutrition or other intravenous nutritional support, and dependence on one of the five treatment procedures listed in (b)(2)(A) through (E) above;	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	4. Dependence on skilled nursing care in the administration of any three of the five treatment procedures listed in (b)(2)(A) through (E) above; Medical necessity shall be further substantiated by all of the following conditions: 1. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a registered nurse in the pediatric subacute unit is medically necessary to meet the patient's health care needs, and not be any less that the nursing staff ratios specified in Section 51215.8 (g) and (i);	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	2. The patient's medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, are not medically necessary; 3. The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing pediatric subacute care services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed. Patients shall be visited by their physician at least twice weekly during the first month of stay, and a minimum of once each week thereafter.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.3 Transitional Inpatient Care (TC) (Nursing Facility)	TC is covered when provided in qualified SNFs that have a TC contract with the Department of Health Services. See 1.1.	Prior authorization is required for TC level of care. The physician must conduct a comprehensive medical assessment and determine the patient has been clinically stable for the 24 hours preceding admission to the TC level of care in a SNF. Preadmission screening must be conducted for all patients admitted to TC level of care in a SNF by an appropriate facility clinician. Bed hold is covered for nursing facility level A or level B patients who are authorized for TC level of care. See 1.1.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found.	Covered for Medi-Cal eligibles under 21 years of age. Includes rehabilitative mental health services for seriously emotionally disturbed children: collateral, assessment, individual therapy, group therapy, medication service, crisis intervention, day care intensive, day care habilitation offered in local and mental health clinics or in the community. Includes Local Education Agency (LEA) Medi-Cal Billing Option Program services (LEA services). LEAs are the governing body of any school district or community college district, the county office of education, a state special school, a California State University campus, or a University of California campus.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

Prior authorization is not required.

Medical necessity is the only limitation.

Service Limitations

LEA services are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services per 12-month period from the beneficiary's:

- Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student,
- California Children Services Program,
- Short-Doyle Program,
- Medi-Cal field office authorization (TAR),
- Prepaid health plan authorization (including Primary Care Case Management).

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	LEA services are defined as: Non-IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 13d). Health and mental health evaluation and education includes parts of the EPSDT assessment such as assessment of nutritional status and nutritional education, vision assessment, hearing assessment, developmental assessment, assessment of psychosocial status, health education and anticipatory guidance appropriate to age and health status which includes wellness counseling.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

LEA services are covered when provided to, or directed exclusively toward the treatment of, a Medicaid eligible student under 21 years of age.

Provider Qualifications

Services must be performed by providers who meet the applicable qualification requirements as described in 42 C.F.R. Part 440 who render services, within their scope of practice, as established in state law. Rendering providers of LEA services are licensed physicians/psychiatrists, licensed physician's assistants, licensed optometrists, licensed registered nurses, licensed credentialed school nurses, certified public health nurses, certified nurse practitioners, licensed vocational nurses, trained health care aides, registered school audiometrists, licensed clinical social workers, licensed psychologists, licensed educational psychologists, licensed marriage and family therapists (formerly licensed marriage, family and child counselors), credentialed school psychologists, credentialed school social workers, credentialed pupil service workers, licensed speech pathologists, licensed audiologists, credentialed language, speech and hearing specialists, licensed physical therapists, registered occupational therapists, and registered dieticians.

Type of Service	Program Coverage**
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 13d) includes psychosocial and developmental assessments to determine a student's eligibility for services under the Individuals with Disabilities Education Act (IDEA) or to obtain information on the student to identify and modify the health related services in the IEP/IFSP. These assessments, referred to as IEP/IFSP assessments, include psychological, speech language, occupational therapy, physical therapy, audiological and health evaluations.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

In addition, the following limitations apply:

- Credentialed school psychologists may provide psychosocial assessments, health education and anticipatory guidance, and psychological treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Section 2909 and Education Code Sections 49422 and 49424 to Medicaid eligible students.
- Credentialed school social workers may provide psychosocial assessments, health education and anticipatory guidance, and psychosocial treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 4996, 4996.9, 4996.14 and 4996.15 and Education Code Section 44874 to Medicaid eligible students.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)	Treatment Services • Physical therapy, (as covered in Subsection 11(a); • Occupational therapy (as covered in Subsection 11(b); • Speech/audiology (as covered in Subsection 11(c); • Physician services (as covered in Subsection 5(a); • Psychology (as covered in Subsections 6(d) and 13(d); • Nursing services (as covered in Subsection 13(c); • School health aide services (as covered in Subsections 13(d) and 24(a); • Medical transportation (as covered in Subsection 24(a).	• Credentialed language, speech and hearing specialists may provide audiological and communication disorders assessments and treatment services, for which a student has been referred by a physician or other licensed practitioner of the healing arts, under the direction of licensed speech pathologists or licensed audiologists only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students. The definition of "under the direction of" a licensed practitioner is that the licensed practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed language, speech and hearing specialists that he or she agrees to direct. The licensed practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

STATE PLAN CHART

Type of Service	Program Coverage**	Authorization and Other Requirements*
4b Early and periodic screening, diagnosis, and treatment services, and treatment of conditions found. Local Education Agency (LEA) Services (cont.)		• Credentialed pupil service workers may provide psychosocial assessments only; • Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only; • School health aides may provide trained health aide services only under the direct supervision of a physician, registered nurse or nurse practitioner or licensed vocational nurse and only to the extent authorized under federal law and the California Business and Professions Code. LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.
4c Family planning services and supplies for individuals of child bearing age.	Covered as physician and pharmaceutical services.	Prior authorization is not required, and informed consent must be properly obtained for all sterilizations. Sterilization of persons under 21 years of age is not covered.
5a Physician's Services	As medically necessary, subject to limitations; however, experimental services are not covered.	Physician services do not require prior authorization except as noted below:

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Procedures generally considered to be elective must meet criteria established by the Director. Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.)	Outpatient medical procedures such as hyperbaric 0^2 therapy, psoriasis day care, apheresis, cardiac catheterization, and selected surgical procedures (generally considered to be elective) are subject to prior authorization. Prior authorization is required for the correction of cosmetic defects. Inhalation therapy when not personally rendered by a physician requires prior authorization. All sterilizations require informed consent.
	Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered to be physician services for purposes of program coverage.	Prior authorization is required for psychiatric services in excess of 8 services in each 120-day period and injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies in excess of 8 in any 120-day period.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5b Medical and surgical services furnished by a dentist, to the extent mandated by 42 U.S.C. Section 1396(a)(5)(B), are covered.	In accordance with 42 U.S.C. Section 1396d (a)(5)(B) and 42 C.F.R. Section 40.50(b), medical and surgical services furnished by a dentist are limited to those services, including maxillofacial surgical services, oral surgery services, and associated diagnostic services, to the extent that these services may be performed under California law either by a doctor of medicine or doctor of dental surgery or dental medicine and would be described as physicians' services if performed by a physician.	Medical and surgical services furnished by a dentist, as described, administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion and oversight, and applicable federal and state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for the above services performed by an enrolled dental provider. Prior authorization of a defined subset of the above services is required.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
Medical care and any other type of remedial care recognized under State law.		
6a. Podiatrists' services.	Routine nail trimming is not covered. Inpatient services are covered only on written order of the physician or podiatrist who admits the patient to the hospital, and only when the period of hospital stay is covered by the program. Podiatry services are limited to treatment of disorders of the feet which complicate, or are secondary to, chronic medical diseases or which significantly impair the ability to walk.	Routine office visits do not require prior authorization. All other podiatry services are subject to prior authorization, except emergencies. All services provided in SNFs and ICFs are subject to prior authorization.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6b	Optometry services	As medically necessary except that orthoptics and pleoptics are not covered. Routine eye examinations with refraction are limited to one service in a 24-month period.	Prior authorization is necessary for low vis aids when the billed amount is over $100 and for contact lenses if they are the extended type or the contacts are to correct anisomet or when facial pathology or deformity preclu the use of eyeglasses. Payment for some procedures may require additional justificat
6c	Chiropractic services	Limited to manual manipulation of the spine.	Prior authorization is not required; however services are limited to a total of two servi or any combination of two services in any on month from among the following: chiropracti acupuncture, psychology, occupational therap speech pathology, and audiology.
6d.1	Psychology	Psychology services are covered subject to the availability of MEDI labels.	
6d.2	Nurse anesthetist services	Nurse anesthetists may administer all types of anesthesia within their scope of licensure.	Since rendered as an adjunct to a physician, clinic, or hospital service, separate authorization is not required.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA 4-88 17

Eff 7-1-88

Apr 1988

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
6d3	Acupuncture services	Covered to prevent, modify, or alleviate the perception of severe, persistent, chronic pain resulting from a generally recognized medical condition.	Same as 6c.
6d.4	Licensed midwife services	All services permitted under scope of licensure.	Limited to the care of mothers and newborns during the maternity cycle, which consists of pregnancy, labor, birth, and a six-week postpartum period; and when performed under the supervision of a licensed physician and surgeon. Prior authorization for some services is required when applicable.
7.	Home Health Services Home health agency services, including nursing services which may be provided by a registered nurse when no home health agency exists in the area, home health aide services, medical supplies and equipment, and therapies.		
7a. 7b.	Home health nursing and aide services	Covered when prescribed by a physician in the home of a beneficiary in accordance with a written treatment plan. The patient's condition must require skilled nursing care or other therapeutic services.	One visit in a six-month period for initial case evaluation is covered without prior authorization. Monthly reevaluations are covered without prior authorization. Additional services require prior authorization.

* Prior authorization is not required for emergency service.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7c.1 Medical supplies	As prescribed by a licensed practitioner within the scope of his or her practice. Common household items, supplies not primarily medical in nature, and articles of clothing are not covered. Medical supplies provided in renal dialysis centers are included in the all-inclusive rate and are not separately billable. Medical supplies commonly used in providing SNF and ICF level of care are not separately billable.	Prior authorization is required for supplie listed in the Medical Supplies Formulary. Certain items require authorization unless for the conditions specified in the Medical Supplies Formulary.
	Blood and blood derivatives are covered when ordered by a physician or dentist.	Prior authorization is not required. Certification that voluntary blood donation cannot be obtained is required from blood b supplying the blood or facility where transf is given.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPM #88-(1)

Eff 7-1-88

App MAR 1 1989

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
7c.2	Durable medical equipment	Covered when prescribed by a licensed practitioner. DME commonly used in providing SNF and ICF level of care is not separately billable. Common household items are not covered.	Prior authorization is required when the purchase exceeds $100. Prior authorization is required when price, repairs, maintenance, or cumulative rental of listed items exceeds $25, except that the provision of more than two "H" oxygen tanks in any one month requires prior authorization. Purchase or rental of "By Report" (unlisted) items are subject to prior authorization regardless of purchase price. Authorization shall be granted only for the lowest cost item that meets medical needs of the patient.
7c.3	Hearing aids	Covered only when supplied by a hearing aid dispenser upon the prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available. Loaner aids, during repair periods covered under guarantee, are not covered. Replacement batteries are not covered.	Prior authorization is required for the purchase or trial period rental of hearing aids and for hearing aid repairs which exceed a cost of $25. Cords, receivers, ear molds, and hearing aid garments are covered without prior authorization. Authorization for hearing aids may be granted only when tests reveal an average loss of 35 dB or greater, or if the difference between the level of 1,000 Hertz and 2, 000 Hertz is 20 dB or more. The hearing loss need only b 30 dB, and speech communication is effectively improved or the need for personal safety is met.
7c.4	Enteral Formulae	Covered only when supplied by a pharmacy provider upon the prescription of a licensed practitioner within the scope of his or her practice. Enteral Formulae commonly used in providing SNF and ICF level of care is not separately billable. Common household items (food) are not covered.	Prior authorization is required for all products. Authorization is given when the enteral formulae is used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food. Dietary supplements or products that cannot be used as a complete source of nutrition are considered non-benefits, except that the program may deem such a product a benefit when it determines that the use of the product is neither investigational nor experimental when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TN 03-12
Supersedes
TN 88-017

Approval date JAN - 2 2004

Effective date: January 1, 2003

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
7d	Physical and occupational therapy, speech pathology and audiology services provided by a home health agency.	See 11.	See 11.
8	Special duty nursing services.	Not covered.	
9	Clinic services	See 2a.	See 2a.
10	Dental services	Pursuant to 42 U.S.C. Section 1396d(a)(10), emergency and essential diagnostic and restorative dental services are covered, subject to limitations contained in applicable state statutes, regulations, manual of criteria, and utilization controls. Cosmetic procedures, experimental procedures, and orthodontic services for beneficiaries 21 years of age and older are not benefits. For beneficiaries 21 years of age and older, there is an $1,800 annual benefit maximum, with the following exceptions: • Emergency dental services • Services that are federally mandated under Part 440 (commencing with Section 440.1) of Title 42 of the Code of Federal Regulations, including pregnancy-related services and for other conditions that might complicate the pregnancy.	Dental services are administered through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI), subject to state statutes, regulations, manual of criteria and utilization controls, the Dental FI approves and provides payment for covered dental services performed by an enrolled dental provider. Prior authorization of a defined subset of dental services is required.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	• Dentures • Maxillofacial and complex oral surgery • Maxillofacial services, including dental implants and implant-retained prostheses. • Services provided in long-term care facilities. For beneficiaries under 21 years of age, medically necessary dental services mandated by Sections 1905(a)(4)(B) and (r) of the Social Security Act (42 U.S.C. Sections 1396d(a)(4)(B) and (r), early and periodic screening, diagnostic, and treatment services are covered.	

* Prior Authorization is not required for emergency service.
** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
11	Physical therapy and related services	Physical therapy and occupational therapy are covered only when prescribed by a physician, dentist, or podiatrist. Speech pathology and audiology may be provided only upon the written prescription of a physician or dentist. Outpatient physical therapy, occupational therapy, speech therapy, and audiology provided in a certified rehabilitation center are payable only when billed by the rehabilitation center. Maintenance therapy services are not covered.	All physical therapy services are subject to prior authorization. Occupational therapy, speech pathology, and audiology services rendered by independent practitioners are subject to the availability of MEDI labels, except that these services, when rendered to patients in SNFs or ICFs are subject to prior authorization. In a certified rehabilitation center, one vis in a six-month period for evaluation of the patient and preparation of an extended treatm plan may be provided without prior authorizat Additional services including other evaluatio can be provided in accordance with an approve treatment plan signed by a physician, subject prior authorization.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

App MAR 2 1 1989

SPH 88-17

Eff 7-1-88

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12a Pharmaceutical services and prescribed drugs	Covered when prescribed by a licensed practitioner. Drugs for the treatment of hospital inpatients are covered as encompassed in the formulary of the hospital. Drugs administered for chronic outpatient hemodialysis in renal dialysis centers and community hemodialysis units are covered, but payable only when included in the all-inclusive rate.	Prior authorization is not required for drugs listed in the Drug Formulary except that certain Formulary drugs are subject to prior authorization unless used as specified therein. Except for hospital inpatients, prescriptions shall not exceed a 100-calendar-day supply. Hospital inpatient drugs, as encompassed in the Formulary of the hospital, do not require prior authorization. Hospital discharge medications may not exceed a ten-day supply. Certain Formulary drugs are subject to minimum or maximum quantities to be supplied. Drugs not on the Drug Formulary are subject to prior authorization, except that certain drugs are excluded from Medi-Cal program coverage. Six- prescription-per-month-limit. Additional prescriptions will be available through the "prior authorization" process. The limit shall not apply to patients receiving care in a nursing facility or to drugs for family planning.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

(Note: **This chart is an overview only.**) Limitations on Attachment 3.1-B

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
12b	Dentures	See 10.	See 10.
12c	Prosthetic and orthotic appliances	Covered when prescribed by a physician or podiatrist. Stock shoes (conventional or orthopedic) are covered when at least one of the shoes is to be attached to a prosthesis or brace. Orthopedic modifications to stock shoes are also covered.	Prior authorization is required when the purchase price is more than $100. Prior authorization is required for rental, or repair when the total cost is more than $50. Custom-made orthopedic shoes may be authorized when there is a clearly established medical need that cannot be satisfied by the modification of stock orthopedic shoes.
12d	Eyeglasses, prosthetic eyes, and other eye appliances	Covered as medically necessary on the written prescription of a physician or optometrist.	Prior authorization is required for some vision aids and contact lenses.
13a	Diagnostic services	See 4b	
13b	Screening services	See 4b	
13c	Preventive services	See 4b EPSDT program coverage. Covered services for pregnant/ postpartum Medi-Cal recipients etc.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

STATE PLAN CHART

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13d.1	Adult day health care	Covered when requested by a physician for elderly persons or other adults with mental or physical impairments which handicap daily living activities, require treatment, or rehabilitative services but which are not of such a serious nature as to require 24-hour nursing care.	Prior authorization is required. Requests for authorization must be accompanied by a multidisciplinary team assessment which ascertains the individual's pathological diagnosis, physical disabilities, functions, abilities, psychological status, and social and physical environment.
13d.2	Chronic dialysis services	Covered as an outpatient service when provided by renal dialysis centers or community hemodialysis units. Includes physician services, medical supplies, equipment, drugs, and laboratory tests. Home dialysis and continuous ambulatory peritoneal dialysis are covered.	Prior authorization is required for the facility but not the physician. Initial authorization may be granted up to three months. Reauthorization may be granted up to 12 months. Inpatient hospitalization for patients under going dialysis requires prior authorization.
13d.3	Outpatient heroin detoxification services.	Daily treatment is covered through the 21st day.	Prior authorization is required. Additional charges may be billed for services medically necessary to diagnose and treat diseases which the physician believes are concurrent with, but not part of, the outpatient heroin detoxification services.
13d.4	Rehabilitative mental health services for seriously emotionally disturbed children.	See 4b EPSDT program coverage.	Medical necessity is the only limitation.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services. Services are available equally to the categorically needy and medically needy.

AUG 0 5 1992

TN No. 91-26 Supercedes TN No. 88-17 Approval Date _____ Effective Date October 1, 1991

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.4 Rehabilitative mental health services (continued)	Short-Doyle/Medi-Cal rehabilitative mental health services are provided in the least restrictive setting appropriate for maximum reduction of psychiatric impairment, restoration of functioning consistent with requirements for learning and development, and/or independent living and enhanced self-sufficiency.	Services are based on medical necessity and in accordance with a coordinated client plan signed by a licensed practitioner of the healing arts.
13.d.5 Substance Abuse Treatment Services	Narcotic treatment program services, including outpatient methadone maintenance and/or levoalphacetylmethadol (LAAM), are covered under Drug Medi-Cal (DMC) when prescribed by a physician as medically necessary to alleviate the symptoms of withdrawal from opioids.	Prior authorization is not required. Post-service periodic reviews are conducted by the Department of Alcohol and Drug Programs (ADP) pursuant to an interagency agreement with the Department of Health Services (DHS), the Single State Agency. Reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Naltrexone provided as an outpatient treatment service directed at serving detoxified opioid addicts is covered under DMC when prescribed by a physician as medically necessary. Pregnant beneficiaries are precluded from receiving these services.	Same as above.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TN No. 00-016
Supercedes TN No. 97-005

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Abuse Treatment Services (continued)	Outpatient drug free treatment services to stabilize and rehabilitate patients who have a substance-related disorder diagnosis are covered under DMC when prescribed by a physician as medically necessary.	Same as above, except in those cases where additional EPSDT services (beyond those available under ADP regulations) are needed for individuals under 21, services are available subject to prior authorization by DHS.
	Day care rehabilitative treatment services provided to patients a minimum of three hours per day, three days a week, are covered under DMC when prescribed by a physician as medically necessary.	Prior authorization is not required. Post-service periodic reviews are conducted by ADP pursuant to an interagency agreement with DHS, the Single State Agency. Reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	See Supplement 2 to Attachment 3.1-A and Enclosure 1 for a description of substance abuse treatment services for pregnant and postpartum women.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TN No. 00-016
Supercedes TN No. 97-005

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

STATE PLAN CHART

(Note: This chart is an overview only.)

Limitations on Attachment 3.1-B

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
14.a. Services for individuals age 65 or older in institutions for tuberculosis	See 1, 4a, 15	See 1, 4a, 15.
14.b. Services for individual age 65 or older in institutions for mental diseases	See 1, 4a, 15.	See 1, 4a, 15.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TN No. 00-016
Supercedes TN No. ~~97-005~~ N/A

Approval Date: JUL 17 2001

Effective Date: JAN - 1 2001

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
15	ICF services	Covered when patient is under the care of a physician and requires out-of-home protective living arrangements with 24-hour supervision and skilled nursing care on an ongoing intermittent basis. The patient must be visited by a physician at least every 60 days.	Prior authorization is required. The patient physician must recertify patient's need for continued care every 60 days.
15a	ICF services for the developmentally disabled, developmentally disabled habilitative, or developmentally disabled nursing	Covered only for developmentally disabled persons who require 24-hour care in a protected setting and who require and will benefit from the services provided. The developmentally disabled nursing services are for those who are more medically fragile.	Prior authorization is required. The patient physician must recertify patient's need for continued care on the same schedule as requir for ICFs.
16	Inpatient psychiatric facility services for individuals under 22 years of age	See 1.	See 1.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPA #88-17

Eff 7-1-88

Apr MAR 2 1 1989

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
17. Nurse Midwife Services	All services permitted under scope of licensure.	Services do not require prior authorization.
18. Hospice Services	Covered when provided by a Medicare certified hospice in the same scope and duration as Medicare. Services are limited to individuals who have been certified by a physician as having a life expectancy of six months or less.	Prior authorization is required for each of the four levels of hospice care described in regulation: routine home care, continuous home care, inpatient respite care, and general inpatient care. Special physicians services do not require prior authorization. Persons electing hospice care agree to waive their right to receive curative services related to their terminal illness.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
19. Case Management Services (Pertains to Supplements 1a-1f to Attachment 3.1-A)	Services are limited to individuals who meet the target population criteria.	Prior authorization is not required. Case Management services do not include: • Program activities of the agency itself which do not meet the definition of targeted case management • Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to targeted case management • Diagnostic and/or treatment services • Services which are an integral part of another service already reimbursed by Medicaid • Restricting or limiting access to services, such as through prior authorization • Activities that are an essential part of Medicaid administration such as outreach, intake processing, eligibility determination or claims processing

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

	TYPES OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS
19b	Special Outpatient Tuberculosis-Related	Services designed to encourage the completion of regimens of prescribed drugs by outpatients, including services to directly observe the intake of prescribed drugs (directly observed therapy (DOT)). Dot includes; delivery of prescribed medications; assisting with the means to ingest medications; monitoring for signs of nonadherence or adverse side effects; documenting that medications have been ingested; and reporting compliance and/or other problems.	Prior authorization is not required.

* Prior authorization is not required for emergency services
**Coverage is limited to medically necessary services

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
20	Preventive Services provided in the home, by Comprehensive Perinatal Services Providers, which are clinics and hospital outpatient departments, as medically necessary for pregnancy-related conditions only. Services are covered throughout pregnancy and through the end of the month in which the 60th day period following termination of pregnancy ends.	Prior authorization is required when services are provided in excess of the basic allowances. Basic allowances are described in Title 22, Sections 51348 and 51504.
21	Ambulatory prenatal care to pregnant women provided during a single limited period of presumptive eligibility. The scope of benefits is limited to specified outpatient pregnancy related services and does not include abortion or labor and delivery services.	Prior authorization is not required.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
23a.	Medical transportation services	Covered when transport by ordinary means is medically contraindicated and the transportation is required for covered medical care, subject to limitation. Only the lowest cost type of medical transportation adequate for the patient's needs is covered.	All nonemergency transportation requires prior authorization and a physician's, dentist's or podiatrist's written prescription. Emergency claims must be accompanied by justification.
23b.	Christian Science practitioners	Limited to the extent allowed under Title XVIII of the Social Security Act.	Services are subject to the two services per month limitation. See 6c.
23c.	Christian Science sanitoria care and services	See 4a.	See 4a.
23d.	SNF services provided for patients under 21 years of age	See 4a.	See 4a.
23d.1	Transitional Inpatient Care (TC) (Nursing Facility)	See 4a.3.	See 4a.3.
23e.	Emergency hospital services	See 1.	See 1.
23f.	Personal care services	Not covered.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

Type of Service	Program Coverage**
23g Local Education Agency (LEA) Services	LEAs are the governing body of any school district or community college district, the county office of education, a state special school. a California State University campus, or a University of California campus. LEA services are defined as: Non-IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and13d). Health and mental health evaluation and education includes parts of the EPSDT assessment such as assessment of nutritional status and nutritional education, vision assessment, hearing assessment, developmental assessment, assessment of psychosocial status, health education and anticipatory guidance appropriate to age and health status which includes wellness counseling.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

Service Limitations

LEA services are limited to a maximum of 24 services per 12-month period for a beneficiary without prior authorization, provided that medical necessity criteria are met. LEAs may obtain authorization for LEA services beyond 24 services per 12-month period from the beneficiary's:

- Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) developed for the special education student,
- California Children Services Program,
- Short-Doyle Program,
- Medi-Cal field office authorization (TAR),
- Prepaid health plan authorization (including Primary Care Case Management).

All Medi-Cal recipients have access to enrolled LEA providers for the services they provide.

Type of Service	Program Coverage**
23g Local Education Agency (LEA) Services (cont.)	IEP/IFSP Assessments • Health and mental health evaluation and education (EPSDT also covered in Subsection 4b and 13d) includes psychosocial and developmental assessments to determine a student's eligibility for services under the Individuals with Disabilities Education Act (IDEA) or to obtain information on the student to identify and modify the health related services in the IEP/IFSP. These assessments, referred to as IEP/IFSP assessments, include psychological, speech language, occupational therapy, physical therapy, audiological and health evaluations.

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

Provider Qualifications

Services must be performed by providers who meet the applicable qualification requirements as defined in 42 C.F.R. Part 440 who render services, within their scope of practice, as established in state law. Rendering providers of LEA services are licensed physicians/psychiatrists, licensed physician's assistants, licensed optometrists, licensed registered nurses, licensed credentialed school nurses, certified public health nurses, certified nurse practitioners, licensed vocational nurses, trained health care aides, registered school audiometrists, licensed clinical social workers, licensed psychologists, licensed educational psychologists, licensed marriage and family therapists (formerly licensed marriage, family and child counselors), credentialed school psychologists, credentialed school social workers, credentialed pupil service workers, licensed speech pathologists, licensed audiologists, credentialed language, speech and hearing specialists, licensed physical therapists, registered occupational therapists, and registered dieticians.

In addition, the following limitations apply:

- Credentialed school psychologists may provide psychosocial assessments, health education and anticipatory guidance, and psychological treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Section 2909 and Education Code Sections 49422 and 49424 to Medicaid eligible students.

Type of Service	Program Coverage**
23g Local Education Agency (LEA) Services (cont.)	Treatment Services • Physical therapy, (as covered in Subsection 11(a); • Occupational therapy (as covered in Subsection 11(b); • Speech/audiology (as covered in Subsection 11(c); • Physician services (as covered in Subsection 5(a); • Psychology (as covered in Subsections 6(d) and 13(d); • Nursing services (as covered in Subsection 4(b) and 13(c); • School health aide services (as covered in Subsections 13(d) and 24(a); • Medical transportation (as covered in Subsection 24(a).

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

- Credentialed school social workers may provide psychosocial assessments, health education and anticipatory guidance, and psychosocial treatment services recommended by a physician or other licensed practitioner of the healing arts only to the extent authorized under Business and Professions Code Sections 4996, 4996.9, 4996.14 and 4996.15 and Education Code Section 44874 to Medicaid eligible students.
- Credentialed language, speech and hearing specialists may provide audiological and communication disorders assessments and treatment services, for which a student has been referred by a physician or other licensed practitioner of the healing arts, under the direction of licensed speech pathologists or licensed audiologists only to the extent authorized under Business and Professions Code Sections 2530.2, 2530.5 and 2532 and Education Code Sections 44225 and 44268 to Medicaid eligible students.

  The definition of "under the direction of" a licensed practitioner is that the licensed practitioner is individually involved with the patient under his or her direction and accepts professional and legal responsibility for the actions of the credentialed language, speech and hearing specialists that he or she agrees to direct. The licensed practitioner must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun.

Type of Service	Program Coverage**
23g Local Education Agency (LEA) Services (cont.)	

*Prior Authorization is not required for emergency service.
**Coverage is limited to medically necessary services.

Authorization and Other Requirements*

- Credentialed pupil service workers may provide psychosocial assessments only;
- Registered dietitians and nutritionists may provide assessments of nutritional status and nutritional education only;
- School health aides may provide trained health aide services only under the direct supervision of a physician, registered nurse or nurse practitioner or licensed vocational nurse and only to the extent authorized under federal law and the California Business and Professions Code.

LEAs providing LEA services may be subject to on-site review and/or audit by the Centers for Medicare and Medicaid Services and/or its agents, the single state agency and/or its agents or the Department of Education under an interagency agreement with the single state agency.

TYPE OF SERVICES	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
26. Personal Care	Personal Care Services authorized by the county worker are based on an assessment of the recipient. Qualified providers shall perform services in the recipient's home or at place of employment. Services may include one or more activities such as assisting with the administration of medications, providing needed assistance or supervision with basic personal hygiene, eating, grooming and toileting. Other incidental services may also be provided as long as they are subordinate to personal care services.	Personal Care Services shall be available to eligible medically needy aged, blind and disabled individuals covered under the state plan and in accordance with state law. Services will be provided to the recipients who have an illness that has been diagnosed to be chronic and/or permanent (lasting at least one year) and who are unable to remain safely at home or are unable to obtain, retain or return to work without this assistance. Personal Care Service hours shall be capped at a maximum of 283 hours per month. Service hours for recipients shall be based on medical necessity as determined by the Statewide Uniform Assessment. Services in support of work are only available to the extent that service hours utilized at work are included in the total personal care service hours authorized for the recipient based on the recipient's need for services in the home. Authorized personal care services utilized by a recipient for work shall be services that are relevant and necessary in supporting and maintaining employment and shall not supplant any reasonable accommodation required of an employer under the Americans with Disabilities Act or other legal entitlements or third-party obligations. Services shall not be available to residents of a facility licensed by the California State Department of Health Services nor to residents of a community care facility or a residential care facility licensed by the California State Department of Social Services Community Care Licensing Division.

* Prior authorization is not required for emergency services.

** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
26. Program for All-Inclusive Care for the Elderly (PACE)	PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE services package includes all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team essential for the care of the enrollee. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees and shall provide enrollees access to necessary and covered items and services 24 hours per day, every day of the year.	PACE services shall be available to eligible individuals who meet the age criteria of 55 years old or older, reside in the service area of the PACE program, are certified as eligible for nursing home care by the California Department of Health Services, and meet other eligibility conditions as may be imposed under the PACE program agreement.

**Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

State/Territory: California

20. Extended Services For Pregnant Women

a. Pregnancy-related and postpartum services for 60 days after pregnancy ends.

PROVIDED: Pregnancy-related and postpartum services include all antepartum (prenatal) care, care during labor and delivery, postpartum care, and family planning. Pregnancy-related services include all care normally provided during pregnancy (examinations, routine urine analyses, evaluations, counseling, and treatment) and labor and delivery (initial and ongoing assessment of maternal and fetal well-being and progress of labor, management of analgesia and local or pudendal anesthesia, vaginal delivery with or without episiotomy, initial assessment and, when necessary, resuscitation of the newborn infant). Postpartum care includes those services (hospital and scheduled office visits during the puerperium, assessment of uterine involution and, as appropriate, contraceptive counseling) provided for 60 days after pregnancy ends. Family planning services include contraceptive counseling and tubal ligation.

Pregnancy-related and postpartum services may also include alcohol and other drug treatment services that ameliorate conditions that complicate pregnancy because the developing fetus is vulnerable to the mother's alcohol or drug dependence. Those services include women-specific treatment and recovery services (therapeutic interventions addressing issues such as relationships, sexual and physical abuse, and parenting), therapeutic child care, parenting skills training, child development education, and transportation services.

Day care rehabilitative services provided to pregnant and postpartum women a minimum of three hours per day, three days a week, are covered under the Drug Medi-Cal program when prescribed by a physician as medically necessary.

Perinatal residential services provided in a 24-hour structured environment are covered for pregnant or postpartum women under the Drug Medi-Cal program when prescribed by a physician as medically necessary. The costs of room and board are not reimbursable under the Medi-Cal. program

b. Services for any other medical conditions that may complicate pregnancy.

PROVIDED Treatment for obstetrical complications (including preexisting or developing maternal or fetal conditions) which create a high-risk pregnancy and which may or may not be pregnancy-related is also covered.

State: California

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATION ON SERVICES

13. d. Rehabilitative Mental Health Services

Rehabilitative Mental Health Services are medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for the maximum reduction of mental disability and restoration of a recipient to his best possible functional level, when provided by local public community mental health agencies and other mental health service providers licensed or certified by the State of California. Services are provided based on medical necessity and in accordance with a coordinated client plan or service plan approved by a licensed physician or other licensed practitioner of the healing arts, excluding crisis services for which a service plan is not required. Rehabilitative mental health services are provided in the least restrictive setting appropriate for reduction of psychiatric impairment, restoration of functioning consistent with the requirements for learning and development, and/or independent living and enhanced self-sufficiency. Services include:

Individual mental health services
Group mental health services
Crisis intervention
Crisis stabilization
Medication management
Day treatment, adult
Day treatment, children and youth
Day rehabilitation
Short term crisis residential treatment
Residential treatment

Provider Qualifications:

Rehabilitative mental health services are provided by qualified mental health organizations, agencies or mental health professionals who agree to abide by the definitions, rules, and requirements for rehabilitative mental health services established by the Department of Mental Health in conjunction with the Department of Health Services and who sign a provider agreement to serve all persons for whom these services are medically necessary, irrespective of ability to pay, subject to caseload capacity.

State: California

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Services are provided by or under the supervision of a Qualified Mental Health Professional functioning within their scope of practice. A Qualified Mental Health Professional means any provider qualified under the Medi-Cal program that has specialized training as required by state law and Medi-Cal regulations.

Assurances:

The state assures that rehabilitative mental health services shall be available to all children found to be eligible under the provisions of Social Security Act (SSA) Sec. 1905(r)(5).

The state assures that services will not be available to residents of an institution for mental disease as defined in SSA Sec. 1905(i) and 42 CFR 435.1009.

The state assures that the Single State Agency shall not delegate to any other state agency the authority and responsibilities described in 42 CFR 431.10(e).

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS(S)

LIMITATION ON SERVICES

13.d.5 Substance Abuse Treatment Services

Substance abuse treatment services are to stabilize and rehabilitate Medi-Cal beneficiaries who are diagnosed by physicians or other licensed practitioners of the healing arts, within the scope of their practices, as having a substance-related disorder. Substance abuse treatment services are provided by certified substance abuse treatment clinics, their certified satellite sites, or certified perinatal residential substance abuse programs; are based on medical necessity; and are provided in accordance with a coordinated patient , treatment or service plan approved by a licensed physician, excluding crisis services for which a service plan is not required. Services include:

- Day Care Rehabilitative Treatment
- Naltrexone Treatment
- Narcotic Treatment Program
- Outpatient Drug Free Treatment
- Perinatal Residential Substance Abuse Services
- Substance Abuse Treatment Services Provided to Pregnant and Postpartum Women as Described in Supplement 1 to Attachment 3.1-B and Enclosure 1.

Provider Qualifications

Stabilization and rehabilitation services are provided by qualified certified substance abuse treatment clinics, their certified satellite sites, or certified perinatal residential substance abuse programs that agree to abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Alcohol and Drug Programs in conjunction with the Department of Health Services, and that sign a provider agreement to serve all persons for whom these services are medically necessary.

Services are provided by or under the supervision of a qualified substance abuse treatment professional functioning within the scope of his/her practice. A qualified substance abuse treatment professional means any provider

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS(S)

qualified under the Medi-Cal program that has specialized training as required by State law and Medi-Cal regulations.

Assurances

The State assures that substance abuse treatment services shall be available to all children found to be eligible under the provisions of Social Security Act section 1905(r)(5).

The State assures that the Single State Agency shall not delegate to any other State Agency the authority and responsibilities described in 42 CFR section 431.10(e).

The State assures that all Medicaid program requirements regarding free choice of providers as defined in 42 CFR 431.51 shall be adhered to.

The States assures that Perinatal Residential Substance Abuse Services are not provided in facilities that are Institutes for Mental Diseases.

State of California
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

The State will set an enrollment limit of 5,850 Medicaid PACE recipients to be funded under the Medicaid program.

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are: See Supplement 4, Attachment 3.1-B, Page 1.1.

(If this option is elected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – Compliance and State Monitoring of the PACE Program.

C. _X_ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

State of California
PACE State Plan Amendment Pre-Print

Medicaid Eligibility Groups Subject to Institutional Eligibility Rules

Individuals receiving services under the PACE Program are eligible under the following eligibility groups(s) in the California State plan. The State will apply all applicable FFP limits under the plan.

1. X The home and community-based group described under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need PACE services in order to remain in the community, and who are covered under PACE).

   Spousal impoverishment rules are used in determining eligibility for the home and community-based group described at 42 CFR 435.217but who are receiving services under PACE.

   X A. Yes _____ B. No

   a. X The PACE Program covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need PACE Services in order to remain in the community. The enrollment of beneficiaries for PACE services under this method of determining eligibility will be capped for each fiscal year (see Supplement 4, Attachment 3.1-B, Page 1).

State of California
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

1. _X_ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

   (a). Sec.435.726 – States which do not use more restrictive eligibility requirements than SSI.

   1. Allowances for the needs of the:
      (A) Individual (check one) community rules apply
      1.____ The following standard included under the State plan (check one):
      (a) ____ SSI
      (b) ____ Medical Needy
      (c) ____ The special income level for the institutionalized
      (d) ____ Percent of the Federal Poverty Level____%*
      (e) _X_ Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(A)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.
      2.____ The following dollar amount: $_____
      Note:If this amount changes, this item will be revised.
      3.____ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

1.____ SSI Standard

State of California
PACE State Plan Amendment Pre-Print

2.____ Optional State Supplement Standard
3.____ Medically Needy Income Standard
4.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
5.____ The following percentage of the following standard this is not greater than the standards above:_____% of _____ standard.
6.____ The amount is determined using the following formula:
7._X__ Not Applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____ standard.
5.____ The amount is determined using the following formula:
_____
_____
6.____ Other
7._X__ Not applicable (N/A)

(2) Medical and remedial care expenses in 42 CFR 435.726

State of California
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

2.____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735 – States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
   1.____ The following standard included under the State plan (check one):
   (a) ____ SSI
   (b) ____ Medically Needy
   (c) ____ The special income level for the institutionalized
   (d) ____ Percent of the Federal Poverty Level:_____%
   (e) ____ Other (specify):_____
2. ____ The following dollar amount: $_____
   Note: If this amount changes, this item will be revised.
3. ____ The following formula is used to determine the needs allowance.

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
1.____ The following standard under 42 CFR 435.121:

_____

2.____ The Medically needy income standard

_____

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

State of California
PACE State Plan Amendment Pre-Print

4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____
5.____ The amount is determined using the following formula:

_____

_____

6.____ Not applicable (N/A)

(C) Family (check one):
1.____ AFDC need standard
2.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3.____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4.____ The following percentage of the following standard that is not greater than the standards above:_____% of _____ standard.
5.____ The amount is determined using the following formula:

_____

_____

6.____ Other
7.____ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under

State of California
PACE State Plan Amendment Pre-Print

Section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:
1. Individual (check one):
(A) _X_ The following standard included under the State plan (check one):
1.____ SSI
2.____ Medically Needy
3.____ The special income level for the institutionalized
4.____ Percent of the Federal Poverty Level:_____%
5._X_ Other (specify): An amount which represents the sum of (1) the income standard used to determine eligibility/share of cost and (2) any amounts of income disregarded during the Section 1902(a)(10)(ii)(VI) eligibility phase. The maximum allowance is $10,000.00 per month.

(B) ____ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C) ____ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

Because this is the same amount that may be retained by individuals in the community to meet their needs.

State of California
PACE State Plan Amendment Pre-Print

II. Rates and Payments

A.. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon one of the following methodologies. Please attach a description of the negotiate rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See Supplement 4, Attachment 3.1-B, Page 7a.

1. X Rates are set at a percent of fee-for-service costs
2. ____ Experience-based (contractors/State's cost experience or encounter data) (please describe)
3. ____ Adjusted Community Rate (please describe)
4. ____ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Gary McCollum, ASA, MAAA	Capitation Rate Unit, DHS
Robert Ruderman, ASA, MAAA	Capitation Rate Unit, DHS
Arlene Livingston, FSA, MAAA	Capitation Rate Unit, DHS

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

State of California
PACE State Plan Amendment Pre-Print

Rate Setting Methodology for PACE

Under a risk contract, Medicaid payments to the contractor, for a defined scope of services to be furnished to a defined number of recipients, may not exceed the cost to the State of providing those same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. The Program of All-Inclusive Care for the Elderly (PACE) is a capitated program for individuals who are eligible for placement in a Long-Term Care facility.

Capitation rates for contracts the State has with PACE contractors in a number of different counties are set using a fee-for-service equivalent (FFSE) methodology. The FFSE is calculated for each plan, and then the capitation rate is set at a percentage of the FFSE, not to exceed 100 percent.

The calculation of the FFSE starts with a statewide base cost from a prior period, expressed as a cost per eligible per month. Adjustments are then made which adjust the base cost for the specific plan rate being calculated. The adjustments are for the following items:

1. Demographics – This adjusts for the specific age/sex demographics of a plan.
2. Contract Adjustments – Since plans do not cover all available services in fee-for-service, reductions for those services not covered are accounted for on this line. The specific type of services not covered would include the following: AIDS Waiver Services, In-Home Waiver Services, Nursing Facility Waiver Services, and other items not covered related to children who would not be enrolled under this program.
3. Medicare Adjustments – Because Medicare pays a significant portion of the medical expenses for individuals over 65, the capitation rate is different for individuals who have Medicare coverage and for those who do not. This adjusts for the plan population relative to the statewide base.

This adjusted base cost then needs to be projected into the future. There are two considerations here; legislative changes and trend.

1. Legislative Changes – This evaluates the financial impact of legislation that has been passed or is expected to be enacted.

State of California
PACE State Plan Amendment Pre-Print

2. Trend – This adjustment predicts the affect of all other changes that may take place in the Medi-Cal population and in the medical services arena. Because the Base Costs are for fiscal year 1996/97, it is necessary to project these forward to the rate year. Trend adjustments for AIDS are the same as trend adjustments for Long Term Care. The calculation of trends is made in two parts; number of units used per eligible and cost per unit.

The rate setting methodology for PACE is the FFSE cost per person per month. The capitation rate paid to a PACE Program is 85, 90, or 95 percent of the FFSE costs. The percentage used is mutually agreed to by the State and the PACE Program.

Historically, the start up of California PACE Demonstrations Programs capitation rates were set at 95 percent of the FFSE costs for two years in order to gain experience as a PACE Program prior to applying for a federal waiver and then recalculated at 85 percent of FFSE costs in subsequent years as a PACE Program became more stable and financially self-sufficient.

AltaMed Senior BuenaCare's (SBC) percent of FFS continues to remain at 95% percent since they have not been able to achieve self-sufficiency. The Department of Health Services will consider to reduce SBC's percent of FFS to 85 percent in the future.

Over the last several years, On Lok had experienced increased difficulties in recruiting new in-home care workers. In July 1999, On Lok had to increase its home care worker wages by 25 percent over the salary scale just to match the wages of the In-Home Supportive Services (IHSS) workers in San Francisco who perform tasks comparable to On Lok's in-home care workers. The high cost of these services in San Francisco justified On Lok receiving an increase from 85 percent to 90 percent of the cost of a comparable population. On Lok continues to increase its wages just to remain competitive with the IHSS wages.

PACE State Plan Amendment Pre-Print

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

California

Standards Established and Methods Used to Assure High Quality Care

Provider standards are set forth in the 512--series of program regulations. These set forth standards that must be met by every category of provider before participation in the program is permitted. In many instances the standards exceed licensing requirements. Compliance with these standards is verified by the Department's Licensing and Certification Section. Adherence to the standards implies at least a certain capacity for providing high quality care.

Further, the Department's Audits and Investigations Division is responsible for administering a program of review of the quality and adequacy of health care services provided by prepaid health plans. These "medical audits" of each prepaid health plan are conducted annually by teams that include a physician, dentist, and pharmacist. This Division also evaluates individual allegations of poor quality of care which are resolved generally on the basis of professional judgement.

The Medical Social Review activities relating to nursing home inpatients involves an assessment of the quality of care being provided in addition to evaluating the appropriateness of the level of care required by the program beneficiary.

TN 84-10
APPROVED 9/21/84
EFFECTIVE 7/1/84

Article 3

SERVICES AND STANDARDS

Sec.
14550. Required services.
14551. Additional services.
14552. Standards for certification as a provider.
14553. Policies and procedures.
14554. Medical records.
14555. Grievance procedures.
14556 to 14565. Repealed.

Article 3 was added by Stats.1977, c. 1066, p. 3231, § 5.

Repeal

Article 3 is repealed on Jan. 1, 1983, see Historical Note under § 14520.

§ 14550. Required services

Adult day health centers shall offer, and shall provide directly on the premises, at least the following services:

(a) Rehabilitation services, including the following:

(1) Occupational therapy as an adjunct to treatment designed to restore impaired function of patients with physical or mental limitations.

(2) Physical therapy appropriate to meet the needs of the patient.

(3) Speech therapy for participants with speech or language disorders.

(b) Medical services supervised by either the participant's personal physician or a staff physician, or both, which emphasize prevention treatment, rehabilitation, and continuity of care and also provide for maintenance of adequate medical records. To the extent otherwise permitted by law, medical services may be provided by registered nurses practicing under standardized procedures, or, if the Board of Registered Nursing defines standards for nurse practitioners, by nurses meeting such standards.

(c) Nursing services, including the following:

(1) Nursing services rendered by a professional nursing staff, who periodically evaluate the particular nursing needs of each participant and provide the care and treatment that is indicated.

(2) Self-care services oriented toward activities of daily living and personal hygiene, such as toileting, bathing, and grooming.

(d) Nutrition services, including the following:

(1) The program shall provide a minimum of one meal per day which is of suitable quality and quantity as to supply at least one-third of the daily nutritional requirement. Additionally, special diets and supplemental feedings shall be available if indicated.

(2) Dietary counseling and nutrition education for the participant and his family shall be a required adjunct of such service.

(e) Psychiatric or psychological services which include consultation and individual assessment by a psychiatrist, clinical psychologist, or a psychiatric social worker, when indicated, and group or individual treatment for persons with diagnosed mental, emotional, or behavioral problems.

(f) Social work services to participants and their families to help with personal, family, and adjustment problems that interfere with the effectiveness of treatment.

(g) Planned recreational and social activities suited to the needs of the participants and designed to encourage physical exercise, to prevent deterioration, and to stimulate social interaction.

(h) Transportation service for participants, when needed, to and from their homes utilizing specially equipped vehicles to accommodate participants with severe physical disabilities that limit their mobility.

(i) Written procedures for dealing with emergency situations. Such written procedures shall include the name and telephone number of a physician on call, written arrangements with a nearby hospital for inpatient and emergency room service, and provision for ambulance transportation.

(Added by Stats.1977, c. 1066, p. 3231, § 5.)

Historical Note

Former § 14550, added by Stats.1965, 2d Ex.Sess., c. 4, p. 127, § 4, specifying that definitions governed construction of chap., was repealed by Stats.1968, c. 21, p. 1035, § 68.

Original § 14550, added by Stats.1965, c. 1784, p. 4064, § 5, derived from former § 4730, added by Stats.1961, c. 1227, p. 2871, § 1, relating to eligibility for assistance to aged, was repealed by Stats.1965, 2d Ex.Sess., c. 4, p. 125, § 3.

Cross References

Subcontracts to provide basic services specified in this section, see § 14577.

Library References

Social Security and Public Welfare ⟨=241.82.

C.J.S. Social Security and Public Welfare § 134.

Sec.
19016. Regulations and statements of policy.
19017. Research and statistics.
19018. Eligibility for services.
19019. Transfer of surplus property in trust to nonprofit corporations for manufacturing centers, opportunity centers, etc.; consideration; agreement; approval; extension.
19019.1. Actions by director of general services to help secure working capital, etc., for nonprofit corporations.
19019.2. Quarterly reports by nonprofit corporations.
19021. Manufacturing centers; qualifications.
19022. Location requirements for transfer of California industries for the blind or opportunity work centers.
19023. Monitor of transfer of California industries for the blind or opportunity work centers; annual reports.

Chapter 1 was added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970.

Cross References

Education of handicapped adults, see Education Code §§ 52570 et seq., 78440 et seq.
Retraining and rehabilitation of injured full-time public employees, see Labor Code § 6200 et seq.
Services for the developmentally disabled, see § 4500 et seq.

Administrative Code References

Conflict of interest code, see 9 CalAdm.Code 7400 et seq.
Department of rehabilitation, see 9 CalAdm.Code 7000 et seq.

Library References

Vocational rehabilitation programs. Report of Senate Social Welfare Subcommittee of General Research, vol. 21, no. 15, p. 134. Vol. 1 of Appendix to Journal of the Senate, Reg. Sess.1969.

§ 19000. Statement of public policy

It is the public policy of the State of California to assist and encourage handicapped individuals to attain their maximum usefulness and self-sufficiency and make adequate provision for such services as will enable them to prepare for and engage in gainful employment in order that they may make their full contribution to society.

This policy should be carried out by strengthening the existing program of vocational rehabilitation, consolidating the basic rehabilitative services in a Department of Rehabilitation, placing emphasis upon the need for maximum efficient utilization of state services, strengthening and developing services where needed, and promoting effective coordination of all public and private agencies serving the handicapped.

(Added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970.)

Historical Note

Derivation: Educ.C. former § 6971, added by Stats.1963, c. 1747, p. 3484, § 1. Educ.C.1943, § 9850, added by Stats. 1953, c. 1647, p. 3369, § 6.

Educ.C. former § 7001, enacted by Stats.1959, c. 2, p. 805, § 7001.

Cross References

Encouragement of education, see Const. Art. 9, § 1.

Law Review Commentaries

Torts and the disabled. Jacobus ten-Broek (1966) 54 C.L.R. 841.

Library References

Social Security and Public Welfare ⇨179.
C.J.S. Social Security and Public Welfare § 102.

Review of rehabilitation policies and programs. Report of the Assembly Interim Committee on Social Welfare, 1965-1967, Vol. 29, No. 14, p. 7. Vol. 2 of Appendix to Journal of Assembly, Reg.Sess., 1967.

§ 19001. Department of rehabilitation

There is in the Health and Welfare Agency the Department of Rehabilitation.

(Added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970. Amended by Stats.1979, c. 373, § 409.)

Historical Note

Construction of provisions of other acts conflicting with sections affected by Stats.1969, c. 138, p. 290, see Historical Note under § 13921.

The 1979 amendment substituted "Health and Welfare Agency" for "Human Relations Agency".

Derivation: Educ.C. former § 6972, added by Stats.1963, c. 1747, p. 3484, § 1, amended by Stats.1969, c. 138, p. 298, § 32.

Library References

States ⇨45.
Social Security and Public Welfare ⇨5.

C.J.S. States §§ 79, 80, 82, 136.
C.J.S. Social Security and Public Welfare §§ 6, 7.

§ 19002. Director of rehabilitation

The Department of Rehabilitation is under the control of an officer known as the Director of Rehabilitation. As used in this division "department" and "director" refer to the Department of Rehabilitation and the Director of Rehabilitation, respectively, unless the context otherwise requires.

(Added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970.)

Historical Note

Derivation: Educ.C. former § 6973, added by Stats.1963, c. 1747, p. 3484, § 1.

Library References

Social Security and Public Welfare ⇨5. C.J.S. Social Security and Public Welfare §§ 6, 7.

§ 19003. Director; chief deputy; appointment; compensation

The director is appointed by the Governor, subject to confirmation by the Senate, and holds office at the pleasure of the Governor. The annual salary of the director is provided for by Chapter 6 (commencing with Section 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

Upon recommendation of the director, the Governor may appoint a chief deputy director of the department who shall hold office at the pleasure of the Governor. The salary of the chief deputy director shall be fixed in accordance with law.

(Added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970. Amended by Stats.1972, c. 618, p. 1154, § 162; Stats.1978, c. 432, § 22.5, eff. July 17, 1978, operative July 1, 1978.)

Historical Note

The 1972 amendment deleted a provision that the director is a member of the Governor's Council.

The 1978 amendment added the second paragraph.

Derivation: Educ.C. former § 6974, added by Stats.1963, c. 1747, p. 3484, § 1.

Cross References

Annual salary of director of rehabilitation, see Government Code § 11554.

Library References

Social Security and Public Welfare ⇨5. C.J.S. Social Security and Public Welfare §§ 6, 7.

§ 19004. Law applicable to director

The provisions of Chapter 2 (commencing with Section 11150), Part 1, Division 3, Title 2 of the Government Code apply to the director and the director is the head of a department within the meaning of the chapter.

(Added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970.)

Historical Note

Derivation: Educ.C. former § 6975, added by Stats.1963, c. 1747, p. 3484, § 1.

Library References

Social Security and Public Welfare ⇐2. C.J.S. Social Security and Public Welfare § 5.

§ 19005. Authorization to cooperate with federal government

The department is vested with all necessary powers and authority to cooperate with the government of the United States or any agency or agencies thereof in the administration of any act of Congress and rules and regulations lawfully adopted thereunder relating to the disabled or rehabilitation of the handicapped.

(Added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970. Amended by Stats.1970, c. 338, p. 733, § 2.)

Historical Note

The 1970 amendment inserted the phrase "and rules and regulations lawfully adopted thereunder" and substituted "the disabled or rehabilitation of the handicapped" for "rehabilitation of the handicapped".

Derivation: Educ.C. former § 6877, added by Stats.1963, c. 1747, p. 3484, § 1.

Law Review Commentaries

Torts and the disabled. Jacobus ten-Broek (1966) 54 C.L.R. 841.

Library References

Social Security and Public Welfare ⇐5. States ⇐4.18. C.J.S. Social Security and Public Welfare §§ 6, 7. C.J.S. States § 28.

§ 19005.1. State agency; vocational rehabilitation services

The Department of Rehabilitation is hereby designated as the sole state agency with full power to supervise every phase of the administration of the state plan for vocational rehabilitation services. All decisions affecting eligibility for and the nature and scope of vocational rehabilitation services to be provided will be made by the department through its organizational units.

(Added by Stats.1975, c. 171, p. 316, § 22, eff. June 30, 1975.)

§ 19006. Rules and regulations

The department may adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act, such rules and regulations as may be reasonably necessary to enable it to carry out its duties and powers.

(Added by Stats.1969, c. 1107, p. 2115, § 17, operative Jan. 1, 1970.)

1 Government Code § 11370 et seq.

Library References :

Social Security and Public Welfare ⇨4.10.

C.J.S. Social Security and Public Welfare §§ 11, 15.

§§ 19100.1 to 19110. Inoperative

Historical Note

The addition of §§ 19100.1 to 19110 by Stats.1959, c. 1565, p. 3178, § 1, failed to become operative. See Historical Note under § 19700.

Chapter 2

DEFINITIONS

Sec.

19150. Vocational rehabilitation services.
19151. Handicapped individual.
19152. Rehabilitation facility.
19153. Blind person.
19154. Establishment of rehabilitation facility.

Chapter 2 was added by Stats.1969, c. 1107, p. 2118, § 17, operative Jan. 1, 1970.

§ 19150. Vocational rehabilitation services

(1) The term "vocational rehabilitation services" means the following services:

(a) Evaluation, including diagnostic and related services, incidental to the determination of eligibility for and the nature and scope of services to be provided;

(b) Counseling, guidance, and placement services for handicapped individuals, including followup services to assist such individuals to maintain their employment;

(c) Training services for handicapped individuals, which shall include personal and vocational adjustment, books, and other training materials;

(d) Reader services for the blind and interpreter services for the deaf; and

(e) Recruitment and training services for handicapped individuals to provide them with new employment opportunities in the fields of rehabilitation, health welfare, public safety, and law enforcement, and other appropriate service employment.

(2) Such term also includes, after full consideration of eligibility for any similar benefit the following services and goods provided to, or for the benefit of, a handicapped individual:

(a) Physical restoration services, including, but not limited to (i) corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and constitutes a substantial barrier to employment, but is of such nature that such correction or modification may reasonably be expected to eliminate or substantially reduce the handicap within a reasonable length of time, (ii) necessary hospitalization in connection with surgery or treatment, (iii) prosthetic and orthotic devices, (iv) eyeglasses and visual services as prescribed by a physician skilled in the diseases of the eye or by an optometrist;

(b) Maintenance, not exceeding the estimated cost of subsistence, during rehabilitation;

(c) Occupational licenses, tools, equipment, and initial stocks and supplies;

(d) In the case of any type of small business operated by the severely handicapped the operation of which can be improved by management services and supervision provided by the department the provision of such services and supervision, alone or together with the acquisition by the department of vending stands or other equipment and initial stocks and supplies;

(e) The provision of other facilities and services which promise to contribute substantially to the rehabilitation of a group of individuals but which are not related directly to the rehabilitation plan of any one handicapped individual;

(f) Transportation in connection with the rendering of any other vocational rehabilitation service;

(g) Any other goods and services necessary to render a handicapped individual employable;

(h) Services to the families of handicapped individuals when such services will contribute substantially to the rehabilitation of such individuals.

(Added by Stats.1969, c. 1107, p. 2118, § 17, operative Jan. 1, 1970.)

Historical Note

Derivation: Educ.C. former § 7010, enacted by Stats.1959, c. 2, p. 506, § 7010. Educ.C.1943, § 8855, added by Stats.1953, c. 1647, p. 3370, § 6, amended by Stats.1955, c. 677, p. 1495, § 10.

Library References

Schools and School Districts ⇐150. C.J.S. Schools and School Districts § 447 et seq.

51009. Confidential Nature of Records.

All individual medical records of beneficiaries acquired by individuals or institutions providing care, the Department, or any other state or local agency, or by any organization contracting to provide administrative services under this program, shall be confidential and shall not be released without the written consent of the beneficiary or his personal representative. This shall not preclude the release of statistical or summary data or information in which individual beneficiaries are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, fiscal intermediaries, and state or local official agencies. Neither shall this section preclude exchange of information necessary for the purpose of effecting recovery as provided in Welfare and Institutions Code, Sections 10020 through 10025, 14024 and 14124.70 through 14124.79 with persons liable thereunder.

HISTORY:

1. Refiled 6-5-67 as an emergency; effective upon filing, Certificate of Compliance filed 6-9-67 (Register 67, No. 23).
2. Amendment filed 11-15-68; effective thirtieth day thereafter (Register 68, No. 43).
3. Amendment filed 7-13-73; effective thirtieth day thereafter (Register 73, No. 28).
4. Editorial correction (Register 81, No. 38).

51011. Identification of Beneficiary.

All out-of-hospital and inpatient services may be provided subject to the limitations specified in the scope of benefits, and subject to the Medical Assistance classification of the beneficiary upon presentation by a beneficiary of a valid medical care eligibility card issued by a local welfare department, except where these regulations specify that prior authorization for a specific service is required, and evidence of such authorization is presented or furnished, such card shall be deemed adequate authorization to provide services up to the expiration date specified on the card.

HISTORY:

1. Refiled 6-5-67 as an emergency; effective upon filing. Certificate of Compliance filed 6-9-67 (Register 67, No. 23).

51013. Crippled Children Services.

Whenever a beneficiary under age 21 has a medical or surgical condition which would qualify for services under Crippled Children Services, he shall be referred to that program for case management services and prior authorization by the appropriate local or state administrative agency for Crippled Children Services in the county in which the patient lives. Needed medical care not normally provided through Crippled Children Services shall be provided through the procedures established in these regulations.

HISTORY:

1. Refiled 6-5-67 as an emergency; effective upon filing. Certificate of Compliance filed 6-9-67 (Register 67, No. 23).

51014. Vocational Rehabilitation Services.

Whenever a service is recommended on behalf of a Medi-Cal beneficiary on the basis that such service is needed for vocational rehabilitation, he shall be referred to the State Department of Rehabilitation for counseling and evaluation. If the Department concurs in the vocational relevancy of the proposed service, it will provide case management services and make appropriate recommendations on requests for prior authorization to the Medi-Cal consultant.

HISTORY:

1. New section filed 5-31-68; effective thirtieth day thereafter (Register 68, No. 21).

Historical Note

Addition of § 219 by Stats.1973, c. 142, p. 388, § 24, allowing the director to investigate the work of licensing boards, failed to become operative under the terms of § 110.5 of that Act upon enactment of Stats.1973, c. 122.

The 1978 amendment inserted, in two places, the words "Department of the" preceding "California Highway Patrol"; substituted "Department" for "Division" preceding "of Forestry"; and added subd. (e).

Library References

Health and Environment ⇐7(1). C.J.S. Health and Environment §§ 9, 11, 54.

§ 220. Inoperative

Historical Note

Addition of § 220 by Stats.1973, c. 142, p. 388, § 25, requiring approval of director for any changes in rules, regulations or fees, failed to become operative under the terms of § 110.5 of that Act upon enactment of Stats.1973, c. 122.

§ 221. Licenses, certificates, etc.; issuance and renewal; two-year basis; fees

Notwithstanding any other provision of law, the department by rule or regulation may provide for the issuance and renewal on a two-year basis of licenses, certificates of registration, or other indicia of authority issued pursuant to this code by the department or any agency in the department.

The department may, by rule or regulation, set the fee for such two-year license, certificate of registration, or other indicia, not to exceed twice the annual fee for issuance or renewal set by statute.

(Added by Stats.1975, c. 57, p. 104, § 2.)

Library References

Licenses ⇐36. C.J.S. Licenses § 42.

Article 2

CALIFORNIA CHILDREN'S SERVICES

Sec.

Sec.

Article 2, Crippled Children Services, was added by Stats.1968, c. 1316, p. 2485, § 2, operative July 1, 1969.

The heading of Article 2 was amended by Stats.1978, c. 857, § 2, to read as it now appears.

Former Article 2, Physically Handicapped Children, enacted in 1939, comprising sections 249 to 273, was repealed by Stats.1968, c. 1316, p. 2485, § 1, operative July 1, 1969.

Cross References

Additional educational service program components, see Education Code § 56332.
Compliance with hereditary disorders act, see § 155.
Establishments for handicapped persons, see § 1500 et seq.

Library References

Crippled children services. Report of Senate Social Welfare Subcommittee of General Research, vol. 21, no. 12, p. 154. Vol. 1 of Appendix to Journal of the Senate, Reg.Sess.1959.
Extention of crippled children services. Reports of joint Interim Committee on the Education of Handicapped Children and Adults, 1959, p. 157. Vol. 1 of Appendix to Journal of the Senate, Reg.Sess.1959.
Rehabilitation of disabled and dependent persons. Report of Senate Interim Committee on the Education and Rehabilitation of Handicapped Children and Adults, 1957, p. 21. Vol. 2 of Appendix to Journal of the Senate, Reg.Sess.1957.

§ 248. Title of act

This article shall be known and may be cited as the Robert W. Crown California Children's Services Act.

(Added by Stats.1973, c. 1085, p. 2201, § 1. Amended by Stats.1978, c. 857, § 3.)

Historical Note

The 1978 amendment substituted "California Children's" for "Crippled Children".

Section 1 of Stats.1978, c. 857, provides: "The Legislature finds that the use of certain descriptive labels which have no medical significance draws negative attention and stigma upon the individual or group concerned, gradually supplants, the unique identity and human potential of persons, and injures social values, status, societal mobility, and freedom. Therefore, it is the intent of the Legislature to change the name of the crippled children's program to the California Children's Services Program and to remove all use of the term crippled from the provisions that provide such program in referring to children with physical handicaps. It is further the intent of the Legislature that such change in name shall not be construed as expanding the list of eligible services available through the program or prohibit the use of existing forms used by the program prior to the use of new forms with the name change."

Administrative Code References

Child health and disability prevention program, see 17 Cal.Adm.Code 6800 et seq.
Immunization against poliomyelitis, diphtheria, pertussis, tetanus, and measles, see 17 Cal.Adm.Code 6000 et seq.
Services for physically handicapped children, see 17 Cal.Adm.Code 2890 et seq.
Tuberculosis screening of employees and volunteers in private, parochial and nursery schools, see 17 Cal.Adm.Code 6600 et seq.

Library References

Social Security and Public Welfare ⇨197.
C.J.S. Social Security and Public Welfare § 127.

§ 249. Services for physically defective or handicapped minors; powers and duties of department

The State Department of Health Services shall establish and administer a program of services for physically defective or handicapped persons under the age of 21 years, in cooperation with the federal government through its appropriate agency or instrumentality, for the purpose of developing, extending and improving such services. The state department shall receive all funds made available to it by the federal government, the state, its political subdivisions or from other sources. The state department shall have power to supervise those services included in the state plan which are not directly administered by the state. The state department shall cooperate with the medical, health, nursing and welfare groups and organizations concerned with the program, and any agency of the state charged with the administration of laws providing for vocational rehabilitation of physically handicapped children.

The reference to "the age of 21 years" in this section is unaffected by Section 1 of Chapter 1748 of the Statutes of 1971 or any other provision of that chapter.

(Added by Stats.1972, c. 27, p. 32, § 2, eff. March 21, 1972, operative July 1, 1973. Amended by Stats.1973, c. 1212, p. 2743, § 26, operative July 1, 1974; Stats.1977, c. 1252, § 131, operative July 1, 1978.)

Historical Note

Operative date of Reorganization Plan No. 1 of 1970, see Historical Note under § 20.

Sections 5, 6, 8 of Stats.1972, c. 27, p. 33, provided:

"Sec. 5. It is the intent of the Legislature, that, if Reorganization Plan No. 1 of 1970 becomes operative, Section 249 of the Health and Safety Code, as amended by Section 1 of this act, shall remain in effect only until Reorganization Plan No. 1 of 1970 becomes operative [July 1, 1973] and on that date Section 249 of the Health and Safety Code, as added by Section 2 of this act, which includes the changes in Section 249 made by both Reorganization Plan No. 1 of 1970 and Section 1 of this act, shall become operative.

"Sec. 6. It is the intention of the Legislature that to the extent permitted by federal law, eligibility of persons for services to physically handicapped children pursuant to Article 2 (commencing with Section 248) of Chapter 2 of Part 1 of Division 1 of the Health and Safety Code shall continue to age 21, but that, persons 18 years of age and over may consent to treatment service under Article 2. Notwithstanding any other provision of law, Sections 249, 250.5, and 263 of the Health and Safety Code, as amended by Sections 1, 2, and 3 of this act, respectively, shall not constitute a change in, but are declaratory of, the preexisting law.

"Sec. 8. Sections 1 to 6, inclusive, of this act shall become operative on March 4, 1972."

The 1973 amendment inserted "State" preceding "Department" in the first sentence; deleted from the second sentence the words "and expend" in the phrase "receive and expend all funds"; rewrote the former second sentence as the present second and third sentences; and deleted the last paragraph which had read: "This section shall become operative on the same date as Reorganization Plan No. 1 of 1970 becomes operative" [July 1, 1973].

Sections 439, 448 of Stats.1973, c. 1212, p. 2733, provide:

"Sec. 439. Upon receipt of a formal ruling from the Secretary of Labor, the Secretary of Health, Education, and Welfare, or the head of any federal agency

Law Review Commentaries

Epilepsies. (1976) 13 San Diego L.Rev. 878.

Library References

Social Security and Public Welfare ⇐195. C.J.S. Social Security and Public Welfare § 125.

§ 250.5. Handicapped child

"Handicapped child," as used in this article, means a physically defective or handicapped person under the age of 21 years who is in need of services. The director shall establish those conditions coming within a definition of "handicapped child" except as the Legislature may otherwise include in the definition. Phenylketonuria, hyaline membrane disease, cystic fibrosis, and hemophilia shall be among such conditions.

The reference to "the age of 21 years" in this section is unaffected by Section 1 of Chapter 1748 of the Statutes of 1971 or any other provision of that chapter.[1]

(Added by Stats.1968, c. 1316, p. 2485, § 2, operative July 1, 1969. Amended by Stats.1971, c. 1811, p. 3915, § 1; Stats.1972, c. 27, p. 32, § 3, eff. March 21, 1972, operative July 1, 1973.)

[1] Civil Code § 25 note.

Historical Note

The 1971 amendment included "hyaline membrane disease".

The 1972 amendment added the second paragraph.

Operative effect of 1972 amendment, see Historical Note under § 249.

Derivation: Former § 250, enacted by Stats.1939, c. 60, p. 457, § 250, amended by Stats.1943, c. 210, p. 1109, § 2; Stats.1961, c. 1829, p. 3917, § 1; Stats.1961, c. 2148, p. 4432, § 2; Stats.1967, c. 1681, p. 4215, § 1.

Pol.C. § 2979b, added by Stats.1927, c. 590, p. 1021, § 1, amended by Stats.1929, c. 752, p. 1430, § 1.

Cross References

Diagnosis for handicapped children, see § 253.5.
Minor, defined, see Civil Code § 25.
Publication of conditions diagnosed, see § 253.5.

Library References

Social Security and Public Welfare ⇐195. C.J.S. Social Security and Public Welfare § 125.
Words and Phrases (Perm.Ed.)

Notes of Decisions

1. In general

Former § 250, as amended, changed the age limit of a handicapped child from 18 to 21 years wherein he could be certified for services and a physically handicapped child who had been certificated by a superior court as eligible for services and who had attained the age of 18 need not have again petitioned the superior court for the issuance of a new certificate provided the age of 18 was attained after the effective date of the statutory amendment. 2 Ops. Atty.Gen. 110.

§ 250.6. Keeping program abreast of advances in medical science; pilot studies

The department shall keep the program abreast of advances in medical science, leading to the inclusion of other handicapping conditions and services within the limits of and consistent with the most beneficial use of funds appropriated for this purpose. With the approval of the agency administrator the department may carry out pilot studies to determine the need for, or the feasibility of, including other handicapping conditions and services in the program within the limits of available funds appropriated for the program.

(Added by Stats.1968, c. 1316, p. 2485, § 2, operative July 1, 1969.)

Library References

Social Security and Public Welfare ⇐195.

C.J.S. Social Security and Public Welfare § 125.

§ 250.7. Repealed by Stats.1973, c. 336, p. 756, § 2

Historical Note

The repealed section, added by Stats. 1970, c. 709, p. 1336, § 1, required priority in the use of 1970 appropriated funds for the crippled children's services program.

§ 251. Services

"Services," as used in this article, means any or all of the following:

(a) Expert diagnosis.

(b) Medical treatment.

(c) Surgical treatment.

(d) Hospital care.

(e) Physical therapy.

(f) Occupational therapy.

(g) Special treatment.

(h) Materials.

(i) Appliances and their upkeep, maintenance, care and transportation.

✳ (j) Maintenance, transportation, or care incidental to any other form of "services."

(Added by Stats.1968, c. 1316, p. 2485, § 2, operative July 1, 1969.)

51009. Confidential Nature of Records.

All individual medical records of beneficiaries acquired by individuals or institutions providing care, the Department, or any other state or local agency, or by any organization contracting to provide administrative services under this program, shall be confidential and shall not be released without the written consent of the beneficiary or his personal representative. This shall not preclude the release of statistical or summary data or information in which individual beneficiaries are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, fiscal intermediaries, and state or local official agencies. Neither shall this section preclude exchange of information necessary for the purpose of effecting recovery as provided in Welfare and Institutions Code, Sections 10020 through 10025, 14024 and 14124.70 through 14124.79 with persons liable thereunder.

HISTORY:

1. Refiled 6-5-67 as an emergency; effective upon filing, Certificate of Compliance filed 6-9-67 (Register 67, No. 23).
2. Amendment filed 11-15-68; effective thirtieth day thereafter (Register 68, No. 43).
3. Amendment filed 7-13-73; effective thirtieth day thereafter (Register 73, No. 28).
4. Editorial correction (Register 81, No. 38).

51011. Identification of Beneficiary.

All out-of-hospital and inpatient services may be provided subject to the limitations specified in the scope of benefits, and subject to the Medical Assistance classification of the beneficiary upon presentation by a beneficiary of a valid medical care eligibility card issued by a local welfare department, except where these regulations specify that prior authorization for a specific service is required, and evidence of such authorization is presented or furnished, such card shall be deemed adequate authorization to provide services up to the expiration date specified on the card.

HISTORY:

1. Refiled 6-5-67 as an emergency; effective upon filing. Certificate of Compliance filed 6-9-67 (Register 67, No. 23).

51013. Crippled Children Services.

Whenever a beneficiary under age 21 has a medical or surgical condition which would qualify for services under Crippled Children Services, he shall be referred to that program for case management services and prior authorization by the appropriate local or state administrative agency for Crippled Children Services in the county in which the patient lives. Needed medical care not normally provided through Crippled Children Services shall be provided through the procedures established in these regulations.

HISTORY:

1. Refiled 6-5-67 as an emergency; effective upon filing. Certificate of Compliance filed 6-9-67 (Register 67, No. 23).

51014. Vocational Rehabilitation Services.

Whenever a service is recommended on behalf of a Medi-Cal beneficiary on the basis that such service is needed for vocational rehabilitation, he shall be referred to the State Department of Rehabilitation for counseling and evaluation. If the Department concurs in the vocational relevancy of the proposed service, it will provide case management services and make appropriate recommendations on requests for prior authorization to the Medi-Cal consultant.

HISTORY:

1. New section filed 5-31-68; effective thirtieth day thereafter (Register 68, No. 21).

(c) The costs of diagnosis and treatment services provided to Medi-Cal beneficiaries as a result of health assessments shall be reimbursed by the State in accordance with the Medi-Cal fee schedules, subject to any applicable Medi-Cal program limitations.

NOTE: Authority cited: Sections 208 and 321, Health and Safety Code. Reference: Section 323, Health and Safety Code.

HISTORY:

1. Amendment filed 11-28-79 as an emergency; effective upon filing (Register 79, No. 48). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 3-28-80.
2. Certificate of Compliance filed 3-27-80 (Register 80, No. 13).

Article 4. Required Services

6840. Required Services.

NOTE: Authority cited: Sections 208 and 321, Health and Safety Code. Reference: Sections 321.2 (a)-(e), Health and Safety Code.

HISTORY:

1. Repealer filed 12-1-79 as an emergency; effective upon filing (Register 79, No. 48). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 3-28-80.
2. Certificate of Compliance filed 3-27-80 (Register 80, No. 13).

6842. Outreach and Health Education.

(a) Plan. Each community child health and disability prevention program shall develop, plan and implement community outreach and health education activities which are related to the community's needs and resources. Activities may include, but are not limited to, community organization, staff training, consultation with children and families, staff services to community child health and disability prevention program advisory boards, and the development and dissemination of informational and educational material for the public, potential users and providers of the program's services, advisory board members, local agencies and community groups.

(b) Outreach. An outreach program shall be as follows:

(1) Community child health and disability prevention programs shall develop outreach programs to involve persons in the use of preventive health services. Outreach and health education services shall be designed to ensure that the only reason eligible persons do not participate in the health assessment and referral for diagnosis and treatment portions of the program is because they intelligently and knowingly decline such participation for reasons unrelated to availability and accessibility of the health assessment, diagnosis and treatment services.

(2) In cooperation with the community child health and disability prevention program, the governing body of every school district or private school which has children enrolled in kindergarten shall, at the time the parent or guardian registers a child in kindergarten, inform the parents or guardians as follows:

(A) It is statutorily required that children provide, within 90 days after entrance into the first grade, either a certificate to the school documenting that within the prior 18 months the child has received the appropriate health assessment required by law, or a waiver signed by the parent or guardian indicating that they do not want or are unable to obtain such health assessments for their children.

(Register 80, No. 21—5-24-80)

(c) Frequency. An annual referral to a dentist for dental services shall be offered each eligible Medi-Cal recipient three years of age and older. Dental providers, approved for participation in the Medi-Cal program, shall be reimbursed for diagnosis resulting from this annual referral, and for dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

(d) Offer of assistance with transportation and scheduling appointments. Medi-Cal beneficiaries shall be offered assistance with transportation and scheduling appointments for initial and periodic dental examinations. The response to this offer shall be recorded, and this assistance shall be provided if requested by the beneficiary.

(e) Completion of referral. All reasonable steps shall be taken to ensure that Medi-Cal beneficiaries eligible to receive an initial or a periodic dental examination, and who request a referral, complete the referral. An *initial* dental examination shall normally be completed within 120 days from either the date the beneficiary requests the referral, or the date the beneficiary was certified eligible to receive Medi-Cal benefits, whichever occurs later. A *periodic* dental examination shall normally be completed within 120 days from either the date the beneficiary requests the referral, or the last day of the month in which the annual dental examination was due, whichever occurs earlier.

(f) Referral sources. The first source of referral for dental services shall be the person's usual source of licensed dental care. If no usual source of licensed dental care can be identified, the person shall be given, without prejudice for or against any one source, the names and locations of at least three sources of dental care, when available, which have been approved as providers of dental services by the California Medical Assistance Program. Although the family or recipient may choose to receive dental diagnostic and treatment services from a provider of its choice, to be eligible for state reimbursement, these services shall be provided by Medi-Cal approved providers and in accordance with the provisions of the California Administrative Code, Title 22, Division 3 and subject to any applicable Medi-Cal program limitations.

(g) Documentation. If initial or periodic dental services were not provided to a Medi-Cal beneficiary who had requested such services and who also had requested assistance with transportation or scheduling appointments for services, documentation must exist showing that the family or person lost eligibility, could not be located despite a good faith effort to do so, or the person's failure to receive the services was due to an action or decision by the family or person, rather than a failure by the community child health and disability prevention program to meet requirements of this subchapter, including the requirement to offer and provide assistance with transportation and scheduling appointments for services.

NOTE: Authority cited: Sections 208 and 321, Health and Safety Code. Reference: Sections 321.2, 322.7 and 323.7, Health and Safety Code.

HISTORY:

1. New section filed 11-28-79 as an emergency; effective upon filing (Register 79, No. 48). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 3-28-80.
2. Certificate of Compliance filed 3-27-80 (Register 80, No. 13).
3. Amendment of subsection (a)(1) filed 5-22-80; effective thirtieth day thereafter (Register 80, No. 21).

~~I-E~~
I(K)

(Register 80, No. 13—3-29-80)

6846. Health Assessment.

(a) Conditions. The following conditions apply to health assessments provided to eligible persons:

(1) A health assessment shall not be provided without the voluntary consent of the patient.

(2) A health assessment shall not be provided to minors without the prior and written consent of the minor's parent or guardian unless one or more of the following circumstances exist:

(A) The minor is emancipated.

(B) The minor is married.

(C) The minor is a member of the military forces.

(D) Provision of the service is exempted from parental consent by federal or state statute or regulation.

(b) Required screening procedures. Unless medically contraindicated or deemed inappropriate by the health assessment provider, or refused by the person, health assessments shall include the following procedures:

(1) Health and developmental history.

(2) Unclothed physical examination including assessment of physical growth.

(3) Assessment of nutritional status.

(4) Inspection of ears, nose, mouth, throat, teeth and gums.

(5) Vision screening.

(6) Hearing screening.

(7) Tuberculin testing and laboratory tests appropriate to age and sex, including tests for anemia, diabetes and urinary tract infections.

(8) Testing for sickle cell trait and lead poisoning where appropriate.

(9) Immunizations appropriate to age and health history necessary to make status current. (Patient shall also receive, subsequent to the health assessment, any immunizations which could not be given during the assessment, and any immunizations necessary to complete a series which could not be completed during the assessment.)

(10) Health education and anticipatory guidance appropriate to age and health status.

(c) Additional screening procedures. A community child health and disability prevention program may include screening procedures in its program, additional to the ones included in this section, if those procedures are approved by the Department and the State Child Health Board.

(d) Rechecks. In those instances where a person is eligible for state reimbursement of health assessment costs, reimbursement may be made for one recheck of those screening procedures (excluding the Health History and Physical Examination) and laboratory tests where such a recheck is medically indicated because questionable or marginal results were obtained during the prior screening.

(e) Results of health assessment. The results of the health assessment shall be handled as follows:

(1) Health assessment providers shall provide the person with a copy of the results of the screening tests, with an appropriate explanation of the results. Such notification and discussion of screening test results, unless provided by a licensed or certified practitioner of the healing arts, shall be free of diagnostic statements or suggestions that the person needs any particular treatment. Specifically, no medical care or special education plan shall be instituted solely on the basis of the health screening results.

(Register 80, No. 21—5-24-80)

The following table is a guide for the minimum frequency at which health assessments shall be provided to persons eligible for periodic assessments:

Under 1 month old	(1 month)
1 through 2 months old	(2 months)
3 through 4 months old	(2 months)
5 through 6 months old	(2 months)
7 through 9 months old	(3 months)
10 through 12 months old	(3 months)
13 through 17 months old	(5 months)
18 through 23 months old	(6 months)
2 years old	(1 year)
3 years old	(1 year)
4 through 5 years old	(2 years)
6 through 8 years old	(3 years)
9 through 12 years old	(4 years)
13 through 16 years old	(4 years)
17 through 20 years old	

(d) Additional Health Assessments. The frequency indicated in this section is considered a minimum for preventive health care. More frequent health assessments will be reimbursed when the additional assessment is deemed appropriate by the health assessment provider. Circumstances which may indicate the need for more frequent assessments include the following:

(1) The parents have or the person has a particular need for education and guidance.

(2) There is the presence or possibility of perinatal disorders (such as low birth weight, low Apgar scores at birth, prolonged labor).

(3) The person is or will be exposed to a potentially stressful environment—for example, camp or contact sports—before the next periodic health assessment indicated by the periodicity schedule is due.

(e) Limitations. Reimbursement at more frequent intervals will not be made for a health assessment of an individual for the purpose of monitoring or treating a specific disease or disorder previously diagnosed, or for a person whose overall health status requires ongoing treatment care. Such individuals are still eligible for regular assessments if they are otherwise eligible for CHDP services.

NOTE: Authority cited: Sections 208, 321 and 323.7, Health and Safety Code. Reference: Sections 320 and 323.7, Health and Safety Code.

HISTORY:

1. New section filed 11-28-79 as an emergency; effective upon filing (Register 79, No. 48). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 3-28-80.
2. Certificate of Compliance filed 3-27-80 (Register 80, No. 13).
3. Amendment of subsections (c) and (d) (2) filed 5-22-80; effective thirtieth day thereafter (Register 80, No. 21).

6848. Certification for School Entry.

(a) If a child receives a health assessment under provisions of this subchapter, and must present documentation to the school in which the child is to enroll that the appropriate health screening procedures specified in Section 6846 have been performed, the physician providing or supervising such screening shall give the child or parent or guardian a certificate documenting that the child has received the appropriate health screening procedures. The certificate shall be provided whether the cost of the health assessment is reimbursed by the State or paid on behalf of the child.

(5) The community child health and disability prevention program shall:

(A) Identify those persons eligible for CHDP services who can obtain needed medical or remedial services through a grantee under Title V of the Social Security Act (Maternal and Child Health and Crippled Children's Services).

(B) Ensure that persons eligible for Title V services are informed of available services, and referred, if they desire, to Title V grantees that offer services appropriate to the persons' needs.

(6) The source of health care selected by the person shall be indicated on the CHDP assessment form. If that source is other than the assessment provider, a copy of the CHDP referral form or equivalent shall be provided, with the person's written permission, to the identified source of health care.

(b) Additional to (a), above, the following shall apply to Medi-Cal beneficiaries for whom diagnosis and treatment is indicated as a result of initial or periodic health assessments:

(1) Medi-Cal beneficiaries, who requested assistance with transportation or scheduling the appointment for the health assessment, shall be offered assistance with transportation and scheduling appointments for diagnosis and treatment. The response to this offer shall be recorded, and this assistance shall be provided if requested by the beneficiary.

(2) Medi-Cal beneficiaries, who did not request assistance with transportation or scheduling the appointment for the health assessment, may request assistance with transportation and scheduling appointments for diagnosis and treatment. If the beneficiary requests such assistance, the request shall be documented and the assistance shall be provided.

(3) Treatment needed as a result of an *initial* health assessment shall normally be initiated within 120 days from either the date the beneficiary requested the health assessment, or the date the beneficiary was certified eligible to receive Medi-Cal benefits, whichever occurs later. Treatment needed as a result of a *periodic* health assessment shall normally be initiated within 120 days from either the date the beneficiary requested the health assessment, or the last day of the month in which the beneficiary's age exceeds the oldest allowable age for the health assessment according to the periodicity schedule specified in Section 6847, whichever occurs earlier.

(4) If diagnostic and treatment services are not provided to a Medi-Cal beneficiary who requests such services and who also requests assistance with transportation or scheduling appointments for such services, documentation must exist showing that the family or recipient declined the services, lost eligibility, could not be located despite a good faith effort to do so, or the recipient's failure to receive the services was due to an action or decision by the family or recipient, rather than a failure by the community child health and disability prevention program to meet requirements of this subchapter, including the requirement to offer and provide assistance with transportation and scheduling appointments for services.

(c) Each community child health and disability prevention program shall be responsible for developing and maintaining a referral and follow-up system for diagnosis and treatment, and for ensuring that referral is carried out. The referral and follow-up system shall be specified in the community's child health and disability prevention program plan. Agreements between the community

§ 317. Units of food and prices

Nutrition coupons, so far as feasible, shall reflect the unit price of foods selected by the department to meet the nutritional needs of the participants in the pilot project. Each coupon shall be specifically designated as to the unit of food for which it is redeemable.

(Added by Stats.1971, c. 1029, p. 1977, § 1.)

Library References

Health and Environment ⇐6.
Infants ⇐13.
C.J.S. Health and Environment § 13.
C.J.S. Infants §§ 5, 92, 93, 95 to 98.

§ 318. Contracts for redemption of coupons

The department shall, if it establishes a pilot program pursuant to Section 311, investigate the feasibility of contracting with one or more banks in the area served by the pilot project for the redemption of nutrition coupons.

(Added by Stats.1971, c. 1029, p. 1977, § 1.)

Library References

Health and Environment ⇐6.
Infants ⇐13.
C.J.S. Health and Environment § 13.
C.J.S. Infants §§ 5, 92, 93, 95 to 98.

§ 319. Report to legislature

If the department establishes a pilot program pursuant to Section 311, it shall submit a report to the Legislature by July 1, 1972, on its findings concerning the need for, and development of, a supplemental nutritional program for needy pregnant mothers and infants under one year of age, suffering from malnutrition.

(Added by Stats.1971, c. 1029, p. 1977, § 1.)

Library References

Health and Environment ⇐6.
Infants ⇐13.
C.J.S. Health and Environment § 13.
C.J.S. Infants §§ 5, 92, 93, 95 to 98.

Article 3.4

CHILD HEALTH DISABILITY PREVENTION PROGRAM

Sec.

Sec.

Article 3.4 was added by Stats.1976, c. 1159, p. 5320, § 2.

Cross References

Compliance with hereditary disorders act, see § 155.

Administrative Code References

Child health and disability prevention program, see 17 Cal.Adm.Code 6800 et seq.

§ 320. Legislative finding and declaration

The Legislature finds and declares that many physical and mental disabilities can be prevented, or their impact on an individual lessened, when they are identified and treated before they become chronic and irreversible damage occurs. The Legislature finds and declares that a community-based program of early identification and referral for treatment of potential handicapping conditions will be effective in reducing the incidence of such conditions and will benefit the health and welfare of the citizens of this state.

It is the intent of the Legislature in enacting this article to establish child health and disability prevention programs, which shall

be financed and have standards established at the state level and which shall be operated at the local level, for the purpose of providing early and periodic assessments of the health status of children. It is further intended that child health and disability prevention programs shall make maximum use of existing health care resources and shall utilize, as the first source of screening, the child's usual source of health care so that health screening programs are fully integrated with existing health services, that health care professionals be appropriately represented and utilized in these programs, that outreach programs be developed to stimulate the use of preventive health services, and that services offered pursuant to this part be efficiently provided and be of the highest quality.

(Formerly § 306, added by Stats.1973, c. 1069, p. 2145, § 1. Amended by Stats.1976, c. 1208, p. 5499, § 1, eff. Sept. 22, 1976. Renumbered § 320 and amended by Stats.1977, c. 579, § 84.)

Historical Note

The 1976 amendment required, in the second sentence of the second paragraph, the use "as the first source of screening, the child's usual source of health care".

Repeal of § 306 (added by Stats.1973, c. 1069, p. 2145, § 1) by Stats.1976, c. 1159, p. 5230, § 1, failed to take effect upon enactment of Stats.1976, c. 1208, p. 5499, § 1, which amended § 306, under the terms of Gov.C. § 9605.

The 1977 amendment renumbered § 306 to be § 320 without change.

Former § 320, added by Stats.1976, c. 1159, p. 5230, § 2, relating to the same subject matter, was repealed by Stats. 1977, c. 579, § 95.

Library References

Social Security and Public Welfare ⇐195.

C.J.S. Social Security and Public Welfare § 125.

§ 320.2. Definitions

As used in this article:

(a) "Board" means the State Child Health Board.

(b) "Department" means the State Department of Health Services.

(c) "Director" means the State Director of Health Services.

(d) "Governing body" means the county board of supervisors or boards of supervisors in the case of counties acting jointly.

(Added by Stats.1976, c. 1159, p. 5230, § 2. Amended by Stats.1977, c. 1252, § 152, operative July 1, 1978.)

(c) Any civil penalty which is assessed pursuant to subdivision (a) shall be paid into the General Fund of the State Treasury.

(Added by Stats.1979, c. 817, p. 2823, § 11.)

§ 319. Inspections and investigations

Any officer, employee, or agent of the state department may enter the premises of any contract retail food vendor to verify food prices or to witness or investigate procedures, or to otherwise determine compliance of such vendor with the provisions of this article.

(Added by Stats.1979, c. 817, p. 2824, § 12.)

1979 Legislation.

Former § 319 was renumbered § 317 and amended by Stats.1979, c. 817, p. 2823, § 8.

§ 319.5. Report to legislature

The state department, if it establishes the program authorized by Section 311, shall submit a report to the Legislature on or before March 1, 1980, describing the components of, and the participation in, the nutritional food supplement program.

(Added by Stats.1979, c. 817, p. 2824, § 13.)

ARTICLE 3.4. CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Sec.
320.5. State maternal, child, and adolescent health board; duration of section.
321.7. Local maternal, child, and adolescent health boards.

Heading of Article 3.4 was amended by Stats.1981, c. 714, p. ——, § 210.

§ 320.2. Definitions

As used in this article:

(a) "State board" means the State Maternal, Child, and Adolescent Health Board.

(b) "Department" means the State Department of Health Services.

(c) "Director" means the State Director of Health Services.

(d) "Governing body" means the county board of supervisors or boards of supervisors in the case of counties acting jointly.

(e) "Local board" means local maternal, child, and adolescent health board.

(f) "Local health jurisdiction" means county health department or combined health department in the case of counties acting jointly or city health department within the meaning of Section 1[illegible]

(Amended by Stats.1981, c. 1038, p. ——, § 3.)

§ 320.5. State maternal, child, and adolescent health board; duration of section

A State Maternal, Child, and Adolescent Health Board advisory to the director is hereby established within the State Department of Health Services.

The state board shall consist of 13 voting members. The membership shall reflect the ethnic and geographic diversity of the State of California and shall include individuals or parents of individuals who are recipients of services administered by the department, health providers, including Board of Medical Quality Assurance certified or qualified physicians, and representatives of other related interests. The Governor shall appoint seven members of the state board, including a county health officer; a member of the Primary Care Clinics Advisory Committee; one family practice physician, one dentist a major part of whose practice is children's dentistry; one pediatrician; one representative of a child health advocacy organization; and one parent, who is not a health care provider, of a child eligible for health services administered by the department. The Chairman of the Senate Rules Committee shall appoint three members of the state board, including a pediatrician, a parent, who is not a health care provider, of a child eligible for health services administered by the department, and

an individual experienced in administering a local family planning agency. The Speaker of the Assembly shall appoint three members of the state board, including a pediatrician, a nurse specializing in child health, and an obstetrician/gynecologist. A member of the State Council on Developmental Disabilities, a member of the State Commission on Special Education, the Directors of the Departments of Health Services, Mental Health, and Social Services and the Superintendent of Public Instruction, or their designees, shall serve as ex officio, nonvoting members of the state board. The term of each member shall be three years, or for the duration that each member maintains the qualifications under which he or she was appointed, whichever is shorter. In order to maintain continuity, present members of the State Child Health Board shall be appointed to the state board for the duration of their current terms.

The members of the state board shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with the performance of their duties under this article. Members who are parents of children eligible for departmental programs may additionally be reimbursed upon request for their actual and necessary costs of additional child care and lost wages. The Director of Health Services shall provide necessary support staff and services to the state board. The state board shall utilize available department staff to carry out specific tasks enumerated in this article. The state board may hire staff for special projects provided the total budget level for board operations does not exceed the existing level, except as provided for by the director or the Legislature by statute.

The state board shall select its own chairperson from among the 18 appointed members by majority vote of the members and shall establish technical advisory committees as it deems necessary and desirable for the efficient and expeditious performance of its duties. The director may provide or the state board may request that the director provide additional technical experts and consultants to facilitate and support the work of the state board. The state board shall meet on call of the chairperson, at least once quarterly, or as often as necessary to fulfill its duties. All meetings and records of the state board shall be open to the public.

The state board shall have all of the following powers, duties and responsibilities:

(a) Conduct independent studies, investigations, and hearings on the health of mothers, children, and adolescents and the system of health services for mothers, children, and adolescents.

(b) Review health related programs which serve women, children, and adolescents for the purpose of recommending steps to facilitate interdepartmental integration of service delivery.

(c) Identify deficiencies and barriers in the maternal, child, and adolescent health delivery system on a statewide basis, recommend priorities for remedying deficiencies, and develop recommendations to remove barriers to appropriate health service utilization.

(d) Review, during the developmental stage, any plans affecting health programs for mothers, children, and adolescents developed by the department and comment on such plans vis a vis consistency with the state board's policy and goals and make recommendations on a unified planning process for programs affecting the health of mothers, children, and adolescents.

(e) Receive from the department for review and comment prior to their adoption all rules, regulations, and standards affecting maternal, child, and adolescent health. The director shall submit to the board a copy of the final statement prepared for the Office of Administrative Law pursuant to Section 11346.7 of the Government Code. The director may impose a reasonable time limit for the review of regulations, including, but not limited to, the following:

(1) Review of standards for health screening, evaluation, and diagnostic procedures for community maternal, child, and adolescent health programs.

(2) Review of standards for directors of community maternal, child, and adolescent health programs.

(3) Review of standards for public and private health providers, facilities, and agencies which participate in community maternal, child, and adolescent health programs.

(f) Review and comment upon proposed department policies affecting maternal, child, and adolescent health programs.

(g) Review policies and develop recommendations regarding:

(1) Health goals with measurable objectives for all children, adolescents, and pregnant females in California.

(2) A standard of financial eligibility for preventive programs which will facilitate program integration.

(3) A reimbursement mechanism that will encourage provider participation in an integrated maternal, child, and adolescent health program.

(4) Current programs that could be combined to foster integrated service delivery.

(5) Systems to assure coordination within the department in order to insure uniform case management and referral of children, youth, and pregnant women.

(6) Coverage of preventive care, health maintenance, and health education and counseling by third party payers.

(h) Review reports and respond to needs and recommendations of the local boards.

(i) Work with local boards to evaluate the success of established programs and assess the potential viability of proposed programs.

(j) Review and make recommendations to the director on written appeals received from local organizations and providers.

(k) Prepare a biennial report to the director summarizing the progress of the state board in fulfilling the above listed duties, powers and responsibilities, which report shall be transmitted to the Legislature and the local boards. The first such report shall be due on or before January 1, 1983.

In order to further the intent of this section and to support the work of the state board, the department shall develop, not later than July 1, 1982, alternative models for the provision of integrated health service delivery to women, children, and adolescents at the local level. Such models shall address the concerns and recommendations of the state board relating to integrated service delivery.

The provisions of this section shall remain in effect only until January 1, 1986, and as of such date is repealed, unless a later enacted statute, which is chaptered before January 1, 1986, deletes or extends such date.

(Added by Stats.1981, c. 1038, p. ——, § 5.)

Repeal

Section 320.5 is repealed by its own terms on Jan. 1, 1986.

1981 Legislation.

Section 1 of Stats.1981, c. 1038, p. ——, provided:

"The Legislature finds and declares that there is a multiplicity of programs and advisory boards influencing policy on maternal, child, and adolescent health services throughout the state. Further, the Legislature finds and declares that while important strides have been made in meeting some specific health needs of mothers and children, no overall plans and standards have as yet been developed for assuring the health of California's children and women of the childbearing age. The resulting fragmented system is characterized by a lack of coordination, continuity, and comprehensive management of maternal, child, and adolescent health services both within local communities and on a statewide basis.

"It is the intent of the Legislature to establish a State Maternal, Child, and Adolescent Health Board, advisory to the Director of the State Department of Health Services in order to develop broad public input and provide consistent statewide policy advice supporting the coordination and integration of state programs serving mothers and children. Further, it is the intent of the Legislature to improve coordination and to promote an innovative and integrated maternal, child, and adolescent health system at the local level, by establishing local maternal, child, and adolescent health boards which may supersede and incorporate other local bodies advisory to local government on programs affecting the health of mothers and children."

Former § 320.5, amended by Stats.1980, c. 1028, p. 3298, § 1, was repealed by Stats.1981, c. 1038, p. ——, § 4.

§ 321.2. Establishment of programs; plan requirements; standards for procedures; record system

The governing body of each county * * * or counties shall establish a community child health and disability prevention program for the purpose of providing early and periodic assessments of the health status of children in the county or counties by July 1, 1974. However, this shall be the responsibility of the department for all counties which contract with the state for health services. Contract counties, at the option of the board of supervisors, may provide services pursuant to this article in the same manner as other county programs, provided such option is exercised prior to the beginning of each fiscal year. Each such plan shall include, but is not limited to, the following requirements:

(a) Outreach and educational services.

(b) Agreements with public and private facilities and practitioners to carry out the programs.

Asterisks * * * indicate deletions by amendment.

§ 1187. Effectuation, purpose and approval of projects

The state department shall plan and put into operation a number of health services development projects. The purpose of the projects shall be to demonstrate effective ways of providing health care services in underserved rural health areas. The director shall make the final decision on approval of a project.

(Added by Stats.1976, c. 1196, p. 5463, § 1.)

Library References

Health and Environment ⇨6. C.J.S. Health and Environment § 13.

§ 1187.1. Application for funds; project operators

Applications may be made for funds for health services development projects and such projects may be initiated and operated by any agency, including, but not limited to:

(a) A community agency, including a National Health Services Corps site.

(b) An ongoing rural health program, including migrant health or Indian health program.

(c) A family practice education program.

(d) A county health department.

(e) The State Department of Health Services.

(f) Any health facility or clinic.

(Added by Stats.1976, c. 1196, p. 5463, § 1. Amended by Stats.1977, c. 1252, § 240, operative July 1, 1978.)

Historical Note

The 1977 amendment substituted "State Department of Health Services" for "State Department of Health" in subd. (e).

Cross References

Clinics, practice of, see § 1240 et seq.
Indian, sufficiency of funding for rural health services, see §
Primary health service hospitals, see § 1329 et seq.

Administrative Code References

Applicants, see 22 Cal.Adm.Code 40213 et seq., 40223 et seq.

Library References

Health and Environment ⇨6. C.J.S. Health and Environment § 13.
States ⇨ et seq. C.J.S. States

United States Code Annotated

Migrant health centers, see 42 U.S.C.A. § 254b.

§ 1187.3. Grants or loans; direct department administration

Projects may be in the form of grants or loans provided under contract between the state department and the contracting nonprofit agency, or may be administered directly by the state department.

(Added by Stats.1976, c. 1196, p. 5463, § 1.)

§ 1187.4. Assistance in preparing grant proposals

The state department may assist community agencies to develop contract proposals.

(Added by Stats.1976, c. 1196, p. 5463, § 1.)

§ 1187.5. Project proposals; project elements

Project proposals shall be considered which address the health needs of rural populations, including, but not limited to, migratory and other agricultural workers, native Americans, and senior citizens, which have insufficient access to adequate levels of health care services due to geographical isolation or economic factors.

Projects which are approved shall contain one or more of the following elements:

(1) Provides primary health care, including preventive health services and diagnostic, treatment, referral, and followup services.

(2) Provides comprehensive health care, including specialized physician services, inpatient and outpatient facilities, laboratory and X-ray services, home health services, and other specialized services.

(3) Provides emergency medical services designed to meet the special problems of rural isolation.

(4) Provides transportation appropriate to achieving the goal of making health care services available to residents of rural areas.

(5) Provides electronic communication technology to improve health care delivery and emergency health services in the designated rural areas.

(6) Establishes regional health systems, including linkage with both rural and urban health programs and facilities.

(7) Improves the quality of medical care and the administrative capabilities of agencies and management systems in rural areas.

(8) Provides health education programs in the designated rural areas, including health and nutrition education, and continuing education for health professionals.

(9) Promotes nurse practitioner and physician assistants programs and other programs for training and placement of health pro-

fessionals in the designated areas to respond to rural manpower shortages.

(Added by Stats.1976, c. 1196, p. 5463, § 1. Amended by Stats.1978, c. 1331, § 4.)

Historical Note

The 1978 amendment deleted "rural" before "nurse practitioner" in subd. (9).

Administrative Code References

Types of assistance, see 22 Cal.Adm.Code 40217.

§ 1187.6. Funding of projects; continuation or termination; evaluation

Project funding shall be for one year at a time and continuation will depend on progress toward achieving the goals of the project. The director shall make the final decision to continue or discontinue a project. In evaluating the success of a project, the director shall take into account the number of additional persons who are receiving quality health care as a result of the operation of the project and the improvement in health status of the population served by the project.

(Added by Stats.1976, c. 1196, p. 5463, § 1.)

Cross References

Advance payment for services, see § 1045.

§ 1187.7. Advisory committee

Each applicant shall form an advisory committee for the project. The advisory committee shall participate in all of the following:

(a) Planning the project.

(b) Reviewing the progress of the project.

(c) Proposing changes in the project.

(d) Planning for the continuation of the project after the grant period through self-sufficiency.

At least one-half of the members of the advisory committee shall be consumers, as defined by Public Law 93-641 [1]. The advisory committee shall include, where feasible, representatives of the health service agencies, the Seasonal Agricultural Workers Advisory Committee, consumers selected from rural target populations, such as native Americans, senior citizens, Medi-Cal recipients, isolated rural residents, and agricultural and forestry workers, providers from rural areas, and persons with knowledge of rural areas from educational institutions, and state, county, and federal agencies.

(Added by Stats.1978, c. 1196, p. 5463, § 1.)

[1] 42 U.S.C.A. § 300k et seq.

Each community child health and disability prevention program shall, pursuant to standards set by the director, establish a record system which contains a health case history for each child so that costly and unnecessary repetition of screening, immunization and referral will not occur and appropriate health treatment will be facilitated as specified in Section 323.5.
(Amended by Stats.1979, c. 373, p. ——, § 178.)

State and local responsibilities, see 17 Cal.Adm.Code 6820.

§ 321.7 Eligibility for services; rules and regulations specifying age groups for screening tests and recommendations for referral; sources of referral

Eligibility for services and reimbursement, see 17 Cal.Adm.Code 6830, 6832.

§ 324.2 School districts and private schools; information to parents or guardians of kindergarten children; withholding of average-daily-attendance funds

In cooperation with the county child health and disability prevention program, the governing body of every school district or private school which has children enrolled in kindergarten shall provide information to the parents or guardians of all children enrolled in kindergarten of the provisions of this article. Every school district or private school which has children enrolled in the first grade shall report by January 15 of each year to the county child health and disability prevention program, the State Department of Health Services, and the Department of Education the following information:

(a) The total number of children enrolled in first grade.

(b) The number of children who have had a health screening examination, as evidenced by the certificate required by Section 308.5.

(c) The number of children whose parents or guardian have given written * * * waiver pursuant to Section 323.5 that they do not want their child to receive a health screening examination.

Each county child health and disability prevention program shall reimburse school districts for information provided pursuant to this section. The Superintendent of Public Instruction may withhold state average-daily-attendance funds to any school district for any child for whom a certification or parental waiver is not obtained.
(Amended by Stats.1979, c. 373, p. ——, § 179.)

ARTICLE 3.6 GENETICALLY HANDICAPPED PERSON'S PROGRAM

§ 341. Establishment and administration; medical and social support services; rules and regulations; priorities

The State Director of Health Services shall establish and administer a program for the medical care of persons with genetically handicapping conditions, including cystic fibrosis, hemophilia, * * * sickle cell disease, Huntington's disease, Friedreich's Ataxia, and Joseph's disease.

The program shall also provide access to social support services, which may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions, in order that the genetically handicapped person may function at an optimal level commensurate with the degree of impairment.

Such medical and social support services may be obtained through physicians, genetically handicapped person's program specialized * * * centers, and other providers that * * * qualify pursuant to the regulations of the department to provide such * * * services. "Medical care" as used in this section shall be limited to noncustodial medical and support services.

The director, with the guidance of the Advisory Committee on Genetically Handicapped Person's Program may, by regulation, expand the list of genetically handicapping conditions covered under this article. The director shall adopt such rules and regulations as are necessary for the implementation of the provisions of this article. The director, with the approval of the advisory committee, shall establish priorities for the use of funds and provision of services under this article.

(Amended by Stats.1979, c. 1155, p. —, § 2.)

1979 Legislation.

Section 1 of Stats.1979, c. 1155, p. —, provides:

"The Legislature finds and declares that the health care management problems of individuals suffering from chronic inherited degenerative illnesses have a cataclysmic and shattering emotional and financial impact on the patients and families afflicted.

"The Legislature further finds and declares that the health care delivery system in the State of California lacks a full range of services and facilities matched to the needs of the chronically ill at all levels of disability. As a consequence, many families unable to afford the high cost of health care are forced to consider bankruptcy or divorce as their only alternatives.

"The Legislature, therefore, finds that in order to ease human suffering, maintain the family unit and encourage individuals to remain self-supportive, the state must assist in the provision of such services."

§ 342. Inclusions in program; medical and social support services

The program established under this article shall include any or all of the following medical and social support services:

(a) Initial intake and diagnostic evaluation;
(b) The cost of blood transfusion and use of blood derivatives, or both;
(c) Rehabilitation services, including reconstructive surgery;
(d) Expert diagnosis;
(e) Medical treatment;
(f) Surgical treatment;
(g) Hospital care;
(h) Physical and speech therapy;
(i) Occupational therapy;
(j) Special treatment;
(k) Materials;
(l) Appliances and their upkeep, maintenance, and care;
(m) Maintenance, transportation, or care incidental to any other form of services; * * *

(n) Respite care or other existing resources (e. g., sheltered workshops);

(o) Genetic and long-term psychological counseling;

(p) Appropriate administrative staff resources to carry out the provisions of this article. Such staff shall include, but not be limited to, at least one case manager per each 350 clients.

(Amended by Stats.1979, c. 1155, p. —, § 3.)

§ 343. Advisory committee

The State Director of Health Services shall appoint an * * * 11-member Advisory Committee on Genetically Handicapped Person's Program composed of professional and consumer representatives who shall serve without compensation and at the discretion of the director. The director shall seek the advice of the advisory committee with respect to rules and regulations to be adopted pursuant to this article.

(Amended by Stats.1979, c. 1155, p. —, § 4.)

§ 347. Uniform standards of financial eligibility; persons with family incomes exceeding $100,000; repayment schedule

The state department shall establish, with the guidance of the advisory committee, uniform standards of financial eligibility for the services under the * * * program * * * established under this article.

Asterisks * * * indicate deletions by amendment

2-675 INDIVIDUALS TO BE SERVED BY THE SAU (Continued) 42-675

.334 For certified individuals who enter unsubsidized employment.

(a) Necessary WIN purchased services shall continue for 30 days to a certified individual who enters unsubsidized employment. It is not required that the services be purchased from WIN supportive service funds if other sources are available, however.

(b) WIN purchased services may continue for an additional 60 days at the discretion of the SAU when necessary to enable the registrant to remain employed.

(c) Such services may continue even though the AFDC grant may have been terminated.

.34 WIN purchased services for working registrants.

.341 In special circumstances, working registrants who are not currently receiving WIN purchased services, may be provided day care services. Such services are limited as follows:

(a) There has been a breakdown in day care due to unforeseeable circumstances. Changes in day care arrangements which can be anticipated, such as the end of the school year, are not considered exceptional circumstances; and

(b) The failure to provide the day care would result in the loss of existing employment; and

(c) Provision of day care would enable the registrant to continue employment; and

(d) The services are not available on a timely basis from Title XX or any other source.

.342 Under special circumstances WIN purchased services other than day care may also be provided.

.343 Provision of the WIN purchased services under this section is limited to a maximum of 30 days.

.344 This service may not be used as a means of automatically extending the usual duration of WIN purchased services.

.345 If the individual is uncertified when the need for the service arises, the SAU is to initiate the certification.

.4 Title XX Services or Services From Other Sources

.41 At times, the registrant or a member of his/her family may require services which cannot be paid for from WIN supportive services funds or which cannot be provided by the SAU worker. In such instances, the SAU worker should make every effort to arrange for such services to be provided from available Title XX or other service programs.

42-675 INDIVIDUALS TO BE SERVED BY THE SAU (Continued) 42-675

.33 WIN purchased services are available to all certified registrants. The duration of such purchased services is limited however, as follows:

.331 Individuals in WIN components.

(a) Necessary WIN purchased services shall continue for the duration of the components, except for WIN/OJT, WIN/PSE components, and suspense to CETA/OJT, and CETA/PSE, even though the AFDC benefits have been terminated.

(b) When a certified individual enters WIN/OJT, WIN/PSE, CETA/OJT, or CETA/PSE, necessary supportive services shall continue for a period of 30 days after the start of subsidized employment even though the AFDC benefits have been terminated.

(c) When the SAU determines it is necessary to enable the registrant to remain in the component, they may authorize the continuation of such services for an additional 60 days even after AFDC benefits have been terminated.

.332 Certified registrants between components.

WIN purchased services may be provided for up to two weeks to a registrant between participation in WIN components or between participation in one component and the start of employment in order to avoid interruption of the employability process.

.333 Certified registrants, unassigned to any component.

WIN purchased services may be provided to certified registrants when required to enable the individual to accept training or employment.

42-675 INDIVIDUALS TO BE SERVED BY THE SAU 42-675

.1 General

.11 The SAU provides services to WIN registrants and their families, when such services are necessary to enable the registrant to accept employment or participate in the WIN program.

Subject to further limitations, registrants can be:

(a) AFDC applicants.

(b) Certified or uncertified AFDC recipients.

(c) Discontinued AFDC recipients who remain in WIN components.

.12 The supportive services to be provided are those specified under Section 42-680.

These are provided in two ways:

(a) Staff Services — which are those services provided by the SAU worker, such as counseling; and

(b) WIN Purchased Services — which are those services purchased using WIN supportive service funds.

Whether an individual can receive WIN purchased services and the duration of any such services depends upon:

(1) Whether he/she is an applicant or recipient.

(2) Whether he/she is certified or uncertified.

.2 Staff Services

.21 Staff services are those services provided by the SAU worker. They include any of the services outlined in Section 42-680 as well as the SAU staff time spent in arranging for WIN purchased services or services to be provided from Title XX or any other available sources.

.22 Staff services can be provided to all registrants and their families. This includes all applicant registrants, certified and uncertified registrants, and all registrants in a WIN component (participants) even though AFDC benefits may have been terminated.

.3 WIN Purchased Services

.31 WIN purchased services are services arranged by the SAU worker, but not actually provided by the SAU worker. WIN purchased services are paid for from WIN supportive service funds.

.32 In order to provide a WIN purchased service, it is required that the service be necessary to enable a registrant to accept and retain employment or training for employment.

WIN purchased services are not available to applicants.

WIN purchased services are not available to an uncertified registrant recipient.

If a WIN purchased service is necessary in order to complete certification and enable the uncertified registrant to accept employment or training for employment the individual must be certified and then the service provided.

42-678 REFUSAL TO ACCEPT SERVICES 42-678

.1 Certified Mandatory Registrants

.11 A Certified Mandatory Registrant may not refuse supportive services if the refusal prevents the individual from accepting an appropriate work or training assignment. Refusal of such services require that a cause determination be made. Such determinations are made by WIN.

.12 The Certified Mandatory Registrant is not required to accept any other supportive services as a condition of eligibility.

.2 All Others

All other registrants may accept or refuse to accept WIN supportive services.

42-680 MANDATED SUPPORTIVE SERVICES 42-680

Supportive Services are social services provided to WIN registrants necessary to enable the registrant to accept employment or participate in WIN, including such services as are necessary to remove or reduce barriers to employment. Mandated services to be provided include: day care, family planning, counseling, employment related medical and remedial care, and selected vocational rehabilitation services.

.1 Child Day Care Services

.11 Definition. Child day care is the comprehensive and coordinated sets of activities providing direct care and protection of infants, preschool and school age children during a portion of a 24-hour day inside or outside of the child's own home.

.12 Child Day Care Standards

Child day care arrangements provided through WIN must meet the same standards as are required under Title XX.

.13 Child Day Care Plans

A child day care plan is a written agreement between the SAU, the provider, and the WIN certified registrant which comprehensively describes for whom and under what specific circumstances child day care will be provided.

There must be a written plan for each certified registrant who receives WIN-funded child day care. This plan will include the following information:

a. The name, address, and case number of the WIN certified registrant.

b. Case name, if different from the above.

c. Date the plan is initiated.

d. Name, birthdate, and sex of child(ren) for whom care is being provided.

e. The component in which the registrant will participate.

f. The duration of the component (beginning and ending dates).

g. The type of care being provided, i.e., in-home, family day care, group day care, or day care center.

42-680 MANDATED SUPPORTIVE SERVICES (Continued) 42-680

h. Beginning and ending dates of provision of care.

i. Number of hours of care, e.g., 7:30 a.m. to 3:30 p.m., including normal transportation time.

j. Total number of hours per week.

k. Name and address of provider.

l. Signatures of SAU, the certified registrant, and the provider.

m. Rate of pay per hour, week or month.

n. Conditions under which provider will be paid or not paid for absences.

The SAU signature on the child day care plan is the instrument which authorizes expenditure of WIN child day care funds. A copy of the signed plan should be sent to the IMU.

.131 The SAU should explain to registrants the type of day care available, the suitability of each type of care in relation to the needs of the children, the importance of stability and continuity of care, the length of time WIN-funded day care payments can continue and the availability of Title XX or other day care after WIN-funded care ends.

.132 The certified registrant should be involved in the development of a suitable day care plan which may include plans for emergency or interim care as well as for long-term, stable day care.

.133 If there is more than one type of day care available, the mother or other caretaker relative may choose among them.

.134 A certified registrant may not refuse the available care unless he/she can arrange for other day care that is no more expensive to the county or WIN and can show that such refusal will not prevent or interfere with WIN participation.

.135 In the case of day care provided at no cost to the WIN program, the SAU worker should discuss the care arrangement with the WIN registrant to determine its potential stability and suitability. Each case folder should contain documentation confirming that the client has obtained his or her own suitable day care. Such documentation may consist of the SAU worker's narrative report in the case record.

.136 As part of the planning process, the SAU should stress the importance of the registrant's informing the SAU immediately if the day care plan breaks down.

42-680 MANDATED SUPPORTIVE SERVICES (Continued) 42-680

.14 Criteria for Child Day Care Plans

In developing plans for suitable day care services, the following factors should be considered:

.141 Accessibility to the child's home and school;

.142 Convenience for the registrant and suitability of the hours of the day care with respect to the registrant's schedule; and

.143 Appropriateness of the plan to the age and special needs of the child.

.15 Emergency Day Care Services

.151 The SAU is responsible for providing or arranging for temporary, emergency day care services when (1) no immediate and permanent arrangement is possible, or (2) care is needed for a short-term period, or (3) an emergency situation arises, disrupting the established day care plan, such as the illness of the provider or child or the unavoidable absence of the provider.

.152 Emergency care is not a substitute for long-term care. It should be provided only until a permanent day care plan can be established or the regular plan can be resumed. If possible, no child should be placed in an emergency care arrangement for more than ten continuous days at any one time. During this period, permanent day care arrangements should be developed.

.153 Emergency day care arrangements should meet the same standards as regular day care arrangements.

.16 Child Day Care Costs

.161 If a registrant declines to accept day care services arranged by the SAU and prefers to make other arrangements, WIN supportive service funds may be used to pay for such alternative arrangements if the arrangement will not be more costly than the WIN arrangement, if the alternative will not conflict with the registrant's participation in WIN, and if the arrangements meet the standards of Section 42-680.12.

.162 All child day care costs for participants are paid from WIN child day care funds following the limitations set forth in Section 42-675.33. Such costs shall be paid on the basis of a monthly claim submitted by the certified registrant or by the provider to the county welfare department. This claim shall be signed by both the certified registrant and the provider. The payment shall not exceed those agreed upon in the child day care plan and, (upon receipt of the expense claim), shall be adjusted to meet the actual allowable expense incurred.

.163 Costs of the transportation to and from day care locations of a child of a certified registrant may be charged to WIN manpower funds as part of the transportation allowance to and from the employment or training.

42-680 MANDATED SUPPORTIVE SERVICES (Continued) 42-680

.163 (Continued)

WIN manpower funds are paid by EDD for those participants in non-waged components. Transportation costs are allowed as a work-related expense. Transportation costs for participants in waged components are allowed as a work-related expense deducted from the income. See EAS Section 44-113.241 (d).

.164 WIN will pay for child care when the child is temporarily absent from care if it is agreed upon in the child day care plan. Payment may be made for temporary absences for only the following verified reasons:

(a) illness or quarantine of the child,

(b) illness or quarantine of the parent,

(c) family emergency, and

(d) court ordered visits with a parent or other relative by the child.

.17 Child Care Provided by State Department of Education Contract Centers

.171 WIN child day care funds are used to pay for WIN child(ren) care in SDE Contract Centers that meet Title XX standards.

.172 The SDE Center must be notified that the child(ren) is provided for by WIN and how long WIN will pay for such care. Submitting a copy of the child day care plan will accomplish this purpose. If the parent drops out of or completes the WIN component, the center must be notified so that it will not continue to bill WIN for child care.

.173 The rates in SDE Centers are the actual program costs of the center. The maximum reimbursement rate is established in the State Budget Act.

WIN counties are required to pay the maximum reimbursement rate or actual operating costs, whichever is less, for WIN children in SDE Centers.

CALIFORNIA'S TITLE XIX STATE PLAN FOR ASSURANCE OF TRANSPORTATION

Under California's Title XIX State Plan, transportation of eligible recipients to and from health care services is assured through a variety of methods. These methods include both the provision of medical transportation as a direct benefit of the Title XIX program and indirectly through other programs and resources.

As a direct benefit, California provides both emergency and nonemergency medical transportation (see Attachment A). Emergency medical transportation does not require prior authorization, but must be medically justified and documented. Nonemergency medical transportation is subject to prior authorization and is covered when the recipient's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindiacated and the transportation is required for the purpose of obtaining necessary health care covered by the Medi-Cal program.

When the recipient does not qualify for medical transportation, the Medi-Cal field office staff will advise the recipient to contact his or her social worker at the county welfare department (Attachment B). Nonmedical transportation of Medi-Cal recipients to Medi-Cal covered services is assured through the programs and methods listed in Attachment C, Summary, or through other local transportation resources.

Attachment(s)

RC:la/jj

51323. Medical Transportation Services.

(a) Ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.

(1) Ambulance services are covered when the patient's medical condition contraindicates the use of other forms of medical transportation.

(2) Litter van services are covered when the patient's medical and physical condition:

(A) Requires that the patient be transported in a prone or supine position, because the patient is incapable of sitting for the period of time needed to transport.

(B) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(C) Does not require the specialized services, equipment and personnel provided in an ambulance because the patient is in stable condition and does not need constant observation.

(3) Wheelchair van services are covered when the patient's medical and physical condition:

(A) Renders the patient incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

(B) Requires that the patient be transported in a wheelchair or assisted to and from residence, vehicle and place of treatment because of a disabling physical or mental limitation.

(C) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

(D) Does not require the specialized services, equipment and personnel provided in an ambulance, because the patient is in stable condition and does not need constant observation.

(b) Authorization shall be granted only for the lowest cost type of medical transportation that is adequate for the patient's medical needs, and is available at the time transportation is required.

(1) Emergency medical transportation is covered, without prior authorization, to the nearest facility capable of meeting the medical needs of the patient. Each claim for program reimbursement of emergency medical transportation shall be accompanied by a written statement which will support a finding that an emergency existed. Notwithstanding Section 51056 (b), the statement may be made by the provider of the emergency transportation, describing the circumstances necessitating the emergency service. The statement shall include the name of the person or agency requesting the service, the nature and time of the emergency, the facility to which the patient was transported, relevant clinical information about the patient's condition, why the emergency services rendered were considered to be immediately necessary and the name of the physician accepting responsibility for the patient at the facility.

(2) All nonemergency medical transportation, necessary to obtain program covered services, requires a physician's, dentist's or podiatrist's prescription and prior authorization. When the service needed is of such an urgent nature that written authorization could not have reasonably been submitted beforehand, the medical transportation provider may request prior authorization by telephone. Such telephone authorization shall be valid only if confirmed by a written request for authorization. Transportation shall be authorized only to the nearest facility capable of meeting the patient's medical needs.

(c) Medical transportation by air is covered under the following conditions:

(1) For emergencies, only when such transportation is medically necessary as demonstrated by compliance with paragraph (b) (1) and either of the following apply:

(A) The medical condition of the patient precludes other means of medical transportation as indicated in the statement submitted in accordance with paragraph (b) (1).

(B) The patient or the nearest hospital capable of meeting the medical needs of the patient is inaccessible to ground medical transportation, as indicated in the statement submitted in accordance with paragraph (b) (1).

(2) For nonemergencies, only when transportation by air is necessary because of the medical condition of the patient or practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated by content of a written order of a physician, podiatrist or dentist.

Memorandum

To : Field Office Administrators

Date : July 9, 1982

Subject: FIN 7-82
Non-emergency Transportation Denial Notices

From : Tom Heerhartz, Chief
Field Services Branch
8/1516

NON-EMERGENCY TRANSPORTATION DENIAL NOTICES

This revision replaces FIN 81-10. This updated notice is to be mailed to beneficiaries, if possible, in all cases when the medical and physical condition is such that he/she can travel by public or private conveyance, but may not have a car , or have access to a car, or be able to afford payment for public transportation to obtain medical services covered under the Medi-Cal program. If you are unable to forward this notice to the beneficiary, send it to the provider.

As before, you should complete the notice with: 1) the name(s) and phone number(s) that beneficiaries may use to contact the local Department of Social Services for assistance with their transportation needs, and 2) information with phone number(s) regarding any free or low cost transportation that exists in all or part of your field office area.

This notice to the beneficiary should be included with any TAR that is returned to a provider on which Medi-Cal transportation authorization is denied because the patient's medical or physical condition does not medically contraindicate the use of public or private transportation. In addition, the notice should be included in letters sent to beneficiaries when their medical transportation services to dialysis, chemotherapy, or radiation therapy are terminated.

If you have any questions regarding this matter or the suggested format for the notice, please let me know. I would like you to start using this new notice immediately.

FIN 83-10
Appvd 1-21-83
Exp. 1-1-83

N O T I C E

To: Medi-Cal Beneficiary

_____

_____

And/
Or Via: Provider of Medical Transportation

_____

_____

From: Medi-Cal Field Office _____

Address _____

Phone Number _____

A Medi-Cal Consultant has determined that your request for authorization or reauthorization of Medi-Cal transportation under Title 22, California Administrative Code, Section 51323 cannot be approved. The reason for the denial is that, in the judgment of the Medi-Cal Consultant, your current medical or physical condition does not contraindicate your use of normal public or private transportation conveyances. Title 22 regulation allows authorization of Medi-Cal payment for transportation only when an individual's condition requires medical transportation such as an ambulance or specially equipped Medi-Van.

In order to assist you in arranging transportation, we have listed the names and phone numbers of any organizations that we are aware of that provide free or low cost transportation.
(FIELD OFFICE ENTERS NAME(S), ADDRESSES, AND PHONE NUMBERS OF FREE OR LOW COST TRANSPORTATION COMPANIES)

We strongly suggest that, before you contact these organizations, you should check with friends, neighbors, or relatives to see if they can provide transportation. You may want to look into the availability of other public and private modes of transportation such as buses, Dial-A-Ride programs, or taxi cabs. In the event you cannot obtain transportation at the time of your appointment, you may wish to reschedule the appointment or investigate obtaining medical care at a location closer to your place of residence.

If you are unable to obtain transportation through your own resources or those we have listed above, you should contact the local office of your county Department of Social Services at the phone number listed below. They may be able to arrange transportation.
(FIELD OFFICE ENTERS NAMES, ADDRESSES AND PHONE NUMBERS OF COUNTY OFFICE(S) OF PUBLIC SOCIAL SERVICES)

TABLE OF CONTENTS

SUMMARY

The following is a summary of other programs and other methods of assuring transportation to and from health services in addition to Title 22, California Administrative Code (CAC), Section 51323 transportation provisions.

1. Section 9000 et. seq., (Welfare and Institutions [W&I] Code), Aging, Section 9002 (f). State policy stipulates that Older Californians Act programs must include transportation services.

2. Section 9400-9407 (W&I Code). These sections make provision for multipurpose senior services, and Section 9407 includes transportation services.

3. Section 13004 (e) (W&I Code), Social Services. This statute requires that counties provide or pay for transportation to and from health care facilities, or the location of other health care providers when there is an urgent need for health care and other transportation resources are not available. Transportation services must be maintained at least at the level provided by counties prior to September 30, 1981.

   Chapter 10, Statutes of 1983, First Extraordinary Session (AB 28) which was signed by the Governor February 17, 1983, removed language which specified that the provisions of Section 13004 (e) expired on December 31, 1982.

4. Sections 30.051, 30.052, 30.053, and 30.054 (Department of Social Services -- Manual of Policies and Procedures [DDS-MPP]). These sections define information and referral services, health-related transportation and urgent need; specify intent, eligibility, and the conditions necessary for provision of health-related transportation.

5. Section 12300, (W&I Code), In-Home Supportive Services. Supportive services under this section include but are not limited to ...necessary travel to health-related appointments or to alternative resource and other essential transportation....

6. Section 14200, (W&I Code), Prepaid Health Plans. The provisions of this section state that members of a health plan shall be informed of all available services including information concerning emergency transportation arrangements offered by the plan and the availability of public transportation.

7. Section 14503 (d), (W&I Code), Family Planning. This section provides that family planning services shall be offered to all eligible individuals who voluntarily request such services. Family planning services shall include, but not be limited to facilitating services such as transportation and child care services needed to attend clinic or other appointments.

8. Section 14520, et. seq., (W&I Code), Adult Day Health Care. Required services, Section 14550 (h), and (i) includes transportation service for participants, and a provision for ambulance transportation.

9. Section 19000 et. seq. (W&I Code), Rehabilitation. Vocational rehabilitation services include health service and transportation in connection with the rendering of any other vocational rehabilitation service. Title 22, CAC, Section 51014 stipulates that if the Department of Health Services concurs in the vocational relevancy of proposed rehabilitation services, Department of Rehabilitation will provide case management and make appropriate recommendations on requests for prior authorization.

10. Section 248, et. seq., (Health and Safety [H&S] Code), California Children Services (CCS) Program. Section 249 makes provision for services for physically defective or handicapped minors, and specifies that the Department of Health Services shall cooperate with the medical, health, nursing, and welfare groups and organizations concerned with the program. Section 251 (j) includes transportation as a service. Title 22, CAC, Section 51013 maintains that needed medical care not normally provided through the CCS program shall be provided through procedures established in Medi-Cal regulations.

11. Section 320, (H&S Code), Child Health Disability Prevention Program (CHDP) It is the intent of this section that CHDP programs shall make maximum use of existing health care resources. CHDP regulations provide for transportation services to health assessments and appointments.

12. Section 341, (H&S Code), Genetically Handicapped Persons Program. The program established under Section 342 (m) includes transportation as a medical and social support service.

13. Section 1187.5 (4), (H&S Code) Rural Health Services. Section 1187.5 (4). Project proposals or project elements may provide transportation appropriate to achieving the goal of making health care services available to residents of rural areas.

14. Section 42-675, Individuals to be Served by the Separate Administrative Unit (SAU), Work Incentive Program (WIN), (DSS-MPP); 42-680, Mandated Supportive Services; 42-682, Optional Supportive Services.

    Sections 42-675 and 42-680 state that when the registrant or a family member may require services which cannot be paid for from WIN supportive services, such services are to be provided from Title XX or other service programs. Section 42-682 states that each local WIN-SAU may provide as a special nonrecurring supportive service the optional WIN service, transportation.

    Section 42-682.1.11 (DSS-MPP) defines transportation, and Section 42-682.1.12 states that transportation may be provided or purchased only when no other means is available.

1(a)

...after final adjournment of the 1972 Regular Session of the Legislature. Until such time the provisions of section 1 shall be administered by the Human Relations Agency."

Library References

Social Security and Public Welfare ⇐5.
C.J.S. Social Security and Public Welfare § 9.

§ 8251. Contracts or agreements

The Office of Special Services may enter into agreements and contracts with any person, agency, corporation or other legal entity and take such other action as is necessary to carry out the purposes of this chapter. The office may require state departments to contract with it for services to carry out the provisions of this chapter.

(Added by Stats.1972, c. 918, p. 1639, § 1, urgency, eff. Aug. 15, 1972, operative March 1, 1973.)

1972 Legislation.

Operative date, see note under § 8250.

§ 8252. Acceptance, management and expenditure of grants, gifts or legacies

The Office of Special Services may accept and expend grants, gifts and legacies of money, and with the consent of the Department of Finance, may accept, manage, and expend grants, gifts, and legacies of other properties in furtherance of the purposes of this chapter.

(Added by Stats.1972, c. 918, p. 1638, § 1, urgency, eff. Aug. 15, 1972, operative March 1, 1973.)

1972 Legislation.

Operative date, see note under § 8250.

DIVISION 8.5. AGING

Division 8.5 was added by Stats.1978, c. 1080, p. 2190, § 1.

PART 1. OLDER CALIFORNIANS [NEW]

Division 8.5 was added by Stats.1978, c. 1080, p. 2190, § 1.

The heading of Part 1 was added by Stats.1982, c. 1478, p. ——, § 4.5. For operative effect, see note under § 9800.

Asterisks * * * indicate deletions by amendment

CHAPTER 1. LEGISLATIVE FINDINGS AND DECLARATION OF POLICY AND PURPOSE

Chapter 1 was added by Stats.1980, c. 912, p. 2890, § 2.

Former Chapter 1, Legislative Findings and Declarations of Policy and Purposes, was added by Stats.1973, c. 1080, p. 2190, § 1, and was repealed by Stats.1980, c. 912, p. 2890, § 1.

§ 9000. Short title

This division establishes the Older Californians Act which reflects the policy mandates and directives of the Older Americans Act of 1965, as amended, and sets forth the state's commitment to its older population.

(Added by Stats.1980, c. 912, p. 2890, § 2.)

1980 Legislation.

Former § 9000, added by Stats.1973, c. 1080, p. 2190, § 1, providing a title for the division on aging and stating the legislative findings, was repealed by Stats.1980, c. 912, p. 2890, § 1.

Derivation: Former § 9000, added by Stats.1973, c. 1080, p. 2190, § 1.

Library References

Social Security and Public Welfare ⇐21.
C.J.S. Social Security and Public Welfare § 14.

§ 9001. Legislative findings

The Legislature hereby finds and recognizes that:

(a) Older persons constitute a fundamental resource of the state which previously has been undervalued and poorly utilized, and that ways must be found to enable older people to apply their competence, wisdom, and experience for the benefit of all Californians;

(b) There is a continuing increase in the number of older people in proportion to the total population;

(c) Today, 12.5 percent of California's population currently is 60 years of age and over;

(d) By the year 2020, older persons will represent 25 percent of California's total population;

(e) While the number of persons over 60 years of age is increasing rapidly, older women, minorities and persons over the age of 75 are expanding at an even greater rate;

(f) Among these persons over 75 years of age, there is a higher incidence of functional disabilities;

(g) The social and health problems of the older person are further compounded by inaccessibility to existing services and by the unavailability of a complete range of services;

(h) Services to older persons are administered by many different agencies and departments and the planning and delivery of these services is not carried out with any degree of coordination among those agencies;

(i) The ability of the constantly increasing number of aged in the state to maintain self-sufficiency and personal well-being with the dignity to which their years of labor entitle them and to realize their maximum potential as creative and productive individuals are matters of profound importance and concern for all of the people of this state.

(Added by Stats.1980, c. 912, p. 2890, § 2.)

1980 Legislation.

Former § 9001, added by Stats.1973, c. 1080, p. 2190, § 1, dealing with legislative intent, was repealed by Stats.1980, c. 912, p. 2890, § 1.

Derivation: Former § 9000, added by Stats.1973, c. 1080, p. 2190, § 1.

§ 9002. State policy

The Legislature declares that it is the policy of the state to:

(a) Insure participation by older persons in the planning and operation in all programs and services that may affect them;

(b) Participate fully in programs at all levels of government the purposes of which are to foster and promote community planning and services for the economic, social and personal well-being of older persons;

(c) Insure that the planning and operation of programs on all levels of government be undertaken as a partnership with older residents, providers of services, area agencies on aging, advisory councils, and community senior groups;

(d) Encourage agencies on all levels of government as well as the private sector to develop alternative services and forms of care that provide a range of services delivered in the community, in the home, in care providing facilities, and services which facilitate access to other services which support independent living in the community and prevent unnecessary institutionalization;

(e) Give priority in planning services and programs to those older persons with the greatest economic and social need;

(f) Provide programs which will assure the delivery of a full array of services to older persons including, but not limited to:

(1) Supportive services.

(2) Health-related services.

(3) Counseling services.

(4) Affordable and safe housing.

(5) Employment services.

(6) Transportation services.

(7) Nutrition services.

(8) Legal services.

(9) Information and referral services.

(10) Cultural services.

(11) Mental health services.

(g) Require joint program planning and policy development among state and local agencies which, (1) recognize and strengthen the personal and community support networks to which people belong and on which they depend, (2) administer programs and deliver services to the older population.

(h) Provide a comprehensive and integrated system of health and social services which respond to individual needs.

(Added by Stats.1980, c. 912, p. 2891, § 2.)

1980 Legislation.
Former § 9002, added by Stats.1973, c. 1080, p. 2191, § 1, regarding participation by state in programs for older persons, was repealed by Stats.1980, c. 912, p. 2890, § 1.

Derivation: Former §§ 9001 to 9003 added by Stats.1973, c. 1080, pp. 2190, 2191, § 1.

Former § 13350, added by Stats.1965, c. 1784, p. 4104, § 5, amended by Stats.1965, c. 2052, p. 4791, § 3.

§ 9003. Conformity with federal requirements

If the United States Department of Health and Human Services issues a formal ruling that any section of this code relating to aging cannot be given effect without causing this state's plan to be out of conformity with federal requirements, the section shall become inoperative to the extent that it is not in conformity with federal requirements.

(Added by Stats.1980, c. 912, p. 2891, § 2.)

1980 Legislation.
Former § 9003, added by Stats.1973, c. 1080, p. 2191, § 1, stating the purposes of the division on aging, was repealed by Stats.1980, c. 912, p. 2890, § 1.

CHAPTER 2. DEFINITIONS

Sec.

Chapter 2 was added by Stats.1980, c. 912, p. 2892, § 4.

Former Chapter 2, Definitions, was added by Stats.1973, c. 1080, p. 2191, § 1, and was repealed by Stats.1980, c. 912, p. 2892, § 3.

§ 9100. Commission

"Commission" means the California Commission on Aging.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

1980 Legislation.
Former § 9100, added by Stats.1973, c. 1080, p. 2191, § 1, regarding construction of definitions, was repealed by Stats.1980, c. 912, p. 2892, § 3.

Derivation: Former § 9101, added by Stats.1973, c. 1080, p. 2191, § 1.

§ 9101. Department

Text of section as added by Stats.1980, c. 912, p. 2892, § 4.

"Department" means the Department of Aging.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 5, see § 9101, post.

§ 9101. Department

Text of section as amended by Stats.1982, c. 1453, p. ——, § 5.

"Department" means the State Department of Aging and Long-Term Care.

(Added by Stats.1980, c. 912, p. 2892, § 4. Amended by Stats.1982, c. 1453, p. ——, § 5.)

Operative effect of 1982 Amendment of § 9101, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2892, § 4, see § 9101, ante.

1980 Legislation.

Former § 9101, added by Stats.1973, c. 1080, p. 2191, § 1, defining commission, was repealed by Stats.1980, c. 912, p. 2892, § 3.

Derivation: Former § 9102, added by Stats.1973, c. 1080, p. 2191, § 1, amended by Stats.1976, c. 157, p. 256, § 1.

§ 9102. Director

Text of section as added by Stats.1980, c. 912, p. 2892, § 4.

"Director" means the Director of the Department of Aging.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 6, see § 9102, post.

§ 9102. Director

Text of section as amended by Stats.1982, c. 1453, p. ——, § 6.

"Director" means the Director of the State Department of Aging and Long-Term Care.

(Added by Stats.1980, c. 912, p. 2892, § 4. Amended by Stats.1982, c. 1453, p. ——, § 6.)

Operative effect of 1982 amendment, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2892, § 4, see § 9102, ante.

1982 Legislation.

Former § 9102, added by Stats.1973, c. 1080, p. 2191, § 1, amended by Stats.1976, c. 157, p. 256, § 1, urgency, eff. May 11, 1976, defining department, was repealed by Stats.1982, c. 912, p. 2892, § 3.

Derivation: Former § 9103, added by Stats.1973, c. 1080, p. 2191, § 1, amended by Stats.1976, c. 157, p. 256, § 2.

§ 9103. Older person; elderly

Text of section as added by Stats.1980, c. 912, p. 2892, § 4.

"Older person" or "elderly" means a person 60 years of age or older unless in conflict with federal requirements.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 7, see § 9103, post.

§ 9103. Older person; elderly

Text of section as amended by Stats.1982, c. 1453, p. ——, § 7.

"Older person" or "elderly" means a person 60 years of age or older * * *.

(Added by Stats.1980, c. 912, p. 2892, § 4. Amended by Stats.1982, c. 1453, p. ——, § 7.)

Operative effect of 1982 amendment, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2892, § 4, see § 9103, ante.

1980 Legislation.

Former § 9103, added by Stats.1973, c. 1080, p. 2191, § 1, amended by Stats.1976, c. 157, p. 256, § 2, urgency, eff. May 11, 1976, defining director, was repealed by Stats.1980, c. 912, p. 2892, § 3.

Derivation: Former § 18352, added by Stats.1965, c. 1784, p. 4105, § 5, amended by Stats.1965, c. 2059, p. 4803, § 4.

Former § 9104, added by Stats.1973, c. 1080, p. 2191, § 1.

Asterisks * * * indicate deletions by amendment

§ 9104. Committee

Text of section as added by Stats.1980, c. 912, p. 2892, § 4.

"Committee" means the California Interdepartmental Committee on Aging.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

For text of section as added by Stats.1982, c. 1453, p. ——, § 9, see § 9104, post.

Repeal

Section 9104, added by Stats.1980, c. 912, p. 2892, § 4, is repealed upon operative effect of Stats.1982, c. 1453, § 8. See note under § 9800.

§ 9104. Functionally impaired client.

Text of section as added by Stats.1982, c. 1453, p. ——, § 9.

"Functionally impaired client" means a person who is 18 years or older and has restricted self-care capabilities. The person shall be limited in his or her functional ability, and shall be unable to independently perform personal and instrumental activities of daily living and associated tasks, or is unable to establish and maintain an independent living arrangement in the absence of long-term care services.

(Added by Stats.1982, c. 1453, p. ——, § 9.)

Operative effect of Stats.1982, c. 1453, p. ——, § 9, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2892, § 4, see § 9104, ante.

1980 Legislation.

Former § 9104, added by Stats.1973, c. 1080, p. 2191, § 1, defining senior adult, older person, elderly, or older resident, was repealed by Stats.1980, c. 912, p. 2892, § 3.

§ 9105. Preventive services

"Preventive services" means services which avoid dependency and assist older persons in maintaining their good health, well-being and growth.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

1980 Legislation.

Former § 9105, added by Stats.1973, c. 1080, p. 2191, § 1, defining planning areas for aging, was repealed by Stats.1980, c. 912, p. 2892, § 3.

§ 9106. Advisory council

"Advisory council" means a specific representative body of laypersons and service providers which represent the interests of the elderly within the boundaries of a planning and service area and which is officially recognized by the area agency on aging, the commission and the department as such.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

§ 9107. Supportive services

"Supportive services" means services which maintain individuals in home environments and avoid institutional care.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

§ 9108. Planning and service area

"Planning and service area" means an area specified by the department as directed by the Older Americans Act of 1965, as amended.

(Added by Stats.1980, c. 912, p. 2892, § 4.)

Derivation: Former § 9105, added by Stats.1973, c. 1080, p. 2191, § 1.

§ 9115. Personal and community support networks

"Personal and community support networks" means families, friends, neighbors, church groups and community organizations to which the elderly naturally turn to for assistance.

(Added by Stats.1980, c. 912, p. 2893, § 4.)

§ 9116. Aging network

"Aging network" means those public and private agencies and organizations funded under the Older Americans Act as well as service providers and other organized bodies expressing interest in aging network communication, such as senior advocacy organizations, local aging commissions, community councils on aging, and local officials.

(Added by Stats.1980, c. 912, p. 2893, § 4.)

§ 9117. Community long-term care delivery system

"Community long-term care delivery system" means those formal and informal programs and services which meet long-term care client's needs on the community level.

(Added by Stats.1982, c. 1453, p. ——, § 12.)

Operative effect of § 9117, see note under § 9800.

§ 9118. The community long-term care agency

"The community long-term care agency" means the designated agency with which the department has contracted to administer the long-term care services at the local level contained in this part within a specified area of this state.

(Added by Stats.1982, c. 1453, p. ——, § 13.)

Operative effect of § 9118, see note under § 9800.

§ 9119. Consolidated fund; capitation; risk sharing; at risk

(a) "Consolidated fund" means the California Long-Term Care Consolidated Fund consisting of funds which, prior to the creation of the consolidated fund, were funding components of services provided by Part 2 (commencing with Section 9800).

(b) "Capitation" means a system of payment based on the number of participants in a long-term care agency with a previously set rate of payment per person. In this method of reimbursement the amount paid is based on a formula and a finite budget with a specific rate per individual rather than an entitlement system based on a fee for service.

(c) "Risk sharing" means the assumption of some percentage of financial responsibility between the local long-term care agency and the state should costs exceed the prospectively capitated budget.

(d) "At risk" means the community long-term care agency is exposed to potential economic loss or benefits.

(Added by Stats.1982, c. 1453, p. ——, § 14.)

Operative effect of § 9119, see note under § 9800.

§ 9120. Screening; comprehensive assessment; reassessment

(a) "Screening" means a short set of questions used to determine overall eligibility for long-term care services, and the need for a comprehensive assessment.

(b) "Comprehensive assessment" means an evaluation of a person's physical, psychological, and social needs, financial resources, and the strengths and weaknesses of the informal support system and the immediate environment as a basis for determining the current functional ability and potential improvement in order to develop the appropriate services needed to maximize functional independence.

(c) "Reassessment" means a short set of questions used to evaluate whether a client's condition or needs have changed, thus warranting an adjustment in the services being delivered.

(Added by Stats.1982, c. 1453, p. ——, § 15.)

Operative effect of § 9120, see note under § 9800.

§ 9121. Participant

"Participant" means the functionally impaired person who is receiving services under the provisions of Part 2 (commencing with Section 9800).

(Added by Stats.1982, c. 1453, p. —, § 16.)

Operative effect of § 9121, see note under § 9800.

§ 9123. Least restrictive environment

"Least restrictive environment" means that care arrangement or service environment which affords a participant the maximum independence permitted by his or her functional ability.

(Added by Stats.1982, c. 1453, p. —, § 18.)

Operative effect of § 9123, see note under § 9800.

§ 9124. Case management

"Case management" means:

(1) Client assessment in conjunction with the development of a service plan with the participant and appropriate others to provide for needs identified by the assessment.

(2) Authorization and arrangement for the purchase of services, or referral to volunteer, informal or third-party payer services with followup.

(3) Service and participant monitoring to determine that services were obtained appropriate to need, adequate to meet the need, of acceptable quality, and provided in a timely manner.

(4) Followup with clients, including periodic contact and initiation of an interim assessment, if deemed necessary prior to scheduled reassessment.

(Added by Stats.1982, c. 1453, p. —, § 19.)

Operative effect of § 9124, see note under § 9800.

§ 9125. Personal activities of daily living; instrumental activities of daily living

(a) "Personal activities of daily living" means dressing, feeding, toileting, bathing, breathing, transferring, and mobility and associated tasks.

(b) "Instrumental activities of daily living" means shopping, housework, meal preparation and cleanup, laundry, taking of medication, money management, transportation, correspondence, telephoning, and related tasks.

(Added by Stats.1982, c. 1453, p. —, § 20.)

Operative effect of § 9125, see note under § 9800.

§ 9126. Authorization

"Authorization" means a signed document stating that the service is appropriate for the participant and is considered a prerequisite to payment.

(Added by Stats.1982, c. 1453, p. —, § 21.)

Operative effect of § 9126, see note under § 9800.

§ 9128. Community long-term care task force

"Community Long-Term Care Task Force" means a designated representative body of consumers, lay persons and professional representatives of service organizations and agencies. There shall be appropriate representation of functionally impaired adults of all age groups.

(Added by Stats.1982, c. 1453, p. —, § 23.)

Operative effect of § 9128, see note under § 9800.

§ 9129. Application of definitions

The definitions contained in Sections 9104, 9117, 9118, and 9120 to 9128, inclusive, shall be applicable only to Part 2 (commencing with Section 9800).

(Added by Stats.1982, c. 1453, p. ——, § 24.)

Operative effect of § 9129, see note under § 9800.

§ 9132.

1982 Legislation.

A § 9132 was added by Stats.1982, c. 1453, p. ——, § 46. Because of its subject matter and placement in that legislation, the section was editorially classified as § 9832.

CHAPTER 3. CALIFORNIA COMMISSION ON AGING

Chapter 3 was added by Stats.1980, c. 912, p. 2893, § 6.

Former Chapter 3, California Commission on Aging, was added by Stats.1973, c. 1080, p. 2191, § 1, and was repealed by Stats.1980, c. 912, p. 2893, § 5.

§ 9200. Existence; membership

Text of section as added by Stats.1980, c. 912, p. 2895, § 6.

There is in the state government the California Commission on Aging. The commission shall be:

(a) Composed of 25 persons.

(1) Nineteen persons appointed by the Governor. Nine of the 19 persons shall be appointed by the Governor from lists of nominees submitted by the area agency on aging advisory councils. At least five names shall be submitted as nominees for each vacancy.

(2) Three persons appointed by the Speaker of the Assembly.

(3) Three persons appointed by the Senate Rules Committee.

(b) Comprised of a majority of members 60 years of age or older.

(c) Comprised of actual consumers of services under the Older Americans Act, as amended.

(d) Composed of representatives of the geographic, cultural, economic and other social factors in the state.

(e) The commission composition requirements shall be complied with as vacancies occur.

(Added by Stats.1980, c. 912, p. 2893, § 6.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 24.5, see § 9200, post.

§ 9200. Commission on aging and long-term care; existence; composition

Text of section as amended by Stats.1982, c. 1453, p. ——, § 24.5.

There is in the state government the California Commission on Aging and Long-Term Care. The commission shall be:

(a) Composed of 25 persons.

(1) Nineteen persons appointed by the Governor. Nine of the 19 persons shall be appointed by the Governor from lists of nominees submitted by the area agency on aging advisory councils. Five of the 19 persons shall be appointed by the Governor from lists of nominees submitted by area boards on developmental disabilities and the California Coalition of the Independent Living Centers. At least five names shall be submitted as nominees for each vacancy.

(2) Three persons appointed by the Speaker of the Assembly.

(3) Three persons appointed by the Senate Rules Committee.

(b) Comprised of a majority of members * * * who have these functional impairments or who are elderly, and who, by the conditions, represent the same percentage of department constituents that have these conditions.

* * *

(c) Composed of representatives of the geographic, cultural, economic and other social factors in the state.

(d) The commission composition requirements shall be complied with as vacancies occur.

(Added Stats.1980, c. 912, p. 2893, § 6. Amended by Stats.1982, c. 1453, p. ——, § 24.5.)

Operative effect of 1982 amendment of § 9200, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2893, § 6, see § 9200, ante.

1980 Legislation.

Former § 9200, added by Stats.1973, c. 1080, p. 2191, amended by Stats.1976, c. 1055, p. 4683, § 1, relating to the existence, membership, and qualifications of members of the commission, was repealed by Stats.1980, c. 912, p. 2893, § 5.

Derivation: Former § 2370, added by Stats.1956, 1st Ex.Sess., c. 59, p. 451, § 1, amended by Stats.1961, c. 1810, p. 3846, § 1; Stats.1963, c. 1746, p. 3482, § 1. Stats.1955, c. 1730, p. 3181, § 1.

Former § 18300, added by Stats.1965, c. 1784, p. 4103, § 5, amended by Stats.1966, 1st Ex.Sess., c. 122, p. 608, § 2; Stats.1968, c. 1460, p. 2916, § 12; Stats.1969, c. 138, p. 383, § 309.

Former § 9200, added by Stats.1973, c. 1080, p. 2191, § 1, amended by Stats.1976, c. 1055, p. 4683, § 1.

Notes of Decisions

1. In general

The director of the department of aging has no authority over the commission on aging's budget except to serve as "the fiscal agent" for the accounting of gifts and grants, and also has no authority with respect to decisions by the commission on aging regarding the rental and allocation of space for use by the commission. 64 Ops.Atty.Gen. 4, 1-8-81.

The secretary of the health and welfare agency has no administrative control over the commission on aging. Id.

Members of the legislature who meet with and participate in the work of the citizens' advisory committee on aging are not members of said committee but do so as members of joint interim legislative committee and they may not vote on resolutions and recommendations made by the citizens' committee. 40 Ops.Atty.Gen. 75.

§ 9200.5. Term of office; officers; attendance at meetings

The term of office of members of the commission shall be three years. Members shall not serve more than two terms. The members shall select one of their members to serve as chairperson and one of their members to serve as vice chairperson on an annual basis.

A commissioner who fails to attend two consecutive monthly meetings or who fails to attend nine meetings per year, without having given written excuse acceptable to the commission, shall cause the commission to notify the appointing authority, and the appointing authority may declare the position vacant.

A representative from the California Interdepartmental Committee on Aging (CICA), other than from the Department of Aging, shall attend the commission meetings.

(Added by Stats.1980, c. 912, p. 2893, § 6.)

1980 Legislation.

Former § 9200.5, added by Stats.1973, c. 1080, p. 2192, § 1, amended by Stats.1976, c. 1055, p. 4685, § 2, relating to terms of office and officers of the commission, was repealed by Stats.1980, c. 912, p. 2893, § 5.

Derivation: Former § 2371, added by Stats.1956, 1st Ex.Sess., c. 59, p. 451, § 1. Stats.1955, c. 1730, p. 3181, § 1.

Former § 18301, added by Stats.1965, c. 1784, p. 4104, § 5, amended by Stats.1966, 1st Ex.Sess., c. 122, p. 608, § 3.

Former § 9200.5, added by Stats.1973, c. 1080, p. 2192, § 1, amended by Stats.1976, c. 1055, p. 4685, § 2.

§ 9201. Duties and functions

Text of section as added by Stats.1980, c. 912, p. 2894, § 6.

The duties and functions of the commission shall be to:

(a) Serve as the principal advocate body in the state on behalf of older persons, including, but not limited to, advisory participation in the consideration of all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older persons.

(b) Participate with the department in training workshops for community, regional and statewide senior advocates, to help older persons understand legislative, regulatory and program implementation processes.

(c) Prepare, publish and disseminate information, findings and recommendations regarding the well-being of older adults.

(d) Actively participate and advise the Department of Aging in the development and preparation of the State Plan on Aging, conduct public hearings on the State Plan on Aging, review and comment on the state plan, and monitor the progress of the plans' implementation.

(e) Meet formally on a monthly basis in order to study problems of older persons, present findings and make recommendations.

(f) At least six of the meetings shall be with the director and at least six of the meetings shall be held in various parts of the state.

(g) Hold hearings throughout the state, in order to gather information and advise the Governor, Legislature, Department of Aging and agencies on all levels of government regarding solutions to problems confronting older persons and the most effective use of existing resources and available services for older persons.

(h) Hire an executive director and, within budgetary limits, such staff as may be necessary for the commission to fulfill its duties.

(i) Develop in cooperation with the department a method for the selection of delegates to the statewide legislative meeting of senior advocates.

(j) The commission shall solicit the advice and recommendations of the California Interdepartmental Committee on Aging (CICA) in a manner that shall include, but not be limited to, attending at least six meetings chosen by the CICA membership, and active involvement by the members of the CICA in providing technical assistance to the committees of the commission.

(k) Perform other duties as may be required by statute, regulation or resolution.

(*l*) Meet and consult with the area agency on aging advisory councils in order to exchange information, and assist in training, planning, and development of advocacy skills.

(Added by Stats.1980, c. 912, p. 2894, § 6.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 25, see § 9201, post.

§ 9201. Duties and functions

Text of section as amended by Stats.1982, c. 1453, p. ——, § 25.

The duties and functions of the commission shall be to:

(a) Serve as the principal advocate body in the state on behalf of older persons and younger functionally impaired adults served under this division, including, but not limited to, advisory participation in the consideration of all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older * * * or functionally impaired adults.

(b) Participate with the department in training workshops for community, regional and statewide senior advocates, to help older persons and younger functionally impaired adults served under this division understand legislative, regulatory and program implementation processes.

(c) Prepare, publish and disseminate information, findings and recommendations regarding the well being of older or functionally impaired adults.

(d) Actively participate and advise the department * * * in the development and preparation of the State Plan on Aging, conduct public hearings on the State Plan on Aging, review and comment on the state plan, and monitor the progress of the plan's implementation.

(e) Actively participate and advise the State Council on Developmental Disabilities in the development and preparation of the California Developmental Disabilities State Plan, review and comment on the state plan, and monitor the progress of the plan's implementation.

(f) Meet formally on a monthly basis in order to study problems of older * * * or functionally impaired adults, present findings and make recommendations.

(g) At least six of the meetings shall be with the director and at least six of the meetings shall be held in various parts of the state.

(h) Hold hearings throughout the state, in order to gather information and advise the Governor, Legislature, department * * * and agencies on all levels of government regarding solutions to problems confronting older persons and younger functionally impaired adults served under this division and the most effective use of existing resources and available services for older persons and younger functionally impaired adults served under this division.

(i) Hire an executive director and, within budgetary limits, such staff as may be necessary for the commission to fulfill its duties.

(j) Develop in cooperation with the department a method for the selection of delegates to the statewide legislative meeting of senior advocates.

(k) The commission shall * * * advise the Governor, the Legislature, the department, and agencies on all levels of government regarding changes needed to improve the operation and efficiency of the long-term care system.

(l) Perform other duties as may be required by statute, regulation or resolution.

(m) Meet and consult with the area agency on aging advisory councils in order to exchange information, and assist in training, planning, and development of advocacy skills.

(Added by Stats.1980, c. 912, p. 2894, § 6. Amended by Stats.1982, c. 1459, p. ——, § 25.)

Operative effect of 1982 amendment of § 9201, see note under § 9800.
For text of section as added by Stats.1980 c. 912, p. 2894, § 6, see § 9201, ante

1980 Legislation.

Former § 9201, added by Stats.1973, c. 1080, p. 2192, § 1, amended by Stats.1976, c. 1055, p. 4686, § 3, relating to duties and functions of the commission, was repealed by Stats.1980, c. 912, p. 2893, § 5.

Derivation: Former § 2372, added by Stats.1961, c. 1810, p. 3846, § 2.

Former § 18302, added by Stats.1965, c. 1784, p. 4104, § 5, amended by Stats.1966, 1st Ex.Sess., c. 122, p. 609, § 4.

Former § 9201, added by Stats.1973, c. 1080, p. 2192, § 1, amended by Stats.1976, c. 1055, p. 4686, § 3.

Notes of Decisions

1. In general

The secretary of the Health and Welfare Agency has no administrative control over the commission on aging. 64 Ops.Atty.Gen. 4, 1-8-81.

Members of the legislature who meet with and participate in the work of the citizens' advisory committee on aging are not members of said committee but do so as members of joint interim legislative committee and they may not vote on resolutions and recommendations made by the citizens' committee. 40 Ops.Atty.Gen. 75.

§ 9202. Annual report

The commission shall prepare and submit a written annual report to the Governor, describing the activities and recommendations of the commission. This report shall reflect the advice of California's older population, and shall include, but not be limited to, information from the area agency on aging advisory councils.

(Added by Stats.1980, c. 912, p. 2895, § 6.)

1980 Legislation. to the committees of the commission. 1080, p. 2193, § 1, amended by Stats.1976, c. 1055, p. 4685, § 4, regarding the annual report, was repealed by Stats.1980, c. 912, p. 2893, § 5.

Derivation: Former § 2375, added by Stats.1961, c. 1810, p. 3847, § 3, amended by Stats.1963, c. 1746, p. 3483, § 2.

Former § 18303, added by Stats.1965, c. 1784, p. 4104, § 5, amended by Stats.1966, 1st Ex.Sess., c. 122, p. 609, § 5; Stats.1968, c. 1460, p. 2916, § 13; Stats.1969, c. 138, p. 383, § 310.

Former § 9202, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 1055, p. 4685, § 4.

§ 9203. Gifts and grants

The commission may accept gifts and grants from any source, public or private, to assist it in the performance of its functions, and * * * the gifts and grants shall operate to augment any appropriation made for the support of the commission, provided that the * * * department shall serve as the fiscal agent for the accounting of * * * the gifts and grants and that no gifts or grants shall be used for the operation by the commission of direct service programs which would conflict with the department's duties and functions as described by law.

(Added by Stats.1980, c. 912, p. 2895, § 6. Amended by Stats.1981, c. 714, p. ——, § 471.)

1980 Legislation.

Former § 9203, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 3, urgency, eff. May 11, 1976 and Stats.1978, c. 380, p. 1218, § 177, regarding gifts and grants, was repealed by Stats.1980, c. 912, p. 2893, § 5.

Derivation: Former § 2376, added by Stats.1963, c. 1525, p. 3105, § 1.

Former § 18304, added by Stats.1965, c. 1784, p. 4101, § 5, amended by Stats.1966, 1st Ex.Sess., c. 122, p. 609, § 6.

Former § 9203, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 3; Stats. 1978, c. 380, p. 1218, § 177.

Notes of Decisions

1. In general

The director of the department of aging has no authority over the commission on aging's budget except to serve as "the fiscal agent" for the accounting of gifts and grants, and also has no authority with the respect to decisions by the commission on aging regarding the rental and allocation of space for use by the commission. 64 Ops.Atty.Gen. 4, 1-8-81.

§ 9204. Reference to citizens advisory committee on aging; construction

Text of section as added by Stats.1980, c. 912, p. 2895, § 6.

Wherever there is a reference in any statute of this state to the Citizens Advisory Committee on Aging of the California Commission on Aging, it shall be construed to refer to the California Commission on Aging; provided that such reference concerns an advisory or advocacy function, or a function described in Section 9201. Any other such reference shall be construed to refer to the Department of Aging.

(Added by Stats.1980, c. 912, p. 2895, § 6.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 26, see § 9204, post.

§ 9204. Reference to citizens advisory committee on aging; construction

Text of section as amended by Stats.1982, c. 1453, p. ——, § 26.

Wherever there is a reference in any statute of this state to the Citizens Advisory Committee on Aging of the California Commission on Aging, it shall be construed to refer to the California Commission on Aging and Long-Term Care; provided that such reference concerns an advisory or advocacy function, or a function described in Section 9201. Any other such reference shall be construed to refer to the department * * *.

(Added by Stats.1980, c. 912, p. 2895, § 6. Amended by Stats.1982, c. 1453, p. ——, § 26.)

Operative effect of 1982 amendment of § 9204, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2895, § 6, see § 9204, ante.

1980 Legislation.

Former § 9204, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 4, urgency, eff. May 11, 1976, regarding construction of statutory reference to citizens advisory committee on aging, was repealed by Stats.1980, c. 912, p. 2893, § 5.

Former § 18306, added by Stats.1966, 1st Ex.Sess., c. 122, p. 609, § 8.

Derivation: Former § 9204, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 4.

§ 9205. Reimbursement of expenses

Members of the commission shall be reimbursed for their actual and necessary travel and other expenses incurred in the performance of their official duties.

1980 Legislation.

Former § 9205, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 1055, p. 4685, § 5, regarding reimbursement of expenses, was repealed by Stats.1980, c. 912, p. 2893, § 5.

Derivation: Former § 18300, added by Stats.1965, c. 1784, p. 4103, § 5, amended by Stats.1966, 1st Ex.Sess., c. 122, p. 608, § 2; Stats.1968, c. 1460, p. 2916, § 12; Stats.1969, c. 138, p. 383, § 309.

Former § 9205, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 1055, p. 4685, § 5.

CHAPTER 4. STATE DEPARTMENT OF AGING AND LONG-TERM CARE

Heading of Chapter 4, Department of Aging, is amended to read as above upon the operative effect of Stats.1982, c. 1453, p. ——, § 27. See note under § 9800.

Chapter 4 was added by Stats.1980, c. 912, p. 2895, § 8.

Former Chapter 4, Department of Aging, was added by Stats.1973, c. 1080, p. 2193, § 1, heading amended by Stats.1976, c. 157, p. 257, § 5, urgency, eff. May 11, 1976, and was repealed by Stats.1980, c. 912, p. 2895, § 7.

§ 9300. Existence

Text of section as added by Stats.1980, c. 912, p. 2895, § 8.

There is in the state government in the Health and Welfare Agency a Department of Aging. (Added by Stats.1980, c. 912, p. 2895, § 8.)

Repeal

Section 9300, added by Stats.1980, c. 912, p. 2895, § 8, is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 28. See note under § 9800.

For text of section as added by Stats.1982, c. 1453, p. ——, § 29, see § 9300, post.

1980 Legislation.

Former § 9300, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 6, urgency, eff. May 11, 1976, regarding the existence of the department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9300, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 6.

Library References

Social Security and Public Welfare ⇐21.
C.J.S. Social Security and Public Welfare § 14.

§ 9300. Creation; powers; program divisions; intra-agency policies and coordinate procedures

Text of section as added by Stats.1982, c. 1453, p. ——, § 29.

(a) There is hereby created in state government in the Health and Welfare Agency, the State Department of Aging and Long-Term Care empowered to administer the provisions of this division and serve as a single state agency for supervision of all programs under the Older Americans Act of 1965, as amended, in accordance with the action plan approved by the Legislature.

The department shall be divided into two program divisions. One division shall be the aging division, which shall be responsible for administering programs provided for, and funds appropriated, under the Older Americans Act and any other program under the jurisdiction of the department for which the long-term care division shall not be given responsibility. The other division shall be the long-term care division which shall be responsible for administering the consolidated fund, all programs for which money is appropriated from the consolidated fund, and any other related program for which the long-term care division is given responsibility.

The two divisions shall establish intra-agency policies and coordinate procedures necessary to ensure that eligible long-term care clients receive the most appropriate services according to need, irrespective of departmental divisions set forth in this division.

(Added by Stats.1982, c. 1453, p. ——, § 29.)

Operative effect of Stats.1982, c. 1453, p. ——, § 29, see note under § 9900.

For text of section as added by Stats.1980, c. 912, p. 2895, § 8, see § 9300, ante.

1982 Legislation.

Section 2 of Stats.1982, c. 1453, p. ——, provided:

"The purpose of this act is to create the State Department of Aging and Long-Term Care, consisting of two divisions. The existing aging network set out in the Older Californians' Act presently administered by the Department of Aging, and a new division within long-term care which consolidates, under a single administrative unit, selected programs and funding currently providing long-term care services.

"This act establishes and delineates the responsibilities of the new division of long-term care within the State Department of Aging and Long-Term Care. This act reflects the directives of the Older Americans Act of 1965, as amended. It reflects the number one priority of the California Senior Legislature convened in 1981, and the recommendations of the State and White House Conferences on Aging. It is the intent of the Legislature to continue its 10-year commitment to improving programs and developing a long-term care delivery system that provides both social and health support systems."

Library References

States ⇐45.

C.J.S. States §§ 79, 80, 82, 136.

§ 9301. Director, deputy director and staff; activities; location

Text of section as added by Stats.1980, c. 912, p. 2895, § 8.

The Department of Aging consists of a director, deputy director and such staff as may be necessary for proper administration. Department activities shall include, but not be limited to: (a) comprehensive program planning, development and evaluation; (b) information and dissemination activities; (c) coordination of all levels of government; (d) administration of programs funded under the Older Americans Act; and (e) shall include training and staff supportive activities.

The Department of Aging shall maintain its main office in Sacramento.

(Added by Stats.1980, c. 912, p. 2895, § 8.)

Repeal

Section 9301 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 30. See note under § 9800.

For text of section as added by Stats.1982, c. 1453, p. ——, § 31, see § 9301, post.

1980 Legislation.

Former § 9301, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 7, urgency, eff. May 11, 1976, regarding the director and staff, services, and location of the department, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9301, added by Stats.1973, c. 1080, p. 2193, § 1, amended by Stats.1976, c. 157, p. 257, § 7.

Notes of Decisions

1. In general

The director of the department of aging has no authority over the commission on aging's budget except to serve as "the fiscal agent" for the accounting of gifts and grants, and also has no authority with respect to decisions by the commission on aging regarding the rental and allocation of space for use by the commission. 64 Ops.Atty.Gen. 4, 1–8–81.

§ 9301. Director and chief deputy directors; deputy directors and staff: duties: department activities; location

Text of section as added by Stats.1982, c. 1453, p. ——, § 31.

The department consists of a director, and two chief deputy directors. One chief deputy shall coordinate the activities of the long-term care division of the department, and the other shall coordinate the activities of the aging division of the department. The director and two chief deputy directors shall each appoint at least one deputy director and such staff as may be necessary for proper administration. Department activities shall include, but not be limited to:

(a) Comprehensive program planning, promotion, development, implementation, and monitoring.

(b) Information and dissemination activities.

(c) Administration of all programs funded under the Older Americans Act, and the Long-Term Care Consolidated Fund (as established by Part 2 (commencing with Section 9800)) and shall include training and staff supportive services.

The Department of Aging and Long-Term Care shall maintain its main office in Sacramento.

(Added by Stats.1982, c. 1453, p. ——, § 31.)

Operative effect of Stats.1982, c. 1453, p. ——, § 31, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2895, § 8, see § 9301, ante.

§ 9302. Appointment of director; qualifications; powers; salary

Text of section as added by Stats.1983, c. 912, p. 2895, § 8.

The Governor, with the consent of the Senate, shall appoint a director of the Department of Aging. The Governor shall consider, but not be limited to, recommendations from the California Commission on Aging. The director shall have: (a) training in the field of gerontology, social work, public health, public administration or other related fields; (b) direct experience or extensive knowledge of programs and services related to the elderly; (c) has demonstrated understanding and concern for the welfare of the elderly; and (d) demonstrated competency and recent working experience in an administrative, supervisory, or management position. The director shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code, and shall receive the salary provided for by Chapter 6 (commencing with Section 11550) of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats.1980, c. 912, p. 2895, § 8.)

Repeal

Section 9302 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 32. See note under § 9800.

For text of section as added by Stats.1982, c. 1453, p. ——, § 33, see § 9302, post.

1980 Legislation.

Former § 9302, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 257, § 8, urgency, eff. May 11, 1976, regarding appointment, powers, salary and qualifications of the director of the department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9302, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 257, § 8.

Notes of Decisions

1. In general

The director of the department of aging has no authority over the commission on aging's budget except to serve as "the fiscal agent" for the accounting of gifts and grants, and also has no authority with respect to decisions by the commission on aging regarding the rental and allocation of space for use by the commission. 64 Ops.Atty.Gen. 4, 1-5-81.

§ 9302. Appointment of director and chief deputy directors; qualifications; powers; salary

Text of section as added by Stats.1982, c. 1453, p. ——, § 33.

The Governor, with the consent of the Senate, shall appoint a director and two chief deputy directors of the department. The Governor shall consider but not be limited to recommendations from the California Commission on Aging and Long-Term Care, the State Council on Developmental Disabilities, and other groups who represent functionally impaired persons. The director shall have:

(a) Direct experience or extensive knowledge of medical and social programs and services related to the elderly and functionally impaired persons.

(b) Demonstrated understanding and concern for the welfare of the elderly and functionally impaired persons.

(c) Demonstrated competency and recent working experience in an administrative, supervisory, or management position. The director shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 5 of Title 2 of the Government Code and shall receive a salary similar to the directors of similar departments such as health services, social services and mental health.

The Chief Deputy Director for the Division on Aging shall have demonstrated experience in, and working knowledge of, the department's elderly constituents, and the issues that are of special concern to them. The chief on long-term care shall have demonstrated experience in, and working knowledge of, the department's adult constituents in whatever age group, who receive long-term care, and the issues of special concern to them.

(Added by Stats.1982, c. 1453, p. ——, § 33.)

Operative effect of Stats.1982, c. 1453, p. ——, § 33, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2895, § 8, see § 9302, ante.

Library References

States ⇐46.

C.J.S. States §§ 61, 80, 84, 102.

§ 9303. Duties of director

Text of section as added by Stats.1980, c. 912, p. 2895, § 8.

The director shall:

(a) Be responsible for the management of the department;

(b) Implement and administer the laws pertaining to this division;

(c) Advise the Secretary of the Health and Welfare Agency and the Governor on new legislation, programs and policy initiatives, especially in the areas of coordinating services for older people that are administered by state agencies and any area supportive of long-term care for older persons;

(d) Participate and serve as a member or designate a representative to participate as a member of regulatory panels or advisory boards such as the California Commission on Aging, the California Association of Area Agencies on Aging, or others deemed appropriate;

(e) Convene and chair the California Interdepartmental Committee on Aging;

(f) With the advice of the Commission on Aging, adopt, amend or repeal regulations and general policies affecting the purposes, responsibilities and jurisdiction of the department and which are consistent with law and necessary for the administration of this division;

(g) Request the commission's recommendations on departmental policy and program activities, and take the commission's findings, recommendations and comments under advisement;

(h) Assist the California Commission on Aging in carrying out its mandated duties and responsibilities; and

(i) Perform other duties as prescribed by law.

(Added by Stats.1980, c. 912, p. 2896, § 8.)

Repeal

Section 9303 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 34. See note under § 9800.

For text of section as added by Stats.1982, c. 1453, p. ——, § 35, see § 9303, post.

1980 Legislation.

Former § 9303, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 9, urgency, eff. May 11, 1976 and Stats.1977, c. 579, p. 1931, § 229, regarding duties of the director of the department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9303, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 9; Stats.1977, c. 579, p. 1931, § 209.

otes of Decisions

I. In general

The director of the department of aging has no authority over the commission on aging's budget except to serve as "the fiscal agent" for the accounting of gifts and grants, and also has no authority with respect to decisions by the commission on aging regarding the rental and allocation of space for use by the commission. 64 Ops.Atty.Gen. 4, 1–8–81.

§ 9303. Appointment of deputy directors; duties of directors; dissemination of regulations

Text of section as added by Stats.1982, c. 1453, p. ——, § 35.

The director and the two chief deputy directors shall each appoint at least one deputy director. These positions shall be exempt from civil service requirements. The director shall:

(a) Be responsible for the management of the department.

(b) Implement and administer laws pertaining to this division.

(c) Advise the Secretary of Health and Welfare Agency and the Governor on new legislation, programs, and policy initiatives, especially in the area of coordinating services for older persons and functionally impaired persons that are administered by state agencies and any area supportive of long-term care for the older persons and functionally impaired persons.

(d) Participate or designate a representative to participate with advisory boards such as the California Commission on Aging and Long-Term Care, the California Association of Area Agencies on Aging, the California Area Agency on Aging Advisory Councils, the State Council on Developmental Disabilities, the organization of area boards on developmental disabilities, the Rehabilitation Advisory Committee, the California Coalition of Independent Living Centers, and others deemed appropriate.

(e) With the advice of the Commission on Aging, adopt amend or repeal regulations and general policies affecting the purposes, responsibilities, and jurisdiction of the department and which are consistent with law and necessary for the administration of this division. Any regulation, policy, procedure, guideline, or waiver shall be adopted, amended, or repealed in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

All of the regulations used by the department and the community long-term care agencies shall be available for public use at each office of the department and at each community long-term care agency. The department shall provide copies of the regulations to interested individuals and community organizations, and any subscription service as may be necessary to assure to those individuals and organizations prompt receipt of all additions and amendments to the regulations. Community organizations shall receive the regulations free of cost. Individuals may receive the regulations free of cost, but in no event shall the cost exceed the actual cost of providing the regulations. Any notice of action to any applicant or recipient shall inform that applicant or recipient of the availability of regulations as provided under this subdivision and other provisions of law.

(f) Request the commission's recommendations on departmental policy and program activities, and take the commission's findings, recommendations and comments under advisement.

(g) Assist the California Commission on Aging and Long-Term Care in carrying out its mandated duties and responsibilities, and insure that the commission's positions and funding be consistent with the provisions in Section 9817 and subdivisions (b) and (c) of Section 9819, and shall remain as an independent administrative agency as prescribed by the Legislature for the 1981–82 fiscal year.

(Added by Stats.1982, c. 1453, p. ——, § 35.)

Operative effect of Stats.1982, c. 1453, p. ——, § 35, see note under § 9800.
For text of section as added by Stats.1980, c. 912, p. 2896, § 8, see § 9303, ante.

Library References

States ⇐46.
C.J.S. States §§ 61, 80, 84, 102.

§ 9304. Assistants and employees; appointment; duties

Subject to the State Civil Service Act, the director shall appoint such assistants and other employees as are necessary for the administration of the affairs of the department, and shall prescribe their duties. Appointments shall be made that ensure programs, policy development and evaluation will be administered by employees having gerontological training or relevant experience. Appointments shall be made in accordance with the age-affirmative policy established by state law, the department, and the State Personnel Board which shall serve as a model for employing qualified persons 60 years of age or older.

The department shall appoint, by January 1, 1982, seven persons with expertise in the following areas: preventative and traditional health services, social service, employment/education/preretirement training, transportation, mental health, housing, and crime against the elderly and elder abuse. Persons serving in these positions shall:

(a) Provide technical assistance to area agencies on aging;

(b) Act as liaisons with appropriate state and federal agencies; and

(c) Be responsible for being currently informed about grants, programs, and services available to older persons in California.

The department shall encourage internships, to be coordinated with schools of gerontology or related disciplines. The department shall also encourage internships for older persons.

The department shall designate employees to provide information and technical assistance to rural area agencies on aging. These staff persons shall be familiar with all the programs and funding available to rural areas and shall inform the rural area agencies on aging of these programs and funding.

(Added by Stats.1980, c. 912, p. 2896, § 8.)

1980 Legislation.

Former § 9304, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 10, urgency, eff. May 11, 1976, regarding appointment of assistants and employees of the department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9304, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 10.

§ 9305. Supervision of programs

Text of section as added by Stats.1980, c. 912, p. 2897, § 8.

The department is the single state unit for supervision of all programs under the Older Americans Act of 1965, as amended.

(Added by Stats.1980, c. 912, p. 2897, § 8.)

Repeal

Section 9305 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 36. See note under § 9800.

For text of section as added by Stats.1982, c. 1453, p. ——, § 37, see § 9305, post.

1980 Legislation.

Former § 9305, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 11, urgency, eff. May 11, 1976, regarding supervision of programs for the elderly, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Formerly § 18357, added by Stats.1965, c. 1852, p. 4791, § 4, renumbered § 18305 and amended by Stats.1966, 1st Ex.Sess., c. 122, p. 609, § 7; Stats.1968, c. 1460, p. 2917, § 14; Stats.1969, c. 138, p. 383, § 311.

Former § 9305, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 11.

§ 9305. Employees; appointment and removal

Text of section as added by Stats.1982, c. 1453, p. ——, § 37.

The director, subject to civil service requirements, shall appoint all employees or remove such employees of the department as deemed necessary to carry out the purposes of this part.

(Added by Stats.1982, c. 1453, p. ——, § 37.)

Operative effect of Stats.1982, c. 1453, p. ——, § 37, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2897, § 8, see § 9305, ante.

§ 9305.1. Area agency on aging; request for designation by an eligible general purpose government

The department, in administering the federal program for grants for state and community programs on aging (under 42 U.S.C.A. 3021 et seq.), shall give due consideration to the request of any eligible general purpose government to be designated an area agency on aging.

(Added by Stats.1980, c. 20, p. 69, § 1, urgency eff. Feb. 29, 1980.)

Library References

Social Security and Public Welfare ⇐178.
C.J.S. Social Security and Public Welfare § 98 et seq.

§ 9306. Duties and powers

The duties and powers of the department shall be:

(a) Give priority to those agencies, programs, services and activities that support independent living;

(b) Administer the State Plan on Aging, as required by federal law;

(c) Establish a formal process that encourages and accommodates local, regional and statewide input into the development stages of the State Plan on Aging which shall be coordinated with and include the area agencies on aging, the California Commission on Aging and other persons or entities having professional responsibilities, or personal interest in programs for older persons;

(d) Coordinate and assist public and nonprofit private agencies in the planning and development of programs, to establish a statewide network of comprehensive, coordinated services and opportunities for older persons; and

(e) Study those aspects of the problems of aging necessary to accomplish the purposes of this division through such activities as: conducting and arranging for research, gathering statistics, and hold hearings.

(Added by Stats.1980, c. 912, p. 2897, § 8.)

1980 Legislation

Former § 9306, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 12, urgency, eff. May 11, 1976, regarding duties and powers of the department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9306, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 12.

Notes of Decisions

1. In general

Since statutory authority is necessary before a state agency may require a licensee or grantee to post a performance bond, the office on aging may not make such a requirement because § 9300 et seq. relating to the office do not give it such authority. 58 Ops.Atty.Gen. 812, 11-5-75.

§ 9306.1. Additional powers and duties

The department shall:

(a) Represent the interests of the state's older population by monitoring and assessing the state and federal regulations and legislative proposals pertaining to the needs of California's older population, and submit recommendations to the Governor, Legislature, regulatory agencies or other entities for relevant action;

(b) Maintain a clearinghouse of information related to the interests and needs of older persons and provide referral services, if appropriate;

(c) Have primary responsibility for information received and dispersed to the area agencies on aging;

(d) Establish and maintain, by July 1, 1982, a management information system which supports the administration of the department;

(e) Establish and maintain, by July 1, 1982, a data base on service utilization patterns and demographic characteristics of the older population to be cross-classified by age, sex, race and other information required for the planning process;

(f) Assess the need for services for the older population within the state and determine the extent to which the state's service delivery system is serving those older persons with the greatest economic or social need;

(g) Encourage and support the involvement of volunteers in services to older persons; and

(h) Seek ways to utilize the private sector to assume greater responsibility in meeting the needs of older persons.

(Added by Stats.1980, c. 912, p. 2897, § 8.)

Derivation: Former § 9306, added by Stats.1973, c. 1080, p. 2194, § 1, amended by Stats.1976, c. 157, p. 258, § 12.

§ 9306.2. Activities promoting development, coordination and utilization of resources to meet long-term care needs

Text of section as added by Stats.1980, c. 912, p. 2898, § 8.

The department shall be responsible for activities which promote the development, coordination and utilization of resources to meet the long-term care needs of older persons. Such responsibilities shall include, but not be limited to:

(a) Developing, by July 1, 1982, the capability to conduct research in the areas of alternative social and health care systems for older persons;

(b) Convening agencies and departments who administer health, social and related services for the purposes of (1) policy development, (2) development of care standards, (3) consistency in application of policy, (4) evaluation of alternative uses of available resources toward greater effectiveness in service delivery, and (5) insure ongoing response to the identified special needs of the chronically impaired to provide support which maximizes their level of functioning; and

(c) Establishing a statewide uniform reporting system to collect and analyze data relative to complaints and conditions in long-term care facilities for the purpose of identifying and resolving significant problems. The department shall submit the data to the state agency responsible for licensing or certifying long-term care facilities and to the federal agency on aging.

(Added by Stats.1980, c. 912, p. 2898, § 8.)

Repeal

Section 9306.2 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 38. See note under § 9800.

For text of section as added by Stats.1982, c. 1453, p. ——, § 39, see § 9306.2, post.

§ 9306.2. Staff exchange program; interdepartmental jointly funded positions

Text of section as added by Stats.1982, c. 1453, p. ——, § 39.

The department shall also develop a staff exchange program to educate personnel involved in planning, implementation or evaluation of programs and services for older persons and younger functionally impaired adults. The Legislature hereby recommends the creation of special jointly funded positions between the department and other departments in the health and welfare agency in order to establish expertise in program planning, implementation and evaluation, in order to encourage sensitivity to the needs of older persons and younger functionally impaired adults.

(Added by Stats.1982, c. 1453, p. ——, § 39.)

Operative effect of Stats.1982, c. 1453, p. ——, § 39, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2898, § 8, see § 9306.2, ante.

§ 9306.3. Monitoring and evaluating programs and services; establishment of criteria

The department shall:

(a) Monitor and evaluate programs and services administered by the department utilizing standardized methodology.

(b) Establish criteria for the designation, sanctioning and defunding of area agencies on aging.

(Added by Stats.1980, c. 912, p. 2898, § 8.)

§ 9306.4. Regulations

The department is hereby granted the authority to promulgate regulations for the purpose of carrying out the provisions of this division.

(Added by Stats.1980, c. 912, p. 2898, § 8.)

§ 9306.5. Priority; services, resources and planning

Priority in services, resources and planning, funded by the Older Americans Act, as amended, shall be given to participants in the long-term care system who are 60 years old or older as long-term care participants, or are older persons with the greatest social or economic need.

(Added by Stats.1982, c. 1453, p. —, § 39.5.)

Operative effect of § 9306.5, see note under § 9800.

§ 9307. Annual report

The department shall prepare and submit each year, on October 30th, a written report to the Governor, Speaker of the Assembly, the Senate Rules Committee and the California Commission on Aging. This report shall:

(a) Be reflective of the progress, problems, and recommendations made throughout the year with regard to the department's three-year State Plan on Aging; and

(b) Include any service data or evaluations completed by the department of programs administered by the department.

(Added by Stats.1980, c. 912, p. 2898, § 8.)

1980 Legislation.

Former § 9307, added by Stats.1973, c. 1080, p. 2195, § 1, amended by Stats.1976, c. 157, p. 259, § 13, urgency, eff. May 11, 1976, regarding the annual report of the department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9307, added by Stats.1973, c. 1080, p. 2195, § 1, amended by Stats.1976, c. 157, p. 259, § 13.

§ 9308. Gifts and grants

The department may accept gifts and grants from any source, public or private, to assist it in the performance of its functions, and such gifts and grants shall operate to augment any appropriation made for the support of the department.

(Added by Stats.1980, c. 912, p. 2899, § 8.)

1980 Legislation.

Former § 9308, added by Stats.1973, c. 1080, p. 2195, § 1, amended by Stats.1976, c. 157, p. 259, § 14, urgency, eff. May 11, 1976, relating to acceptance of gifts and grants by the department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9308, added by Stats.1973, c. 1080, p. 2195, § 1, amended by Stats.1976, c. 157, p. 259, § 14.

§ 9309. Nutrition programs and projects

In addition to any nutrition programs conducted under the McCarthy-Kennick Nutrition Program for the Elderly Act of 1972 (Chapter 5.7 (commencing with Section 18325) of Part 6 of Division 9), the department, with the approval of the Department of Finance, may make funds available from Section 17 of Chapter 157 of the Statutes of 1976 and Chapter 3 (commencing with Section 9200) to other nutrition projects serving the needs of individuals aged 60 or over and their spouses provided by public or private nonprofit persons or agencies upon such terms and conditions as the department specifies.

(Added by Stats.1980, c. 912, p. 2899, § 8.)

1980 Legislation.

Former § 9309, added by Stats.1973, c. 1080, p. 2195, § 1, amended by Stats.1976, c. 157, p. 259, § 15, urgency, eff. May 11, 1976, regarding office holding and employment of commission, director and staffs of department of aging, was repealed by Stats.1980, c. 912, p. 2895, § 7.

Derivation: Former § 9312, added by Stats.1976, c. 157, p. 259, § 16, amended by Stats.1977, c. 579, p. 1931, § 210; Stats.1977, c. 211, p. 735, § 1.

§ 9310. Nutrition programs; state grants

The department may make grants from available state funds to fund senior nutrition programs which complement programs implemented pursuant to Title III of the federal Older Americans Act. To qualify for such grants, a program shall include the following:

(a) Participation of senior volunteers in the operation of the program.

(b) Utilization of entirely donated food.

(c) Distribution of food on a regular basis.

Grant funds shall be used for the collection, storage, and distribution of food, but not for personnel costs.

(Added by Stats.1980, c. 912, p. 2899, § 8.)

1979 Legislation.

Former § 9310, added by Stats.1974, c. 239, p. 446, § 1, amended by Stats.1975, c. 116, p. 189, § 1; Stats.1977, c. 1252, p. 4628, § 712, providing for the furnishing of flu vaccine to local governments and private agencies, was repealed by Stats.1979, c. 1139, p. 4156, § 2, urgency, eff. Sept. 30, 1979. See, now, Health & S.C. § 429.64.

Derivation: Former § 9314, added by Stats.1978, c. 310, p. 649, § 2.

§ 9312. Repealed by Stats.1980, c. 912, p. 2895, § 7

The repealed section, added by Stats.1976, c. 157, p. 259, § 16, urgency, eff. May 11, 1976, amended by Stats.1977, c. 579, p. 1931, § 210; Stats.1977, c. 211, p. 735, § 1, urgency, eff. June 30, 1977, related to nutrition programs and projects for the elderly. See, now, § 9339.

§ 9314. Repealed by Stats.1980, c. 912, p. 2895, § 7

The repealed section, added by Stats.1978, c. 310, p. 649, § 2, urgency, eff. June 30, 1978, dealt with state grants to fund senior nutrition programs. See, now, § 9310.

CHAPTER 4.1. PROGRAMS FOR OLDER PERSONS: A FRAMEWORK FOR THE COORDINATION AND INTEGRATION OF STATE SERVICES

Chapter 4.1 was added by Stats.1980, c. 912, p. 2899, § 9.

§ 9320. Legislative declaration; state policy

The Legislature declares that a major portion of the fragmentation of service delivery to older persons at the state and local levels can be corrected by coordinating information with, and receiving commitments from agencies who administer services to the older population.

(a) The coordination will allow the department to:

(1) Stay informed of new policy and program developments that affect older persons;

(2) Inform the area agencies on aging and senior groups of those policy and program developments; and

(3) Review and comment on those policy and program changes.

(b) The commitments received from other departments and agencies shall include, but not be limited to:

(1) Informing the Department of Aging of any change in policy, program or activity that affects older persons; and

(2) Identifying for the Department of Aging the planning, review and comment cycle of each major plan, grant or regulatory scheme administered by that department or agency.

(c) Furthermore, it is the policy of the state to:

(1) Assign a single state department the lead authority to coordinate the information and commitments administered by state agencies;

(2) Ensure that state departments and agencies develop and implement programs pursuant to the policy directives of this act;

(3) Promote accessibility and efficiency in the planning, coordination and delivery of services to older persons; and

(4) Designate the Department of Aging as the state department with lead authority.

(Added by Stats.1980, c. 912, p. 2899, § 9.)

§ 9321. State department of health services

The State Department of Health Services shall:

(a) Develop overall goals, objectives and priorities for the health care of the older population pursuant to the policy objectives of this act, and in coordination with the Department of Aging;

(b) Advocate the development of more viable alternatives to institutionalization to ensure an array of available services;

(c) Emphasize preventative health services for older persons that support and encourage independent living;

(d) Develop, support and conduct research on long-term care;

(e) Develop alternatives to long-term care in cooperation with the Department of Social Services;

(f) Coordinate the postsecondary education community for input and research in gerontology;

(g) Develop and encourage teaching and training opportunities in the field of geriatrics; and

(h) Develop, stimulate and support the network of health services for older persons through the local health departments and the area agencies on aging.

(Added by Stats.1980, c. 912, p. 2900, § 9.)

Repeal

Section 9321 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 40. See note under § 9800.

§ 9322. State department of mental health

The State Department of Mental Health shall:

(a) Provide for the inclusion of geriatric services in departmental policies and programs that would commit both state and local agencies toward meeting the needs of the mentally impaired older person;

(b) Develop overall goals, objectives and priorities for the mental health care of older people, earmark funds for geriatric services;

(c) Require counties to develop programs that would enable older persons to function at their optimum capacity in the community;

(d) Include a geriatric component in the county minimum standards guidelines; and

(e) Develop joint training programs with the Department of Aging on analyzing county mental health plans, influencing local mental health policy, and promoting geriatric programs.

(Added by Stats.1980, c. 912, p. 2900, § 9.)

§ 9323. Office of statewide health planning and development

The Office of Statewide Health Planning and Development shall:

(a) Establish formal communication between local health systems agencies and area agencies on aging, in order to encourage an increased awareness of the health care needs and problems of older people;

(b) Request age-related data from those facilities required by law to submit annual reports; and

(c) Encourage the development of a wide range of facilities that supports the continuum of care concept.

(Added by Stats.1980, c. 912, p. 2900, § 9.)

§ 9324. Department of transportation

The Department of Transportation shall:

(a) Work toward reducing fragmentation and overlap in transportation services;

(b) Establish joint transportation policies which augment the state's health and social service system for older adults; and

(c) Promote the establishment of an accessible transportation system which is directed toward assisting those older persons with the greatest economic or social need.

(Added by Stats.1980, c. 912, p. 2901, § 9.)

§ 9325. Department of housing and community development

The Department of Housing and Community Development shall:

(a) Conduct a joint departmental study on the present status and future projections of housing and issues of concern that face the state's older population;

(b) Establish a procedure whereby staff persons from the two departments shall train the area agencies on aging on how to intervene in the planning and review process for county housing plans and community development block grants;

(c) Develop programs and policies which are directed toward the provision of suitable, affordable, culturally sensitive, and attainable housing for the state's low-income older population in both rural and urban areas; and

(d) Provide technical assistance and advice on alternative housing opportunities available to older persons.

(Added by Stats.1980, c. 912, p. 2901, § 9.)

§ 9326. California arts council and department of aging

The California Arts Council and the Department of Aging shall:

(a) Work together to identify those creative and cultural needs related to older persons;

(b) Provide for coordination in furnishing intergenerational art programs as enhancement of the quality of life for older persons;

(c) Provide advice and technical assistance in the development of intergenerational art programs;

(d) Provide arts information as a component of the existing information and referral service network to assure access to community art programs to older persons; and

(e) Encourage all applicants for contracts and services to include older persons in their programs.

(Added by Stats.1980, c. 912, p. 2901, § 9.)

§ 9327. Department of education

The Department of Education shall:

(a) Encourage the utilization of public school facilities in meeting the nutritional needs of older persons;

(b) Encourage increased cooperation with other community agencies and organizations to use school facilities as a site for delivering services to the elderly;

(c) Encourage greater opportunities for older people to participate in education, recreational and cultural activities in the schools and to utilize their skills and talents in the educational system;

(d) Help the general population understand the process of aging, the life cycle and the valuable contributions to society made by older citizens;

(e) Promote the study of aging as a normal part of the life process by encouraging intergenerational discussion, curricula development and cooperation with teacher training institutions;

(f) Encourage programs which educate and train older adults in order to help them develop new career skills; and

(g) Encourage educational opportunities for older persons in adult, vocational and continuing education.

(h) Encourage access by culturally diverse populations to such opportunities by employing culturally sensitive procedures to inform them.

(Added by Stats.1980, c. 912, p. 2901, § 9.)

§ 9328. Employment development department

The Employment Development Department shall:

(a) Provide such services as are necessary and available to ensure equal employment opportunities for older workers in competition with other workers of similar qualifications;

(b) Ensure equity of effort between those readily placeable and the hard-to-place by providing the hard-to-place with job search workshops, employment counseling, individual job development contracts and other employment-directed services;

(c) Ensure that within available resources, staff will be assigned who are knowledgeable regarding the special needs of older people;

(d) Maintain a continuing campaign on age, racial and sex discrimination in employment;

(e) Contact and involve the area agencies on aging and local comprehensive employment and training prime sponsors (CETA) in the local comprehensive planning process;

(f) Assess the employment needs of older workers as well as identifying the resources available in the community to meet the needs of older workers;

(g) Explore, coordinate and further develop alternative work opportunities for older persons.

(Added by Stats.1980, c. 912, p. 2902, § 9.)

§ 9329. State department of social services

The State Department of Social Services shall:

(a) Confer with the Department of Aging on those findings and recommendations contained in the social service plan as required by the Social Services Planning Act of 1978; and

(b) Emphasize those social services that provide an array of services designed to maintain maximum independence for older individuals.

(Added by Stats.1980, c. 912, p. 2902, § 9.)

Repeal

Section 9329 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 41. See note under § 9800.

§ 9330. State department of developmental services

Text of section as added by Stats.1980, c. 912, p. 2902, § 9.

The State Department of Developmental Services shall:

(a) Assure that an appropriate share of funds available to the department for services to persons with special development needs are earmarked for older persons;

(b) Include age-related objectives in individual program plans;

(c) Encourage a working relationship between regional centers and area agencies on aging;

(d) Initiate an agreement with the Department of Aging to exchange appropriate data and information on older persons;

(e) Include specific reference to services provided to older persons in the State Plan For Developmental Disabilities; and

(f) Share information on the case management services to older persons with special developmental needs to assure that future case management efforts by the Department of Aging are not duplicatory or incompatible.

(Added by Stats.1980, c. 912, p. 2902, § 9.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 42, see § 9330, post.

§ 9330. State department of developmental services

Text of section as amended by Stats.1982, c. 1453, p. ——, § 42.

The State Department of Developmental Services shall:

(a) Assure that an appropriate share of funds available to the department for services to persons with special developmental needs are earmarked for * * * functionally impaired persons.

(b) Include age-related objectives in individual program plans.

(c) Encourage a working relationship between regional centers, area agencies on aging * * * and community long-term care agencies.

(d) Initiate an agreement with the department * * * to exchange appropriate data and information on * * * functionally impaired persons.

* * *

(e) Share information on the case management services to older functionally impaired persons with special developmental needs to assure that future case management efforts by the department * * * are not duplicatory or incompatible.

(Added by Stats.1980, c. 912, p. 2902, § 9. Amended by Stats.1982, c. 1453, p. ——, § 42.)

Operative effect of 1982 amendment of § 9330, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2902, § 9, see § 9330, ante.

§ 9330.1. State council on developmental disabilities

The State Council on Developmental Disabilities shall include specific references to services provided to elderly developmentally disabled persons in the California Developmental Disabilities State Plan.

(Added by Stats.1982, c. 1453, p. ——, § 42.5.)

Operative effect of § 9330.1, see note under § 9800.

§ 9331. Franchise tax board

The Franchise Tax Board shall:

(a) Maintain a tax assistance counseling program to assist older persons to make applications for and taking advantage of special tax programs; and

(b) Review tax forms used specifically by older persons in order to ensure that they contain only necessary information, be printed in large print and be simplified.

(Added by Stats.1980, c. 912, p. 2903, § 9.)

§ 9332. Department of parks and recreation

The Department of Parks and Recreation shall:

(a) Encourage the increased utilization of the state parks system by older persons through program coordination with the Department of Aging and the area agencies on aging; and

(b) Give priority to community grants applicants that take into consideration recreational needs of older persons.

(Added by Stats.1980, c. 912, p. 2903, § 9.)

§ 9333. Legislative declaration; other state agencies and departments

Text of section as added by Stats.1980, c. 912, p. 2903, § 9.

The Legislature hereby declares that all other state agencies and departments not mentioned in the legislative guidelines under this chapter shall consult with the Department of Aging prior to the implementation of policies or services which impact the older population. All departments administering programs that have impact on California's older population are encouraged to adopt formal interagency policies with the Department of Aging and other departments and describing the integration of services and information between the two departments.

(Added by Stats.1980, c. 912, p. 2903, § 9.)

For text of section as amended by Stats.1982, c. 1453, p. ——, § 43, see § 9333, post.

§ 9333. Legislative declaration; other state agencies and departments

Text of section as amended by Stats.1982, c. 1453, p. ——, § 43.

The Legislature hereby declares that all other state agencies and departments not mentioned in the legislative guidelines under this chapter shall consult with the department * * * prior to the implementation of policies or services which impact the older population. * * *

(Added by Stats.1980, c. 912, p. 2903, § 9. Amended by Stats.1982, c. 1453, p. ——, § 43.)

Operative effect of 1982 amendment of § 9333, see note under § 9800.

For text of section as added by Stats.1980, c. 912, p. 2903, § 9, see § 9333, ante.

§ 9334. State library

The State Library shall:

(a) Provide consulting services and training resources to assist and encourage public and institutional libraries in developing programs and services for mobile, housebound, and institutionalized elderly;

(b) Encourage public and institutional libraries to promote the use of library services specially provided for the blind and physically handicapped to eligible elderly;

(c) Cooperate with other state level service agencies in the development of a statewide information and referral network and encourage public and institutional libraries similarly to cooperate at local and regional levels; and

(d) Coordinate such information and referral services through and with existing information and referral centers.

(Added by Stats.1980, c. 912, p. 2903, § 9.)

§ 9335. Department of consumer affairs

The Department of Consumer Affairs shall:

(a) Assess the impact of its Division of Consumer Services' Programs, in the division's annual planning processes, in considering the special needs of older persons.

(b) Periodically review and monitor the impact of its boards' and bureaus' licensees' practices on older persons, and assure that their licensing policies do not discriminate against older workers.

(c) Establish a technical assistance program to encourage the development of community discount programs for senior citizens, known as the Golden State Senior Citizen Discount Program.

(d) Promote cooperation for the maintenance of an affirmative statewide network of groups representing older persons and consumers.

(Added by Stats.1980, c. 912, p. 2903, § 9.)

Asterisks * * * indicate deletions by amendment

CHAPTER 4.2. CALIFORNIA INTERDEPARTMENTAL COMMITTEE ON AGING

Chapter 4.2 was added by Stats.1980, c. 912, p. 2904, § 10.

Repeal

Chapter 4.2 is repealed upon operative effect of Stats.1982, c. 1453, p. ——, § 44. See note under § 9800.

§ 9340. Legislative declaration

The Legislature hereby declares that the California Interdepartmental Committee on Aging shall exist on a state level. This policy development committee shall work toward providing services and programs for older Californians that result in a comprehensive and coordinated service system.

(Added by Stats.1980, c. 912, p. 2904, § 10.)

§ 9341. Membership

The directors of all state agencies and departments who sponsor, administer or participate in programs of current or future benefit to older persons, shall be members of the California Interdepartmental Committee on Aging.

(Added by Stats.1980, c. 912, p. 2904, § 10.)

§ 9342. Powers and duties

The California Interdepartmental Committee on Aging shall:

(a) Convene monthly as called by the Department of Aging;

(b) Identify programs and services that affect older persons in California;

(c) Collect and analyze available data and promote the development of uniform data collection on the older population;

(d) Identify priority issues to be studied and addressed, and implemented as mandated by Chapter 3 (commencing with Section 9200) and Chapter 4 (commencing with Section 9300);

(e) Identify duplications and gaps in services and programs for older persons, and develop policies and plans for their elimination through both joint and individual efforts of member departments;

(f) Require each member department to include in its plans, a description of efforts it will undertake to identify and eliminate duplications and gaps in services;

(g) Establish ad hoc committees that focus on identified priority issues and present findings for action by the full committee;

(h) Seek and utilize outside services for additional program resources;

(i) Establish a standing committee to develop recommendations for the coordination of those health and social services necessary to the provision of long-term care;

(j) Establish other standing or ad hoc committees to focus on priority issues and present findings and recommendations to the full committee;

(k) Require that one or more of its members meet at least six times annually with the California Commission on Aging to report on the CICA's activities and to make recommendations to the commission; and

(*l*) Assign its members to provide ongoing technical assistance to the various committees of the commission.

(Added by Stats.1980, c. 912, p. 2904, § 10.)

§ 9342. Staffing by department of aging; gerontological training and direction; exchange program; special jointly funded positions

The committee shall be staffed by the Department of Aging. The Department of Aging shall provide for gerontological training to members of the interdepartmental committee and provide direction to the committee based on the department's perceptions of priority and need for California's older people.

The Department of Aging shall also develop a staff exchange program to educate personnel involved in planning, implementation or evaluation of programs and services for older persons. The Legislature hereby recommends the creation of special jointly funded positions between the Department of Aging and member departments in order to establish expertise in program planning, implementation and evaluation and to encourage sensitivity to the needs of older persons.

(Added by Stats.1980, c. 912, p. 2905, § 10.)

CHAPTER 4.3. AREA AGENCIES ON AGING

Sec.
9350. Legislative declaration.
9351. Duties and powers.
9352. Additional duties and powers.
9353. Director; staff.

Chapter 4.3 was added by Stats.1980, c. 912, p. 2905, § 11.

§ 9350. Legislative declaration

The Legislature hereby declares and recognizes the area agencies on aging to be the local unit on aging.

(Added by Stats.1980, c. 912, p. 2905, § 11.)

§ 9351. Duties and powers

The duties and powers of the area agencies on aging shall be to:

(a) Represent older persons within the planning and service area;

(b) Assist older persons in obtaining the rights, benefits and entitlements currently available under the law;

(c) Identify special needs or barriers to maintaining personal independence;

(d) Ensure that community services within the planning and service area consider the needs of the older population by educating and actively encouraging older people to become involved in the development of other agency plans that affect older people;

(e) Conduct public hearings on the needs of older persons;

(f) Coordinate activities in support of the statewide long-term care ombudsman program; and

(g) Represent the interests of older persons to public officials, public and private agencies or organizations.

(Added by Stats.1980, c. 912, p. 2905, § 11.)

§ 9352. Additional duties and powers

Also, the duties and powers of the area agencies on aging shall be to:

(a) Develop and administer an area plan for a comprehensive and coordinated service delivery system in the planning and service area;

(b) Ensure that the area plan contributes to and is reflected in the State Plan on Aging;

(c) Encourage and provide opportunities for public input by:

(1) Holding public hearings on the area plans and on problems and needs of older persons in conjunction with the area agency advisory councils;

(2) Establish communication linkages with the local media to inform the public on an ongoing basis of available services and opportunities to contribute to the planning and implementation of those services;

(d) Assess the need for services within the planning and service area and determine the effectiveness of existing services in meeting the needs of older persons;

(e) Take advantage of opportunities to educate and inform the public in general of the needs of older persons;

(f) Promote case management whenever possible, as a system to respond to those older persons needing special help with personal, social or economic needs;

(g) Designate an interagency committee on aging composed of local public agencies, such as health systems agencies and health and transportation agencies, private service providers and senior organizations in order to improve the coordination of services to older persons;

(h) Review and comment on area plans prepared by other agencies that may affect older persons;

(i) Provide information to the department on special needs, experiences and programs within the planning and service area;

(j) Receive information from the department regarding legislation, regulation and policy direction; and

(k) Coordinate and assist local public and nonprofit private agencies in the planning and development of programs to establish an areawide network of comprehensive, coordinated services and opportunities for older persons.

(Added by Stats.1980, c. 912, p. 2905, § 11.)

§ 9352. Director; staff

The area agencies on aging shall:

(a) Be headed by a full-time director;

(b) Request other staff in the area plan, subject to the approval of the Department of Aging; and

(c) Have a staffing level sufficient to carry out its powers and duties as required.

(Added by Stats.1980, c. 912, p. 2906, § 11.)

CHAPTER 4.4. AREA AGENCY ON AGING ADVISORY COUNCIL

Chapter 4.4 was added by Stats.1980, c. 912, p. 2906, § 12.

§ 9360. Legislative declaration

The Legislature hereby declares and recognizes each area agency on aging advisory council as a principal advocate body on behalf of older persons within a planning and service area.

(Added by Stats.1980, c. 912, p. 2906, § 12.)

§ 9361. Duties and powers

The duties and powers of each area agency on aging advisory council shall be to:

(1) Serve as adviser to the area agency on aging;

(2) Act as an independent advocate for older persons, taking positions on matters pertaining to federal, state and local policies, programs and procedures, and any legislation affecting older persons;

(3) Actively seek advice from community councils on aging, senior advocacy organizations, local aging commissions, elected officials, and the general public for the purpose of advocating for and making formal presentations on issues of concern to older persons;

(4) Inform local senior advocates and organizations on specific legislation pending before local, state and federal governments;

(5) Disseminate information of interest and concern to older persons;

(6) Be actively involved in the development, implementation and monitoring of the area plan;

(7) Hold an annual areawide meeting of senior advocates and organizations to prepare for the priorities for the ensuing year and elect delegates for the statewide legislative meeting of senior advocates; and

(8) Hold public hearings on the area plans with no less than 30-day notification to the general public and the aging constituency regarding dates, time, and location. Such notification shall contain understandable descriptions of area agency on aging and community-level plans in order to promote informed input.

(Added by Stats.1980, c. 912, p. 2906, § 12.)

§ 9361.5. Nonpartisan advisory council

Each advisory council shall be nonpartisan in the conduct of its duties and functions.

(Added by Stats.1980, c. 912, p. 2907, § 12.)

§ 9362. Staff assistance; reimbursement for expenses; specialized training

It is the intent of this act that each area agency on aging should provide staff assistance to each advisory council to assist in carrying out its duties as specified.

Each area agency on aging shall reimburse its advisory council members for actual and necessary expenses incurred while carrying out the duties of the advisory council within the planning and service area.

The Department of Aging in cooperation with the California Commission on Aging and the area agencies on aging shall annually provide specialized training for members of each advisory council in order to improve their functioning as advocates and for improving and expanding the role of older persons in the planning, implementation, delivery, and evaluation of services to older persons.

(Added by Stats.1980, c. 912, p. 2907, § 12.)

§ 9363. Annual report

Each advisory council shall prepare annually a report that gives its recommendations to improve the lives of older persons, and a summary of its activities for the previous year. The report shall be made available to its area agency on aging, the Department of Aging, the California Commission on Aging, the Assembly Committee on Aging, and, insofar as resources permit, to all other interested parties that seek a copy of the report.

(Added by Stats.1980, c. 912, p. 2907, § 12.)

§ 9364. Bylaws; membership; terms; meetings; appointments; composition requirements

(1) Each advisory council shall adopt and follow bylaws concerning, but not necessarily limited to:

(a) Terms of membership and office,

(b) Election of officers,

(c) Frequency and notice of meetings,

(d) Accessibility of meetings to members of the general public,

(e) Rules regarding the conduct of council and council committee meetings,

(f) Removal of members and officers and the filling of vacancies.

(2) Members of advisory councils shall serve on the council for fixed terms.

(3) Advisory councils shall meet at least 10 times a year.

(4) No more than 50 percent of the council's membership shall be appointed by one official or body of officials.

(5) The advisory council membership shall be appointed through a process designated by the local governing bodies in the planning and service area within which the area agency on aging operates.

(6) Membership shall be composed of:

(a) A majority of persons 60 years of age or older.

(b) Service providers.

(c) Members who reflect the geographic, racial, economic, and social complexion of the planning and service area they represent.

(d) At least one member who represents the interests of the disabled.

(7) The advisory council composition requirements shall be complied with as vacancies occur.

(Added by Stats.1980, c. 912, p. 2907, § 12.)

§ 9365. Advisory council as advocate for older persons

Nothing in this act shall be construed as limiting in any way the ability of each advisory council to serve as an advocate for all older persons.

(Added by Stats.1980, c. 912, p. 2908, § 12.)

CHAPTER 5. PILOT MULTIPURPOSE SENIOR SERVICES PROJECTS

Chapter 5 was added by Stats.1977, c. 1199, p. 3986, § 8.

Former Chapter 5 Multipurpose Senior Centers, added by Stats.1976, c. 1350, p. 6160, § 3, was repealed by Stats.1977, c. 1199, p. 3986, § 7.

1976 Legislation.

Former Chapter 5, Multipurpose Senior Centers, added by Stats.1976, c. 1350, p. 6160, § 3, consisted of Article 1. General Provisions and Definitions, comprising §§ 9400 to 9403; Article 2. Administration, comprising §§ 9425, 9426; Article 3. Qualifications, comprising §§ 9450 to 9454; and Article 4. Fiscal Provisions, comprising §§ 9475 to 9478.

ARTICLE 1. LEGISLATIVE INTENT AND DEFINITIONS

Article 1 was added by Stats.1977, c. 1199, p. 3986, § 8.

§ 9400. Pilot projects; establishment; purpose

The purpose of this chapter is to establish pilot projects which would develop information about effective methods:

(a) To prevent premature disengagement of older persons from their indigenous communities and subsequent commitment to institutions.

(b) To provide optimum accessibility of various important community social and health resources available to assist active older persons maintain independent living.

(c) To provide that the "at risk" moderately impaired or frail older person who has the capacity to remain in an independent living situation has access to the appropriate social and health services without which independent living would not be possible.

(d) To provide the most efficient and effective use of public funds in the delivery of these social and health services.

(e) To coordinate, integrate, and link these social and health services including county social services by removing obstacles which impede or limit improvements in delivery of these services.

(f) To allow the state substantial flexibility in organizing or administering the delivery of social and health services to its senior citizens.

(Added by Stats.1977, c. 1199, p. 3986, § 8.)

Section 48 of Stats.1982, c. 1453, p. ——, provided:

"In accordance with Section 2176 of the federal Omnibus Budget Reconciliation Act of 1981, (P.L. 97-35), the Health and Welfare Agency shall develop a waiver proposal to be submitted to the United States Department of Health and Human Services in order to permit the provision of home and community based services pursuant to Chapter 5 (commencing with Section 9400) of Division 8.5 of the Welfare and Institutions Code.

"The Multipurpose Senior Service project, which would have been repealed on June 30, 1983, except for the deletion of this date pursuant to Section 45 of this act, shall continue to serve clients determined to be eligible under Section 2176 of P.L. 97-35. These clients shall be certified or certifiable for placement in a skilled nursing facility. Individual Multipurpose Senior Service project sites shall be allowed to continue in modified form if the individual project site demonstrates cost-effectiveness. The transition from project to program status shall include cooperative efforts between the Health and Welfare Agency and the Department of Aging in concert with other affected departments."

Derivation: Former § 9400, added by Stats.1976, c. 1350, p. 6160, § 3.

Library References

Social Security & Public Welfare ⇐0.5.
C.J.S. Social Security and Public Welfare § 1.
C.J.S. Paupers §

§§ 9401 to 9403. Repealed by Stats.1977, c. 1199, p. 3986, § 7

The repealed sections, added by Stats.1976, c. 1350, p. 6160, § 3, defined "agency", "older person" and "center". See, now, §§ 9405, 9406.

§ 9405. Agency

"Agency" means the Health and Welfare Agency.

(Added by Stats.1977, c. 1199, p. 3987, § 8.)

Derivation: Former § 9401, added by Stats.1976, c. 1350, p. 6160, § 3.

§ 9406. Older person

"Older person" means a person of age * * * 65 years or older.

(Added by Stats.1977, c. 1199, p. 3987, § 8. Amended by Stats.1980, c. 685, p. 1856, § 2, urgency, eff. July 20, 1980.)

1980 Amendment. Raised the age from 60 to 65 years.

Derivation: Former § 9402, added by Stats.1976, c. 1350, p. 6160, § 3.

§ 9407. Multipurpose senior services

"Multipurpose senior services" means a coordinated, integrated system of delivery of the following social and health services designed for older persons: recreation services, educational services, senior center programs, information and referral services, transportation, income maintenance counseling, housing services, outreach services, volunteer programs, employment services, legal services, home repair services, escort services, telephone reassurance services, friendly visiting services, health screening services, psychological screening services, nutrition services, home health services, preventive health services, mental health services, homemaker chore services, portable meals, day care services, adult day health care services, nonmedical respite care services, night services, intermediate care, skilled nursing care, acute hospital care, and hospice care.

(Added by Stats.1977, c. 1199, p. 3987, § 8. Amended by Stats.1978, c. 800, p. 2573, § 1, urgency, eff. Sept. 18, 1978.)

Asterisks * * * indicate deletions by amendment

ARTICLE 2. ADMINISTRATION

Sec.
9410. Health and welfare agency; powers of head of department; waiver of regulations and policies; designation of department to implement chapter.
9411. Formulation of criteria for pilot projects; evaluation; inclusions.
9412. Duties of agency.
9413. Legislative intent; evaluation pilot project report.
9425, 9426. Repealed.
9450 to 9454. Repealed.
9475 to 9478. Repealed.

Article 2 was added by Stats.1977, c. 1199, p. 3987, § 8.

§ 9410. Health and welfare agency; powers of head of department; waiver of regulations and policies; designation of department to implement chapter

The provisions of this chapter shall be administered by the Health and Welfare Agency. In addition to its other powers, the agency shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150), Part 1, Division 3, Title 2 of the Government Code.

To the extent permitted by federal law, each department within the agency, including departments designated as single state agencies for the programs described in Section 9407, shall waive regulations and general policies and make resources available which are necessary for the administration of this chapter, upon request of the agency.

The agency may designate a department under its jurisdiction to implement the provisions of this chapter.

(Added by Stats.1977, c. 1199, p. 3987, § 8.)

Derivation: Former § 9425, added by Stats.1976, c. 1350, p. 6160, § 3.

§ 9411. Formulation of criteria for pilot projects; evaluation; inclusions

The agency shall formulate criteria for pilot multipurpose senior services projects. The criteria shall include, but need not be limited to, the following:

(a) Specifications for a * * * social and health review team to evaluate older persons and to assure that a continuity of social, economic, and health services are provided to maintain such persons at the appropriate level of care.

(b) Development of social and health services necessary to maintain the older person at the appropriate level of care in the project area.

(c) Specifications for the quality of the social and health services to be provided.

(d) Development of a sliding fee schedule.

(e) Coordination and integration of the social and health services described in Section 9407.

(f) Access to as many services specified in Section 9407 as possible at the same location in a facility known as a multipurpose senior services center.

(g) The number of pilot projects shall be consistent with the moneys made available for purposes of this chapter.

(h) Coordination with local governmental agencies concerned with multipurpose senior services.

(i) Specifications for the evaluation of the proposal submitted for the pilot projects and for the evaluation of the pilot projects. The evaluation of the pilot projects shall measure the effectiveness and the efficiency of the projects in:

(1) Identifying the health and social needs of the older persons and the coordination of the available services required to maintain persons at the appropriate level of care.

(2) Assuring that the continuity of social and health services are provided to maintain persons at the appropriate level of care.

The evaluation shall include, but not be limited to:

(1) A description of the social and economic characteristics of the older persons served by the projects.

(2) The range of problems presented by the persons served, and the services provided in response to those problems.

(3) A description of those problems best handled by the pilot project and a description of the problems least effectively handled by the pilot project.

(4) The costs of the services required to maintain persons at the appropriate level of care under a continuity of care program compared with the costs of services for persons who have not received services as components of a continuity of care program.

(Added by Stats.1977, c. 1199, p. 3987, § 8. Amended by Stats.1978, c. 890, p. 2573, § 2, urgency, eff. Sept. 18, 1978.)

Derivation: Former § 9426, added by Stats.1976, c. 1350, p. 6166, § 3.

§ 9412. Duties of agency

The agency shall do the following:

(a) Enter into agreements and negotiated contracts with any nonprofit organization or governmental entity to operate the one or more of the selected pilot projects consistent with the criteria adopted pursuant to Section 9411. In letting such contracts, the agency shall not anticipate future appropriations.

(b) Make grants to pilot projects from available funds.

(c) Monitor pilot projects.

(d) Cause the pilot projects to be evaluated in accordance with the established criteria.

(e) Seek and utilize any available federal, state, or private funds which may be available for carrying out the purposes of this chapter.

Notwithstanding any other provision of law, pilot projects established pursuant to this chapter may contract with the Director of the State Department of Health Services as Medi-Cal pilot programs pursuant to Chapter 8 (commencing with Section 14200) of Part 3 of Division 9. Contracts with such pilot projects shall be deemed to be for the purposes specified in Section 14494, and may utilize funds appropriated from the Health Care Deposit Fund pursuant to Section 14157.

(f) Request and secure such waivers of single-state-agency requirements as are necessary under the Federal Intergovernmental Cooperation Act of 1968 (P.L. 90-577) [1], and such other federal requirements as are necessary in order to utilize available federal funds for the purposes of this chapter.

(g) Assist in coordinating pilot projects with local governmental programs and services for older persons.

(h) Submit to the Legislature and the Governor an initial report on the administration of this chapter by April 30, 1979, and * * * subsequent reports each April 30 * * * thereafter until termination of the project on the administration of this chapter. Such reports shall include a description and evaluation of the pilot projects, characteristics of the persons served, the information required for evaluations under subdivision (i) of Section 9411, and recommendations for administrative and legislative changes.

(Added by Stats.1977, c. 1199, p. 3988, § 8. Amended by Stats.1980, c. 665, p. 1856, § 3, urgency, eff. July 20, 1980.)

[1] 42 U.S.C.A. § 4201 et seq.

1980 Amendment. Inserted the paragraph following subd. (e) relating to Medi-Cal pilot programs; and substituted in subd. (h) "subsequent reports each April 30 thereafter until termination of the project" for "a second report by April 30, 1980".

Asterisks * * * indicate deletions by amendment

§ 9413. Legislative intent; evaluation pilot project report

* * * It is the intent of the Legislature to evaluate the * * * reports submitted pursuant to subdivision (h) of Section 9412 to determine whether pilot projects conducted under this chapter have had sufficient positive impact to warrant their continuation.

(Added by Stats.1977, c. 1199, p. 3989, § 8. Amended by Stats.1980, c. 665, p. 1856, § 4, urgency, eff. July 20, 1980; Stats.1982, c. 1453, p. ——, § 45.)

1980 Amendment. Substituted "June 30, 1983" for "January 1, 1981" in two places; and substituted in the second sentence "the reports" for "the second report".

1982 Amendment. Deleted the former first sentence which read: "This chapter shall remain in effect only until June 30, 1983, and on such date is repealed, unless a later enacted statute, which is chaptered before June 30, 1983, deletes or extends such date."; and deleted "In this regard," from the beginning of the section.

§§ 9425, 9426. Repealed by Stats.1977, c. 1199, p. 3986, § 7

The repealed sections, added by Stats.1976, c. 1350, p. 6160, § 3, related to powers of the head of the agency and of the agency generally. See, now, §§ 9410, 9411.

§§ 9450 to 9454. Repealed by Stats.1977, c. 1199, p. 3986, § 7

The repealed sections, added by Stats.1976, c. 1350, p. 6160, § 3, related to the qualifications, programs and services of the multipurpose senior centers. See, now §§ 9400 to 9413.

Nutrition and volunteer services for senior citizens, see § 9500 et seq.

§§ 9475 to 9478. Repealed by Stats.1977, c. 1199, p. 3986, § 7

The repealed sections, added by Stats.1976, c. 1350, p. 6160, § 3, related to the fiscal provisions for the multipurpose senior centers. See, now, §§ 9400 to 9413.

CHAPTER 6. NUTRITION AND VOLUNTEER SERVICES PROGRAM FOR SENIOR CITIZENS [REPEALED]

Chapter 6, added by Stats.1981, c. 251, p. ——, § 1, urgency eff. July 1, 1981, was repealed under the terms of § 9518, added by c. 251, on July 1, 1982.

§§ 9500 to 9512. Repealed by Stats.1981, c. 251, p. ——, § 1, operative July 1, 1982

The repealed section, added by Stats.1981, c. 251, p. ——, § 1, providing for the operation of the nutrition and volunteer services program for senior citizens, was repealed under the terms of § 9512, added by c. 251, on July 1, 1982. The repealed sections were derived from §§ 9500 to 9512, added by Stats.1977, c. 1199, pp. 3989 to 3992, § 9; Stats.1980, c. 20, p. 70, § 4 and amended by Stats.1978, c. 800, p. 2574, § 3; Stats.1978, c. 1002, p. 3080, §§ 1, 2; Stats.1980, c. 20, p. 70, §§ 2, 3, 5; Stats.1980, c. 1292, p. 69, §§ 1, 2.

Former §§ 9500 to 9512, added by Stats.1977, c. 1199, pp. 3989 to 3992, § 9; Stats.1980, c. 20, p. 70, § 4, amended by Stats.1978, c. 800, p. 2574, § 3; Stats.1978, c. 1002, p. 3080, §§ 1, 2; Stats.1980, c. 20, p. 70, §§ 2, 3, 5; Stats.1980, c. 1292, p. 69, §§ 1, 2, relating to similar subject matter, was repealed under the terms of former § 9512 on July 1, 1981.

CHAPTER 7. SENIOR COMPANION PROGRAM

Sec.
9520. Legislative finding and declaration.
9521. Legislative intent.
9522. Memorandum of agreement; administration of program.
9523. "Senior companions"; eligibility; transportation expenses; meals; benefits; time of participation.
9524. Adults eligible for services.
9525. Assignment of senior companions.

(d) At least one member who represents the interests of the disabled.

(f) The advisory council composition requirements shall be complied with as vacancies occur.

(Added by Stats.1980, c. 912, p. —, § 12.)

§ 9365. Advisory council as advocate for older persons

Nothing in this act shall be construed as limiting in any way the ability of each advisory council to serve as an advocate for all older persons.

(Added by Stats.1980, c. 912, p. —, § 12.)

CHAPTER 5. PILOT MULTIPURPOSE SENIOR SERVICES PROJECTS [NEW]

Chapter 5 was added by Stats.1977, c. 1199, p. 3986, § 8.

Repeal

Chapter 5 is repealed under the provisions of § 9413 on June 30, 1983.

Former Chapter 5: Multipurpose Senior Centers, added by Stats.1976, c. 1350, p. 6160, § 3, was repealed by Stats.1977, c. 1199, p. 3980, § 7.

Former Chapter 5, Multipurpose Senior Centers, added by Stats.1976, c. 1350, p. 6160, § 3, consisted of Article 1, General Provisions and Definitions, comprising §§ 9400 to 9403; Article 2, Administration, comprising §§ 9425, 9426; Article 3, Qualifications, comprising §§ 9450 to 9454; and Article 4, Fiscal Provisions, comprising §§ 9475 to 9478.

ARTICLE 1. LEGISLATIVE INTENT AND DEFINITIONS

Sec.

9400. Pilot projects; establishment; purpose.
9401 to 9402. Repealed.
9405. Agency.
9406. Older person.
9407. Multipurpose senior services.

Article 1 was added by Stats.1977, c. 1199, p. 3986, § 8.

§ 9400. Pilot projects; establishment; purpose

The purpose of this chapter is to establish pilot projects which would develop information about effective methods:

(a) To prevent premature disengagement of older persons from their indigenous communities and subsequent commitment to institutions.

(b) To provide optimum accessibility of various important community social and health resources available to assist active older persons maintain independent living.

(c) To provide that the "at risk" moderately impaired or frail older person who has the capacity to remain in an independent living situation has access to the appropriate social and health services without which independent living would not be possible.

(d) To provide the most efficient and effective use of public funds in the delivery of these social and health services.

(e) To coordinate, integrate, and link these social and health services including county social services by removing obstacles which impede or limit improvements in delivery of these services.

(f) To allow the state substantial flexibility in organizing or administering the delivery of social and health services to its senior citizens.

(Added by Stats.1977, c. 1199, p. 3986, § 8.)

Derivation: Former § 9400, added by Stats.1976, c. 1350, p. 6160, § 3.

Library References
Social Security & Public Welfare ⇨5.1.

§§ 9401 to 9403. Repealed by Stats.1977, c. 1199, p. 3988, § 7

The repealed sections, added by Stats.1976, c. 1350, p. 6160, § 3, defined "agency", "older person" and "center". See, now, §§ 9405, 9406.

§ 9405. Agency

"Agency" means the Health and Welfare Agency.

(Added by Stats.1977, c. 1199, p. 3987, § 8.)

Derivation: Former § 9401, added by Stats.1976, c. 1350, p. 6160, § 3.

§ 9406. Older person

"Older person" means a person of age * * * 65 years or older.

(Added by Stats.1977, c. 1199, p. 3987, § 8. Amended by Stats.1980, c. 692, p. ——, § 2, urgency, eff. July 20, 1980.)

1980 Amendment. Raised the age from 60 to 65 years.

Derivation: Former § 9402, added by Stats.1976, c. 1350, p. 6160, § 3.

§ 9407. Multipurpose senior services

"Multipurpose senior services" means a coordinated, integrated system of delivery of the following social and health services designed for older persons: recreation services, educational services, senior center programs, information and referral services, transportation, income maintenance counseling, housing services, outreach services, volunteer programs, employment services, legal services, home repair services, escort services, telephone reassurance services, friendly visiting services, health screening services, psychological screening services, nutrition services, home health services, preventive health services, mental health services, homemaker chore services, portable meals, day care services, adult day health care services, nonmedical respite care services, night services, intermediate care, skilled nursing care, acute hospital care, and hospice care.

(Added by Stats.1977, c. 1199, p. 3987, § 8. Amended by Stats.1978, c. 800, p. 2573, § 1, urgency, eff. Sept. 15, 1978.)

ARTICLE 2. ADMINISTRATION

Article 2 was added by Stats.1977, c. 1199, p. 3987, § 8.

§ 9410. Health and welfare agency; powers of head of department; waiver of regulations and policies; designation of department to implement chapter

The provisions of this chapter shall be administered by the Health and Welfare Agency. In addition to its other powers, the agency shall have the powers of a head of a department pursuant to Chapter 2 (commencing with Section 11150), Part 1, Division 3, Title 2 of the Government Code.

To the extent permitted by federal law, each department within the agency, including departments designated as single state agencies for the programs described in Section 9407, shall waive regulations and general policies and make resources available which are necessary for the administration of this chapter, upon request of the agency.

CHAPTER 1453

An act to add Article 1.8 (commencing with Section 16369) to Chapter 2 of Part 2 of Division 4 of Title 2 of the Government Code, and to amend Sections 9101, 9102, 9103, 9200, 9201, 9204, 9330, 9333, 9413, and 14132 of, and to amend the heading of Chapter 4 (commencing with Section 9300) of Part 1 of Division 8.5 of, and to add Sections 9104, 9110, 9117, 9118, 9119, 9120, 9121, 9123, 9124, 9125, 9126, 9128, 9129, 9300, 9301, 9302, 9303, 9305, 9306.2, 9306.5, and 9330.1 to, and to add a new part heading immediately preceding Section 9000 of, and to add Part 2 (commencing with Section 9800) to Division 8.5 of, and to repeal Sections 9104, 9110, 9300, 9301, 9302, 9303, 9305, 9306.2, 9321, and 9329 of, and to repeal Chapter 4.2 (commencing with Section 9340) of Part 1 of Division 8.5 of, the Welfare and Institutions Code, relating to public social services, and making an appropriation therefor

[Approved by Governor September 27, 1982. Filed with Secretary of State September 28, 1982.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2860, Torres. Aging and long-term care.

Existing law provides for the Department of Aging which administers various programs to provide services to elderly persons.

This bill would expand this department by creating the State Department of Aging and Long-Term Care, with the department to administer not only those programs currently administered by the department, but also health and social services programs which provide long-term care to and functionally impaired disabled individuals, as defined.

The bill contains provisions relating to the organization of the department, including provisions for appointment of personnel. The bill would provide that the department shall be divided into two divisions, a long-term care division, for administration of specified long-term care programs and an aging division for administration of all other programs within the department's jurisdiction.

The bill also specifies the general powers and duties of the department.

The bill provides that effective July 1, 1983, funds used for various segments of the current long-term care system for the elderly and functionally impaired, under specified programs, shall be appropriated to the Long-Term Care Consolidated Fund.

The bill empowers the department to allocate money from this fund to community long-term care agencies for provision of long-term care services.

The bill would require community long-term care agencies to

assure provision of assessments to specified individuals in order to determine whether they are in need of long-term care services, and would allow assessments for other persons to be made under other circumstances and under specified conditions.

The bill would require the department to designate and contract with the community long-term care agencies, after receiving recommendations from community long-term care task forces and would give the department direct authority to provide for long-term care services prior to that date.

The bill would provide that the community long-term care agencies shall administer the provision of long-term care services.

The bill also contains provisions detailing the scope of the long-term care services which shall be provided to elderly and functionally impaired disabled persons as defined. The bill sets forth specified needs which shall be met by long-term care services.

The bill contains requirements which the department and community long-term care agencies shall meet in carrying out their respective responsibilities for administering long-term care.

The bill would require establishment of community long-term care agency advisory groups.

The bill would provide that the Governor shall submit an action plan concerning the reorganization of the state structure provided for under the bill, as well as the consolidated fund.

The bill would further specify that except for specified provisions, its provisions would not become effective until specified actions, including statutory approval of the Governor's action plan, have been taken.

Existing law provides for the Multipurpose Senior Services program, under which pilot projects are funded in order to provide various types of services to elderly persons.

Under existing law this program would be terminated on June 30, 1983.

This bill would delete the provision terminating the program.

The bill would further require the Health and Welfare Agency to develop a waiver proposal for submission to the federal government for provision of home and community based services as part of the Multipurpose Senior Service project.

Existing law provides for the Medi-Cal program, which is governed and funded by both state and federal law, and which provides health care services to specified categories of low-income recipients.

Existing federal law would allow the state to receive federal funding for providing home and community based services under the Medi-Cal program subsequent to approval of a plan by the United States Department of Health and Human Services.

This bill would add to those benefits which are provided under the Medi-Cal program home and community based services, to the extent that a waiver from the federal government is received,

appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to such persons. Such services may be provided to patients placed in facilities such as skilled nursing or intermediate care facilities, or to persons in shared-or-congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary.

(u) Home and community based services, as set forth in Section 2176 of P.L. 97-35 shall be reimbursable as Medi-Cal covered benefits upon the approval of the federal Department of Health and Human Services. These home and community based services shall be included in the Medi-Cal scope of benefits as Medi-Cal covered and reimbursable services for the duration of the approved federal waiver and to the extent the State Department of Health Services can claim and be reimbursed by federal financial participation funds for these services.

SEC. 48. In accordance with Section 2176 of the federal Omnibus Budget Reconciliation Act of 1981, (P.L. 97-35), the Health and Welfare Agency shall develop a waiver proposal to be submitted to the United States Department of Health and Human Services in order to permit the provision of home and community based services pursuant to Chapter 5 (commencing with Section 9400) of Division 8.5 of the Welfare and Institutions Code.

The Multipurpose Senior Service project, which would have been repealed on June 30, 1983, except for the deletion of this date pursuant to Section 45 of this act, shall continue to serve clients determined to be eligible under Section 2176 of P.L. 97-35. These clients shall be certified or certifiable for placement in a skilled nursing facility. Individual Multipurpose Senior Service project sites shall be allowed to continue in modified form if the individual project site demonstrates cost-effectiveness. The transition from project to program status shall include cooperative efforts between the Health and Welfare Agency and the Department of Aging in concert with other affected departments.

SEC. 49. Except for the provisions of Sections 1, 4, 45, 47, and 48 of this act, the provisions of this act, shall not become operative until:

(a) The Governor submits the action plan and the fiscal proposal, as provided for in this act, to the Legislature.

(b) The Legislature approves these plans by statute.

(c) Funds are appropriated to implement these plans, in the State Budget for the 1984-85 fiscal year.

(d) The necessary waivers requested are approved by the federal government.

O

in the same manner that other assessments are collected.

SEC. 36. Section 13021 of the Unemployment Insurance Code is amended to read:

13021. (a) Every employer required to withhold any tax under Section 13020 shall for each calendar quarter, whether or not wages are paid in the quarter, file a withholding return in a form prescribed by the department, and pay over the taxes so required to be withheld. Except as provided in subdivisions (b) and (c) of this section, the employer shall file a withholding return and remit the total amount of income taxes withheld during the calendar quarter on or before the last day of the month following the close of the calendar quarter.

(b) The employer shall remit the total amount of income tax withheld during each first or second month of each calendar quarter, on or before the 16th day of the second calendar month or within three banking days of the 19th day of the third calendar month, respectively, if the income tax withheld for that month is more than three hundred fifty dollars ($350)

(c) The employer shall remit the total amount of income tax withheld from the first through the 19th calendar day of the third month of each calendar quarter, within three banking days of the 19th day of the third month if the income tax withheld for that period is more than two hundred twenty-two dollars ($222). Notwithstanding Section 1112, no interest or penalties shall be assessed against any employer who remits at least 95 percent of the amount required by this subdivision provided that the failure is not willful and any remaining amount due is paid with the next payment.

(d) The department may, if it believes such action is necessary, require any employer to make the return required by this section and pay to it the tax deducted and withheld at any time, or from time to time but no less frequently than provided for in subdivision (a).

(e) For the purpose of this section, payment is deemed complete when it is placed in a properly addressed envelope, bearing the correct postage, and it is deposited in the United States mail.

SEC. 37. Section 13004 of the Welfare and Institutions Code is amended to read:

13004. Counties, in expending the allocation for other county social services, shall provide (a) protective services for children and foster care services pursuant to Chapters 5 (commencing with Section 16500), 5.3 (commencing with Section 16525), and 5.5 (commencing with Section 16550) of Part 4, (b) protective services and foster care services for adults pursuant to Section 12251; (c) In-Home Supportive Services administration, (d) information referral services, and (e) transportation to and from health care facilities, or the location of other health care providers, when there is an urgent need for health care and transportation which is not otherwise available from other resources. These transportation services shall be maintained at least at the level provided by counties,

1 (d)

as part of health-related services as provided for in Section 12251, on September 30, 1981.

SEC. 38. Section 4 of Chapter 322 of the Statutes of 1982 is amended to read:

Sec. 4. There is hereby appropriated to the Secretary of the Business, Transportation and Housing Agency from the Transportation Planning and Development Account in the State Transportation Fund, the sum of one hundred seventy-three million dollars ($173,000,000) for allocation in the 1982–83 and 1983–84 fiscal years pursuant to the following sections of the Public Utilities Code:

(a) Section 99313	
Fiscal year 1982–83	$49,000,000
Fiscal year 1983–84	$72,000,000
(b) Section 99314	
Fiscal year 1982–83	$21,000,000
Fiscal year 1983–84	$31,000,000

SEC. 39. Section 19.13 of Chapter 326 of the Statutes of 1982 is amended to read:

Sec. 19.13. Notwithstanding any other provisions of law, the Department of Finance shall authorize the Controller to make periodic transfers from the Transportation Planning and Development Account, State Transportation Fund, to the General Fund. The total amount of the transfers shall be $36,216,000.

SEC. 40. Section 5 of Chapter 502 of the Statutes of 1982, as amended by Section 4 of Chapter 1610 of the Statutes of 1982, is amended to read:

Sec. 5. (a) On July 1, 1983, the Controller shall transfer six million dollars ($6,000,000) from the General Fund to the Ridesharing and Alternative Transportation Fund established by Section 1 of this act in anticipation of increased revenues as a result of the provisions of Section 2 of this act.

(b) On May 1, 1984, and on every May 1 thereafter, through May 1, 1988, the Franchise Tax Board shall provide to the Controller an estimate of the net revenue gain to the General Fund resulting from the amendments to Section 17204 of the Revenue and Taxation Code made by Section 2 of this act. The estimate shall include, but is not limited to, all of the following:

(1) An estimate of the revenue gain or loss to the General Fund which would have resulted if Section 2 of this act had not been enacted.

(2) A separate estimate of the revenue gain or loss to the General Fund resulting from each of the following provisions of Section 17204 of the Revenue and Taxation Code contained in Section 2 of this act:

(A) Subparagraph (B) of paragraph (4) of subdivision (a)

(B) Subparagraph (C) of paragraph (4) of subdivision (a)

(C) Subparagraph (E) of paragraph (4) of subdivision (a)

Assembly Bill No. 28

CHAPTER 10

An act to add Section 1656.2 to the Civil Code, to add Section 13337.5 to, to add and repeal Chapter 3 (commencing with Section 17281) of Part 4 of Division 4 of Title 2 of, and to add and repeal Part 5 (commencing with Section 17300) of Division 4 of Title 2 of, the Government Code, to amend Sections 6459, 6471, 6471.5, 6472, 6472.5, 6477, 6482, 6513, 6591, 6907, 6936, 19269, 25951, 25952, and 25954 of, to add Sections 100.6, 6051.5, 6051.6, 6051.7, 6051.8, 6201.5, 6201.6, 6201.7, 6201.8, and 25954.2 to, and to repeal Sections 25566 and 25951.5 of, the Revenue and Taxation Code, to amend Sections 803, 1111, 1113, 1129, 1184, and 13021 of the Unemployment Insurance Code, to amend Section 13004 of the Welfare and Institutions Code, to amend Section 4 of Chapter 322 of the Statutes of 1982, to amend Section 19.13 of Chapter 326 of the Statutes of 1982, and to amend Section 5 of Chapter 502 of the Statutes of 1982, relating to fiscal affairs, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 17, 1983. Filed with Secretary of State February 17, 1983.]

LEGISLATIVE COUNSEL'S DIGEST

AB 28, Robinson. Fiscal affairs.

(1) This bill would state that the purpose of the bill is to enact legislation to reflect an agreement between the Legislature and the Governor to achieve specified objectives.

(2) Existing law requires the Governor to annually submit to the Legislature a budget for the ensuing fiscal year, containing itemized statements for recommended state expenditures and estimated state revenues.

This bill would provide that the annual Budget Act shall not provide for projected expenditures in excess of projected revenues. It would also state that it is the intention of the Legislature that in the event, after enactment of the Budget Act, revised estimates of expected revenues or expenditures, or both, show that expenditures will exceed estimated revenues, expenditures should be reduced or revenues increased, or both, to ensure that actual expenditures do not exceed actual revenues for that fiscal year.

These provisions would become operative on July 1, 1983.

(3) Existing law permits various methods of temporary borrowing by the state.

This bill would in addition allow, until June 30, 1985, temporary borrowing by the issuance of notes or other short-term instruments authorized by the Pooled Money Investment Board upon written request of the Governor. Any note issued would be a general

CHAPTER 30-050 SERVICE PROGRAM NO. 1: INFORMATION AND REFERRAL SERVICES

30-051 GENERAL 30-051

.1 Information and referral services means those activities by social service staff to:

.11 Enable persons to have current and accurate knowledge about the available public and private resources established to help alleviate socio-health problems.

.12 Provide short-term help to enable persons to identify and gain access to resources appropriate to their needs.

.13 Provide beneficiaries under the California Medical Assistance Program (Medi-Cal) with health-related transportation to meet an urgent need as specified in Welfare and Institutions Code 13004.

.113 Welfare and Institution Code 13004 states: The transportation services shall be maintained at least at the level provided by counties as part of health-related services as provided for in the Welfare and Institutions Code Section 12251 on September 30, 1981.

a. Welfare and Institutions Code Section 12251 stated as of September 30, 1981, in part: the term "social services" includes health-related services and transportation services as such services are defined in order to secure maximum federal financial participation.

.2 Goals

.21 This service program, because of its special, generalized characteristics, shall be considered to be serving goals I, II, III, IV, V designated in 30-001.21.

.22 Services activities provided to an individual under this service program may be directed at any goals designated in 30-001.21. Such goals need not be specified.

30-052 SPECIAL DEFINITIONS 30-052

.1 "Health-related transportation" means taxing a Medi-Cal beneficiary to and from a provider of health care services which are within the scope of benefits of the Medi-Cal program.

.2 "Urgent need" means a medical condition for which prompt medical treatment is required to avoid permanent injury or severe pain.

30-053 SPECIAL PROGRAM CHARACTERISTIC 30-053

The intent of this service program is to provide immediate, short-term response to needs for information and referral in connection with human service resources. All other considerations shall be subordinate to that intent. Therefore:

.1 Services under this program may be provided to individuals without requiring a formal application, developing a service plan, specifying a goal and maintaining an individual client record.

EXCEPTION: A SOC 295 form, or an approved CWD equivalent, shall be completed before health-related transportation is provided to any eligible person. The form may be completed through either personal or telephone contact.

.2 Recipients with needs, identified during the brief information and referral episode which require more extensive involvement shall be given the opportunity to apply for the services of another more appropriate service program.

30-054 PERSONS SERVED 30-054

.1 Eligibility.

All persons, regardless of income or status, are eligible to receive services under this program.

EXCEPTION: Only currently eligible and certified Medi-Cal beneficiaries are eligible for the health-related transportation component of this program.

.2 Need for service.

Any person who requests information and/or referral services shall be considered to be in need of those services.

Subsequent to the first increase pursuant to this section, each additional increase in the Title XVI federal benefit levels added to the payment schedules of Section 12200, excepting subdivision (h), shall be based on the difference between the federal benefit levels immediately applicable prior to an increase thereto and the federal benefit levels immediately applicable thereafter.

The director shall notify the Secretary of the United States Department of Health, Education and Welfare of the amount of the increases to be added pursuant to this section to the payment schedules in Section 12200, no later than 15 working days following the date on which the director is notified by the secretary in writing of the amounts of the increases to federal benefits. * * *

(Amended by Stats.1980, c. 511, p. 1433, § 8.)

1 42 U.S.C.A. § 1382 et seq.

2 42 U.S.C.A. § 401 et seq.

1980 Amendment. Deleted provisions relating to the effect of an increase in federal benefits under Part A of Title XVI of the Social Security Act by reason of § 161 of the Social Security Act or an increase for reasons other than cost of living and accompanied by an increase in federal benefits under Title II of the Social Security Act.

§§ 12205.1, 12205.2. Repealed by Stats.1980, c. 511, p. 1433, §§ 9, 10

Section 6.4 of Stats.1976, c. 348, p. 974, quoted in the Historical Note under this section in the main volume, was repealed by Stats.1980, c. 511, p. 1434, § 11.

ARTICLE 6. SERVICES

§ 12251. Social services

As used in this article, and Article 7 (commencing with Section 12300), the term "social services" includes * * * in-home supportive services, information and referral services, * * * protective services, * * * and out-of-home care services as such services are defined by the department in order to secure maximum federal financial participation.

(Amended by Stats.1982, c. 978, p. ——, § 31, urgency, eff. Sept. 13, 1982, operative July 1, 1982.)

ARTICLE 7. IN-HOME SUPPORTIVE SERVICES

Sec.
12301.2. Use of time for task guidelines [New].
12306. Payment of matching funds by state; reimbursement of counties.
12306.1. Application of section 12306; financial obligation of state.
12310. Pilot projects; methods for reducing program costs.
12311. Waivers; evaluation of pilot studies.
12312. Pilot projects; legislative reports.
12314. Pilot program [New].

§ 12300. Purpose; inclusions; remuneration of persons under a legal duty to provide services: respite care

The purpose of this article is to provide in every county in a manner consistent with the provisions of this chapter and the Annual Budget Act those supportive services identified in this section to aged, blind, or disabled * * * persons, as defined under this chapter, who * * * are unable to perform the services themselves and who cannot safely remain in * * * their homes or * * * abodes of * * * their own choosing * * * unless such services are provided.

Supportive services shall include, to the extent available funds allow, domestic services and services related to domestic services, heavy cleaning, nonmedical personal services, accompaniment by a provider when needed during necessary travel to health related appointments or to alternative resource sites and other essential transportation as determined by the director, yard hazard abatement, protective supervision, teaching and demonstration directed at reducing the need for other supportive services, and paramedical services which make it possible for the recipient to establish and maintain an independent living arrangement.

Where such supportive services are provided by a person having the legal duty pursuant to the Civil Code to provide for the care of his or her child who is the recipient, such provider of supportive services shall receive remuneration for such services only when the provider leaves full-time employment or is prevented from obtaining full-time employment because no other suitable provider is available and where the inability of such provider to provide supportive services may result in inappropriate placement or inadequate care.

Such providers shall be paid only for the following supportive services: services related to domestic services, nonmedical personal services, accompaniment by a provider when needed during necessary travel to health related appointments or to alternative resource sites, * * * other essential transportation as determined by the director, and protective supervision only as needed because of the functional limitations of the child and paramedical services * * *.

To encourage maximum voluntary services, so as to reduce governmental costs, respite care shall also be provided. Respite care is temporary or periodic service for eligible recipients to relieve persons who are providing care without compensation.

(Amended by Stats.1981, c. 69, p. ——, § 16, urgency, eff. June 17, 1981, operative July 1, 1981.)

1982 Legislation.

Section 3 of Stats.1982, c. 1309, p. ——, provides: "It is the intent of the Legislature in deleting the word 'comfort' from Section 12300 of the Welfare and Institutions Code, in Section 16 of Chapter 69 of the Statutes of 1981 (Senate Bill No. 633), to allow counties to provide services to individuals who apply for or receive in-home supportive services based upon their individual need for services. It is not the intent of the Legislature in deleting the word 'comfort' to authorize the state or counties to make reductions in service levels without an individual assessment."

§ 12301. Legislative intent; program reductions caused by insufficient appropriations

The intent of the Legislature in enacting this article is to provide supplemental or additional services to the social and rehabilitative services in Article 6 (commencing with Section 12250) of this chapter. The Legislature further intends that necessary in-home supportive services shall be provided in a uniform manner in every county based on individual need consistent with the appropriation provided for such services in the annual Budget Act and the provisions of this chapter, in the absence of alternative in-home supportive services * * * provided by an able and willing individual or local agency at no cost to the recipient, except as required under Section 12304.5. An able spouse who is available to assist the recipient shall be deemed willing to provide at no cost any services under this article except non-medical personal services and paramedical services.

If the amount appropriated by the annual Budget Act is insufficient to meet all service needs, program reductions shall occur. The department shall notify counties and the Joint Legislative Budget Committee whenever the department's estimate of the cost of providing all the service needs exceed the amount appropriated in the Budget Act.

The following priorities are established to direct counties and the department on how to implement needed program reductions:

(a) Reduction in the frequency with which non-essential services are provided.

(b) Elimination of non-essential service categories.

(c) Termination or denial of eligibility to persons requiring only domestic services.

(d) Termination or denial of eligibility to persons who, in the absence of services, would not require placement in a medical out-of-home care facility.

(e) Per capita reduction in the cost of services authorized.

Any program reductions shall be implemented so as to avoid, to the extend feasible within budgetary constraints, out-of-home placements.

The counties and the State Department of Social Services shall utilize these options in the order of their appearance. In no event shall services be terminated or denied to any eligible person who in the absence of services would require medical out-of-home care. In no event shall services be terminated or denied to any eligible person who in the absence of such services would become unemployed.

Nonessential services are routine mending, ironing, heavy cleaning, domestic services, yard hazard abatement except for snow removal, teaching and demonstration and any other services specified by the department. Restrictions on nonessential services shall be excepted on a case by case basis when denial or termination of such services would result in placement in a medical out-of-home facility or in

Article 1 —

GENERAL PROVISIONS

Sec.
14200. Short title.
14200.1. Purpose.
14201. Legislative intent.
14203. State agency; designation; regulations.
14204. Contracts by department with one or more prepaid health plans on nonbid basis; exception.
14205. Applicability of provisions of chapter 7.
14206. Prepaid health plan or pilot project not deemed transaction of insurance or subject to certain Insurance Code provisions; security requirements.

Article 1 was added by Stats.1972, c. 1366, p. 2721, § 9, operative July 1, 1973.

Administrative Code References

Prepaid health plans, see 22 Cal.Adm.Code 53000 et seq.

Law Review Commentaries

California's prepaid health plan program: Can patient be saved? David F. Chavkin and Anne Treseder (1977) 25 Hast.L.J. 655.

§ 14200. Short title

This chapter shall be known and may be cited as the Waxman-Duffy Prepaid Health Plan Act.

(Added by Stats.1972, c. 1366, p. 2721, § 9, operative July 1, 1973.)

Historical Note

Applicability of Stats.1972, c. 1366, to existing prepaid health plan contracts renewed prior to July 1, 1973, see Historical Note under § 14000.

Cross References

Plan contracts, see Health and Safety Code § 1373.

Notes of Decisions

1. Validity

This chapter which deals with prepaid health plans is not unconstitutional as violative of equal protection because chiropractors must become part of a prepaid health plan established by other providers of health care services and director of health care services in order to participate in a prepaid health plan. California Chiropractic Ass'n v. Human Relations Agency (1979) 154 Cal.Rptr. 255, 91 C.A.3d 141.

§ 14200.1. Purpose

The purpose of this chapter is to afford persons eligible to receive benefits under Chapter 7 (commencing with Section 14000) of

this part the opportunity to enroll as regular subscribers in prepaid health plans, without reference to the race, sex, age, religion, creed, color, national origin or ancestry of any eligible person.

(Added by Stats.1972, c. 1366, p. 2721, § 9, operative July 1, 1973.)

Historical Note

Applicability of Stats.1972, c. 1366, to existing prepaid health plan contracts renewed prior to July 1, 1973, see Historical Note under § 14000.

Administrative Code References

Prepaid health plans, see 22 Cal.Adm.Code 53000 et seq.

§ 14201. Legislative intent

The intent of the Legislature is to provide, to the extent feasible, through the provisions of this chapter and the necessarily related provisions of Chapter 7 (commencing with Section 14000) of this part, recipients of public assistance and medically indigent aged and other persons with the opportunity to enroll in prepaid health plans. It is further intended that this legislation is to benefit the people of the State of California by:

(a) Encouraging the development of more efficient delivery of health care to Medi-Cal recipients.

(b) Reducing the inflationary costs of health care.

(c) Improving the quality of medical services rendered to those eligible enrollees as defined in this chapter and Chapter 7 (commencing with Section 14000) of this part.

(d) Reducing administrative costs of operating the Medi-Cal Act by allowing prepaid health plans to assume substantial costs of administration and utilization controls that are now assumed by the State Department of Health Services.

(Added by Stats.1972, c. 1366, p. 2721, § 9, operative July 1, 1973. Amended by Stats.1973, c. 142, p. 432, § 97, eff. June 30, 1973, operative July 1, 1973; Stats.1977, c. 1252, p. 4678, § 859, operative July 1, 1978.)

Historical Note

Applicability of Stats.1972, c. 1366, to existing prepaid health plan contracts renewed prior to July 1, 1973, see Historical Note under § 14000.

The 1973 amendment substituted in subd. (d) "State Department of Health" for "Department of Health Care Services".

The 1977 amendment added "Services" to the departmental name.

§ 14203. State agency; designation; regulations

For purposes of administering this chapter and Chapter 7 (commencing with Section 14000) of this part, the department is hereby

designated as the single or appropriate state agency with full power to administer and adopt regulations in order to secure full compliance with applicable provisions of state and federal laws.

(Added by Stats.1977, c. 1046, p. 3175, § 7. Amended by Stats.1979, c. 373, § 390.)

Historical Note

The 1979 amendment substituted "department" for "State Department of Health".

Library References

Social Security and Public Welfare ⇐241.105.

C.J.S. Social Security and Public Welfare § 125.

§ 14204. Contracts by department with one or more prepaid health plans on nonbid basis; exception

Pursuant to the provisions of this chapter, the department may contract with one or more prepaid health plans in order to provide the benefits authorized under this chapter and Chapter 7 (commencing with Section 14000) of this part. Contracts entered into pursuant to this chapter shall be awarded on a nonbid basis, except that contracts with prepaid health plans which are fiscal intermediaries at risk may be awarded on either a bid or nonbid basis.

(Added by Stats.1977, c. 1036, p. 3104, § 6, eff. Sept. 23, 1977. Amended by Stats.1978, c. 704, § 1, eff. Sept. 11, 1978.)

Historical Note

The 1978 amendment added the exception at the end of the section.

Library References

Social Security and Public Welfare ⇐241.65.

C.J.S. Social Security and Public Welfare §§ 137, 138.

§ 14205. Applicability of provisions of Chapter 7

Except where the context otherwise requires, or where specific exceptions are authorized, all provisions of Chapter 7 (commencing with Section 14000) of this part shall be applicable to the provisions of this chapter and the violation of the provisions of this chapter or any rule or regulation adopted pursuant thereto shall be deemed to be a violation of Chapter 7.

(Added by Stats.1977, c. 1036, p. 3104, § 6.1, eff. Sept. 23, 1977.)

§ 14206. Prepaid health plan or pilot project not deemed transaction of insurance or subject to certain Insurance Code provisions; security requirements

(a) No prepaid health plan or pilot program shall be deemed to transact insurance or to be subject to any provision of the Insurance Code by virtue of negotiating, executing, or performing a prepaid health plan or pilot program contract under this chapter, or by virtue of compliance with the provisions of such a prepaid health plan or pilot program contract, including, but not limited to, creation, segregation, or maintenance of security to protect or safeguard the performance of such a prepaid health plan or pilot program contract. The director may require such security in respect to any such contract including, but not limited to, securities, surety bonds, or evidences of governmental debt, of the kinds, in the manner, and to the extent provided by the prepaid health plan or pilot program contract.

(b) Prepaid health plans or pilot programs to which the state is a party under the provisions of this chapter, and contracts and arrangements embodying such plans or programs shall not be subject to the provisions of law prescribing the forms of hospital or medical service or insurance contracts or requiring approval thereof or of the form thereof, by any state officer or agency except the director or the department.

This exemption applies, but is not limited to: (1) Chapter 4 (commencing with Section 10270) of Part 2 of Division 2 of the Insurance Code, (2) Section 11069 of the Insurance Code, and (3) Section 11513 of the Insurance Code. However, the exemption provided for in this section shall not exempt any insurer subject to taxation under Part 7 (commencing with Section 12001) of Division 2 of the Revenue and Taxation Code from the tax imposed under such part on gross premiums derived from contracts under this chapter.

(Added by Stats.1977, c. 1036, p. 3104, § 6.2, eff. Sept. 23, 1977.)

Library References

Insurance ⊂⊃2. C.J.S. Insurance § 1 et seq.

(7) Debt instruments.

(8) Any ownership interest which consists of, or is convertible to, equity investments in a current or proposed prepaid health plan or subcontractor.

(b) Ownership interest in terms of fair market value shall not be less than the greater of:

(1) $1,000.

(2) Five percent or more of the total fair market value of all equity investments in the entity, including ownership interests convertible to such investments.

(c) Convertible debt includes bonds, notes, debentures and mortgages.

NOTE: Authority cited: Sections 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14201, 14251, 14256, 14261, 14262 (a) (b) (c), 14300, 14301, 14302, 14303, 14303.1, 14303.2, 14304, 14308, 14312, 14402, 14405, 14406 (a) (b), 14408 (d), 14409 (a) (b), 14410, 14411 (a) (b), 14412, 14413, 14450, 14451, 14451.5 (a) (b), 14452, 14452.5, 14454, 14455, 14456, 14459, 14460, 14475, 14476, 14477, 14478, 14479, 14480, 14481 and 14482, Welfare and Institutions Code.

HISTORY:

1. New section filed 7-5-78; effective thirtieth day thereafter (Register 78, No. 27).

53150. Unit Medical Record.

NOTE: Authority cited: Sections 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14201, 14251, 14256, 14261, 14262 (a) (b) (c), 14300, 14301, 14302, 14303, 14303.1, 14303.2, 14304, 14308, 14312, 14402, 14405, 14406 (a) (b), 14408 (d), 14409 (a) (b), 14410, 14411 (a) (b), 14412, 14413, 14450, 14451, 14451.5 (a) (b), 14452, 14452.5, 14454, 14455, 14456, 14459, 14460, 14475, 14476, 14477, 14478, 14479, 14480, 14481 and 14482, Welfare and Institutions Code.

HISTORY:

1. New section filed 7-5-78; effective thirtieth day thereafter (Register 78, No. 27).
2. Repealer filed 12-30-81; effective thirtieth day thereafter (Register 82, No. 1).

53152. Vendor.

Vendor means any person who provides services or supplies to a prepaid health plan or subcontractor of a prepaid health plan and who does not have a subcontract with the prepaid health plan or plan subcontractors.

NOTE: Authority cited: Sections 14124.5 and 14312, Welfare and Institutions Code. Reference: Sections 14201, 14251, 14256, 14261, 14262 (a) (b) (c), 14300, 14301, 14302, 14303, 14303.1, 14303.2, 14304, 14308, 14312, 14402, 14405, 14406 (a) (b), 14408 (d), 14409 (a) (b), 14410, 14411 (a) (b), 14412, 14413, 14450, 14451, 14451.5 (a) (b), 14452, 14452.5, 14454, 14455, 14456, 14459, 14460, 14475, 14476, 14477, 14478, 14479, 14480, 14481 and 14482, Welfare and Institutions Code.

HISTORY:

1. New section filed 7-5-78; effective thirtieth day thereafter (Register 78, No. 27).

Article 3. Operational Requirements

53200. Organization and Administration.

(a) Each plan shall have the organizational and administrative ability to carry out its contractual obligations, including but not limited to the following:

(1) An unrestricted Knox-Keene license or pending application therefor.

(2) A medical director as specified in Section 53246.

(3) A grievance procedure as specified in Section 53260.

(4) Member and enrollment reporting systems which fulfill the plan's contractual obligations.

(5) A data-reporting system which provides reports required under the contract to the Department on a timely basis.

(6) Financial records and books of account fully disclosing the disposition of all Medi-Cal program funds received. Such records and books shall be maintained on the accrual basis in accordance with generally accepted accounting principles.

NOTE: Authority cited: Section 14312, Welfare and Institutions Code. Reference: Sections 14251, 14308, 14450, and 14459, Welfare and Institutions Code.

HISTORY:

1. Amendment filed 12-30-81; effective thirtieth day thereafter (Register 82, No. 1).

53210. Scope of Services.

(a) Except as provided in Section 14257 of the Welfare and Institutions Code, each plan shall provide the following health care services:

(1) Physician services.

(2) Hospital outpatient department services.

(3) Laboratory and X-ray services.

(4) Pharmaceutical services and prescribed drugs.

(5) Hospital inpatient care.

(6) Skilled nursing facility care.

(7) A continuing program of preventive health care services, appropriate to the needs of the projected plan population, which:

(A) Satisfies the requirements of Title 10, California Administrative Code, Section 1300.67(f).

(B) Includes the provision of Child Health and Disability Prevention Program services to members under the age of 21 in accordance with the provisions of Title 17, California Administrative Code, Sections 6800–6874.

(b) In addition to the health care services specified in (a), above, each plan shall provide the full scope of services set forth in this subdivision in Chapter 3, Article 4, beginning with Section 51301, and in Chapter 11, beginning with Section 59998, unless certain services are specifically excluded under the terms of the contract.

(c) The Director shall establish the scope and duration of services to be covered by any plan contract.

(d) A plan may elect to provide services which are not included in Section 14053, Welfare and Institutions Code. A plan shall obtain the prior approval of the Director if such services are provided at a cost to members. Each member shall be notified of the scope of such additional services offered by the plan and the charges therefor:

(1) During the enrollment process.

(2) Any time the scope of such services is changed.

(3) Prior to rendering such services.

(e) Each plan shall meet the requirements of Sections 51163 and 51305.1 through 51305.7 of this subdivision, in providing needed human reproductive sterilization services.

NOTE: Authority cited: Section 14312, Welfare and Institutions Code. Reference: Sections 14304.5 and 14256, Welfare and Institutions Code.

HISTORY:

1. Amendment of subsection (d) filed 12-10-79; effective thirtieth day thereafter (Register 79, No. 50). For prior history, see Register 78, No. 27.

2. Amendment filed 12-30-81; effective thirtieth day thereafter (Register 82, No. 1).

53212. Availability of Services.

(a) The Director shall determine the availability of services to be provided under the plan contract.

(b) Each plan shall obtain departmental approval prior to making any substantial change in availability or location of services to be provided under the contract, except in the case of unforeseen circumstances. A proposal to change the location of services or reduce their availability shall be given to the Department at least 30 days prior to the proposed effective date.

NOTE: Authority cited: Section 14312, Welfare and Institutions Code. Reference: Sections 14450, 14452.3, 14452.4 and 14452.5, Welfare and Institutions Code.

HISTORY:

1. Amendment filed 7-5-78; effective thirtieth day thereafter (Register 78, No. 27).
2. Amendment of subsection (h) filed 12-10-79; effective thirtieth day thereafter (Register 79, No. 50).
3. Repealer of subsections (c)–(h) filed 12-30-81; effective thirtieth day thereafter (Register 82, No. 1).

53214. Pharmaceutical Services and Prescribed Drugs.

(a) Each plan shall provide, either directly or through subcontracts, the services of pharmacies and pharmacists. Such pharmaceutical services shall be available to members during reasonable hours as specified in the contract.

(b) Prescribed drugs shall be provided to members in accordance with all applicable laws and regulations.

(c) Pharmaceutical services shall include as a minimum the following functions:

(1) Supervising the efficient distribution of drugs.

(2) Providing pharmaceutical consultative services when appropriate, which are:

(A) Consultation with members concerning drug therapy in which the pharmacist asks the member if he is currently taking any drugs, and informs him on what is being taken, how to take it, what to expect, what special precautions should be observed and how the medication is to be properly stored. The purpose of this consultation is to assure that the member understands the proper use of the drug and that the prescriber's intentions will materialize in a drug regimen of optimal effectiveness, safety and duration.

(B) Professional consultation with prescribers, or other members of the health care team, in which the pharmacist discusses drug effects, dosage regimens, interactions, side effects, toxicities, antidotes, drugs of choice for disease conditions and in all other ways acts as the drug information specialist to the health care team.

(3) Participating in in-service training programs for plan staff to provide current information about pharmaceuticals and their proper use in member treatment.

(4) Participating in drug utilization review. This shall include a review of:

(A) Member medical records to determine the range and types of drugs taken by members, and

(B) Drug utilization patterns of the plan in general.

(5) Participating in professional review activities relating to the use of pharmaceuticals.

HISTORY:

1. Amendment of subsection (c) filed 7-5-78; effective thirtieth day thereafter (Register 78, No. 27).

53216. Care Under Emergency Circumstances.

(a) Each plan shall provide, directly or by subcontract, at least one physician and a nurse on duty 24 hours a day, 7 days a week, at each location designated as a location where members can obtain medical services in the event of emergency circumstances, as defined in Section 51056.

(b) Written procedures shall be developed and applied by the plan regarding care under emergency circumstances provided by nonplan providers in and outside the service area. These procedures shall include but not be limited to the following:

(1) Verification of membership.

(2) Transfer of the medical management of the member to a plan provider.

(3) Payment within 60 days of receipt of properly documented bills for the services rendered to the member. Bills for services rendered to the member shall be submitted not later than the second month following the month of service, except for good cause.

(4) Written notice of action within 60 days of receipt of bills which are denied or reduced for any reason by the plan. The notice shall include a statement, subject to prior approval by the Department, of the provider's right to:

(A) Dispute the plan's rejection or reduction of the bill.

(B) Submit the dispute to the Department pursuant to Article 7.

(c) The plan shall provide or pay for medical transportation, as defined in Sections 51151 and 51323, to members needing care when such transportation is necessary due to the medical condition of the member.

(d) Each provider who agrees with a plan to provide emergency medical services shall furnish, when the course of treatment of a plan member under emergency circumstances requires the use of drugs, a sufficient quantity of such drugs to last until the member can reasonably be expected to have a prescription filled.

NOTE: Authority cited: Sections 14312 and 14454, Welfare and Institutions Code. Reference: Section 14454, Welfare and Institutions Code.

HISTORY:

1. Amendment filed 7-5-78; effective thirtieth day thereafter (Register 78, No. 27).
2. Amendment of subsection (b) filed 6-12-79; effective thirtieth day thereafter (Register 79, No. 24).

53218. Preventive Health Care Services.

NOTE: Authority cited: Sections 14132 and 14308, Welfare and Institutions Code. Reference: Sections 14304.5 and 14308, Welfare and Institutions Code.

HISTORY:

1. Amendment filed 12-10-79; effective thirtieth day thereafter (Register 79, No. 50). For prior history, see Register 78, No. 27.
2. Repealer filed 12-30-81; effective thirtieth day thereafter (Register 82, No. 1).

53220. Member Billing.

(a) A prepaid health plan, affiliate, vendor, subcontractor or sub-subcontractor shall not submit a claim to, demand or otherwise collect reimbursement from, a member or persons acting on behalf of a member for any services provided under this Chapter except to collect:

§ 14501.5. Sliding fee schedule

The Office of Family Planning shall develop and implement a sliding fee schedule for family planning services provided to individuals under this chapter. The fee schedule shall be based on family size and income.

(Added by Stats.1981, c. 69, p. —— § 26, urgency, eff. June 17, 1981, operative July 1, 1981.)

Library References

Social Security and Public Welfare ⇐241.100.
C.J.S. Social Security and Public Welfare § 134.

§ 14503. Eligibility for services; services offered; contracts

Family planning services shall be offered to all former, current or potential recipients of childbearing age (as provided by Public Law 92–603)[1] and provided to all such eligible individuals who voluntarily request such services. Such services shall be offered and provided without regard to marital status, age, or parenthood. Notwithstanding any other provisions of law, the furnishing of these family planning services shall not require the consent of anyone other than the person who is to receive them. Within the meaning of this section, the term "former, current or potential recipient" shall mean all persons eligible for Medi-Cal benefits under Chapter 7 (commencing with Section 14000) of this part and all persons eligible for public social services for which federal reimbursement is available under the federal Social Security Act,[2] except that the term "potential recipients" shall in all cases include all persons in a family where current social, economic and health conditions of the family indicate that the family would likely become a recipient of financial assistance within the next five years.

Family planning services shall include, but not be limited to:

(a) Medical treatment and procedures defined as family planning services under the published Medi-Cal scope of benefits.

(b) Medical contraceptive services such as diagnosis, treatment, supplies, and followup.

(c) Informational and educational services.

(d) Facilitating services such as transportation and child care services needed to attend clinic or other appointments.

To the extent the services under this section are not available under the Medi-Cal program, they shall be provided by contracts between authorized public or private agencies offering family planning services and the State Department of Health Services. Such contracts shall include to the maximum extent possible, cooperative funding and other financial arrangements which permit maximum use of available federal funds. Information and referral services only shall be available to all other families and children.

As the single state agency responsible for the state plan under Title XX of the federal Social Security Act,[3] the State Department of Social Services may provide family planning services pursuant to a purchase of services agreement with the State Department of Health Services from funds appropriated for such services. The agreement shall authorize the Office of Family Planning to implement a sliding fee schedule for family planning services provided to clients pursuant to Title XX of the federal Social Security Act in accordance with Section 14501.5.

(Amended by Stats.1981, c. 69, p. ——, § 26.5, urgency, eff. June 17, 1981, operative July 1, 1981.)

[1] 42 U.S.C.A. § 401 note.

[2] 42 U.S.C.A. § 301 et seq.

[3] 42 U.S.C.A. § 1397 et seq.

1981 Amendment. Inserted the second sentence of the fourth paragraph.

Law Review Commentaries

Minor's right to contraceptives: Problems in law and medicine. (1974) 7 U.C.D. Law Rev. 270.

Asterisks * * * indicate deletions by amendment

CHAPTER 8.7. ADULT DAY HEALTH CARE PROGRAMS

Operative Effect

Chapter 8.7 remains operative, subject to funding. See note under § 14520.

ARTICLE 1. GENERAL PROVISIONS

Operative Effect

Article 1 remains operative subject to funding. See, note under § 14520.

§ 14520. Short title

1982 Legislation.

Section 18 of Stats.1982, c. 1490, p. ——, repealed § 7 of Stats.19??, c. 1066, leaving Chapter 8.5 [now Chapter 8.7] in full force and effect.

Section 19 of Stats.1982, c. 1490, p. ——, provides:

"Chapter 3.5 (commencing with Section 1570) of Division 2 of the Health and Safety Code and Chapter 8.5 [probably should read Chapter 8.7] (commencing with Section 14520) of Part 3 of Division 9 of the Welfare and Institutions Code shall be operative only in a fiscal year during which the budget act for that fiscal year provides funding for the purposes of those chapters."

§ 14521. Legislative intent

It is the intent of the Legislature in enacting this chapter to establish adult day health care as a Medi-Cal benefit and allow persons eligible to receive the benefits under Chapter 7 (commencing with Section 14000) of this part, and who have medical or psychiatric impairments, to receive adult day health care services. It is the intent of the Legislature in authorizing such a Medi-Cal benefit to establish and continue a community-based system of quality day health services which will (1) ensure that older persons not be institutionalized prematurely and inappropriately, (2) provide appropriate health and social services designed to maintain older persons in their own homes, and (3) establish adult day health care centers in locations easily accessible to the economically disadvantaged older person.

(Amended by Stats.1982, c. 1490, p. ——, § 11.)

ARTICLE 2. ELIGIBILITY, PARTICIPATION, AND DISCHARGE

Operative Effect

Article 2 remains operative, subject to funding. See note under § 14520.

§ 14529. Multidisciplinary health team

The multidisciplinary health team conducting an assessment pursuant to Section 14528 shall consist of at least the individual's personal physician or a staff physician, or both, a registered nurse, social worker, occupational therapist, and physical therapist. The assessment team shall:

(a) Determine the medical, psychosocial, and functional status of each participant.

(b) Develop an individualized plan of care, including goals, objectives, and services designed to meet the needs of the person, which shall be signed by each member of the multidisciplinary team, except that the signature of only one physician member of the team shall be required.

(c) At least quarterly reassess the participant's individualized plan of care and make any necessary adjustments to the plan.

(Amended by Stats.1982, c. 1490, p. ——, § 12.)

§ 14530. Individualized plans of care; participation agreement

Individualized plans of care and individual monthly service reports shall be submitted to the department. Each provider shall supply a written statement to the participant explaining what services will be provided and specifying the scheduled days of attendance. Such statement, which shall be known as the participation agreement, shall be signed by the participant and retained in the participant's file.

(Amended by Stats.1982, c. 1490, p. ——, § 13.)

State/Territory: California

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

California's Medicaid program covers the following transplants: bone marrow, cornea, kidney, heart and liver. Transplant centers must follow the prescribed protocols outlined in Section 1138 (a) of the Social Security Act. State law mandates each general acute care hospital to develop a protocol for identifying potential organ and tissue donors. Participating hospitals must assure that the deceased individual's next of kin are informed of all their options including the option to decline. The hospital's protocol must encourage reasonable discretion and sensitivity to the family circumstances and must take into account the deceased individual's religious beliefs . Finally, the hospital is also required to notify an organ and tissue procurement organization of potential organ donors and cooperate in the procurement of the anatomical gift. Kidney transplant centers must meet Medicare's requirements for facilities, conditions of participation, and conditions of coverage. Except for cornea transplants, all organ transplants require prior authorization to be obtained from a Medi-Cal field consultant. The following is a description of each transplantation and criteria for selection of patients and facilities.

BONE MARROW TRANSPLANT

Bone Marrow Transplant (BMT) is covered for certain types of anemia, leukemia, osteopetrosis, immunodeficiency diseases, lymphomas, Hodgkin's Disease, neuroblastomas, genetic diseases, and Thalassemia. Criteria for selection of patients and facilities are as follows:

A. Patient Selection Criteria:

1. The patient must be less than 50 years old except when a syngeneic donor is available.

2. The patient is one for whom current medical therapy is not as likely as BMT to be curative or to prevent progressive disability or death.

3. The BMT is intended to cure the patient of the disease for which BMT is performed.

4. After the BMT is performed the patient is expected to have a range of physical and social function consistent with activities of daily living.

5. The patient does not have an additional progressive disorder which would otherwise seriously jeopardize survival; i.e., another life-shortening or seriously disabling condition.

6. A Medi-Cal approved BMT center has evaluated the patient and has recommended a BMT.

7. Either a syngeneic or HLA histocompatible sibling (allogeneic) donor is available or current medical literature has established that a less favorable related donor match, without in vitro treatment of the marrow, produces equivalent results. Except for a three locus match for SCID and Autologous Bone Marrow Transplant (ABMT) for selected high risk cases of Acute lymphoblastic leukemia (ALL) and Acute non lymphoblastic leukemia (ANL), BMT procedures involving in vitro treatment of the donor marrow are not covered. Any subsequent BMT requires prior authorization by a Department medical consultant, based on separate justification and documentation of the reasons for failure of the previous graft(s) and presentation of evidence to establish that the subsequent graft will be successful.

B. Facility Selection Criteria.

1. The facility must be a fully equipped tertiary hospital with:

   a. a major commitment to teaching and research.

   b. active hematology/oncology, radiation/oncology, immunology and infectious disease departments, and

   c. Reverse isolation facilities:

2. The facility must have a successful performance record.

3. It must be documented that there is a need for a BMT Center in the facility's region.

4. The facility must have appropriate patient management plans and protocols, including patient selection criteria and plans for the long-term management and liaison with the patient's family and referring physician.

5. Patients selected for BMT must be reviewed by an interdisciplinary transplant review (or equivalent) committee.

6. The facility must be committed to the performance of at least ten BMT's per year and there is evidence that:

   a. the facility staff has the appropriate expertise and commitment for participation.

   b. the facility has an active clinical organ transplant program involving immunosuppressive techniques and reverse isolation and qualified nursing staff trained in these areas.

7. The facility has the capacity and commitment to conduct a systematic evaluation of clinical outcome and costs of BMT.

8. For bone marrow transplants for persons under 21 years of age, the facility must have approval of California Children Services and comply with its standards.

LIVER TRANSPLANT

Liver transplantation (LT) is a Medi-Cal program benefit for the treatment of end-stage liver disease. Related services such as obtaining, preserving and transporting the homograft, evaluation of the candidate, and transporting the candidate when medically necessary are covered subject to prior authorization. Criteria for the selection of patients and facilities are as follows:

Patient Selection Criteria

1. LT is only available for patients in instances where current medical therapy will not prevent progressive disability and death.

2. Current medical therapy will not prevent progressive disability and death;

3. The patient does not have other major system disease (e.g., lung, heart, brain, or renal damage) which would preclude surgery or indicate a poor potential for rehabilitation and there is every reasonable expectation, upon considering all the circumstances involving the patient, that there will be strict adherence to the long-term difficult medical regimen which is required;

4. The LT is likely to prolong life for at least five years and to restore a range of physical and social function suited to activities of daily living;

5. A Kasai procedure (portoenterostomy) is not indicated or has failed to prevent progressive deterioration;

6. The patient is not in an irreversible terminal state (moribund) and on a life support system;

7. The patient does not have portal vein thrombosis, cancer, bacterial or fungal infection outside the hepatobiliary system, or active abuse of alcohol or other hepatotoxic drugs;

8. The underlying original hepatic disease is not expected to recur and/or to cause substantial disability within a period of five years;

9. The patient does not have multiple uncorrectable severe major system congenital anomalies;

10. The patient has a diagnosis appropriate for LT (see supplemental lists of approved diagnoses, Attachments 3 and 4); and

11. A facility with appropriate expertise has evaluated the patient and has recommended a LT and a facility with a LT service which meets the criteria below has indicated willingness to undertake the procedure.

Facility selection criteria:

1. The facility has available expertise in hepatology, gastroenterology, immunology, infectious disease, nephrology, pulmonary medicine, pediatrics, pathology, pharmacology, anesthesiology, and oncology;

2. The LT program staff has extensive experience and expertise in the medical and surgical treatment of hepatic disease;

3. Transplant surgeons trained in the technique at an institution with a well-established LT program, are available on the staff;

4. The transplantation program has adequate services to provide specialized psychosocial and social support for patients and families;

5. Blood bank services capable of supplying large quantities of blood on short notice are available;

6. Satisfactory arrangements exist for donor procurement services;

7. The institution is committed to a program of at least 25 LTs a year;

8. The center has a consistent, equitable, and practical protocol for selection of patients (at a minimum the above Patient Selection Criteria must be met);

9. The center has the capacity and commitment to conduct a systematic evaluation of outcome and cost;

10. In addition to hospital administration and medical staff endorsement, hospital staff support exists for such a program;

11. The hospital is licensed for renal dialysis and has an active dialysis service;

12. The hospital is licensed for renal transplantation or has an active ongoing organ transplantation program with a tissue laboratory and extensive skills in tissue typing and immunological techniques;

13. The hospital is licensed for open-heart surgery or has demonstrated capability to do hemoperfusion;

14. The facility is a full service tertiary hospital with significant teaching and research functions; and

15. Initial and continuing approval of a LT center requires evidence of a record of success and safety with LT and that the program continues to meet the above criteria. Initial approval as a LT center requires performance of at least 12 LTs with a one-year survival of at least 67 percent.

HEART TRANSPLANT

Heart transplantation (HT) is a Medi-Cal program benefit for the treatment of end-stage heart disease; coverage includes preoperative evaluation, HT surgery and harvesting, preservation, and transportation of the donor heart. Only one HT evaluation per patient may be authorized within a 12-month period and repeat of expensive tests, such as cardiac catheterization, performed outside the HT center, will not be covered unless the medical necessity is documented. All services related to HT require prior authorization. Patient and facility selection criteria are as follows:

Patient Selection Criteria:

1. The patient is one for whom current medical therapy will not prevent progressive disability and death and the expectation of survival does not exceed a few months;

2. The HT is likely to prolong life for at least five years and to restore a range of physical and social function suited to activities of daily living;

3. The patient does not have other major system disease (e.g., lung, liver, brain, or renal damage) which would preclude surgery or indicate a poor potential for rehabilitation;

4. There is reasonable expectation, upon considering all the circumstances involving the patient, that there will be strict adherence to the long-term difficult medical regimen which is required;

5. The patient is not in an irreversible terminal state (moribund);

6. The patient does not have any active infection, a recent pulmonary infarct, insulin-dependent diabetes mellitus, evidence of elevated and fixed pulmonary vascular resistance, or a positive cross-match between recipient serum and donor lymphocytes;

7. The patient has a diagnosis of:

   a. End-stage congestive heart failure, or

   b. (In selected cases) inoperable congenital heart disease, or cardiovascular trauma, or cardiovascular tumor; and

8. A facility with appropriate expertise has evaluated the patient and has recommended a HT and a HT facility is willing to perform the operation.

Criteria for approval of a facility as an HT center:

1. The facility must be a fully equipped tertiary hospital with major teaching and research programs and with a licensed, active, large scale open heart program (minimum of 500 cardiac catheterizations per year), an established program of percutaneous transvenous endomyocardial biopsy, and an identified, stable surgical team that has demonstrated low mortality rates in an active open heart program involving at least 250 procedures per year);

2. Initial and continuing approval of a HT center requires it to have significant experience with HT and a record of acceptable success and safety. Prior to consideration of any application by an institution to be designated as a HT center under the Medi-Cal program, there must be submitted evidence of performance of at least 10 per year. Costs must not be significantly higher than those at established HT centers.

3. The facility must have patient selection criteria at least as strict as those listed above and requests for Treatment Authorization Requests (TARs) must first be approved by the facility's interdisciplinary transplant review committee or equivalent committee(s).

4. The facility must have adequate patient management plans and protocols, including plans for the long term management of the patient and liaison with the patient's referring physician;

5. The facility is committed to performance of at least 25 HTs a year and there is evidence that:

   a. The commitment of the facility includes all departments and is at all staff levels;

   b. Facility staff has both the expertise and the commitment for participation in the medical, surgical and other relevant areas including cardiology, cardiovascular surgery, anesthesiology, immunology, infectious diseases, nursing, neurology/neurosurgery, oncology (particularly for the diagnosis and treatment of lymphoproliferative disease) and social services;

   c. The component staff teams are integrated into a comprehensive team with clearly defined leadership and corresponding responsibility;

   d. The facility has an active clinical organ transplantation program (other than heart) involving appropriate immunosuppressive techniques and a satisfactory record of efficacy and safety;

   e. The nursing staff is trained in the special problems of managing immunosuppressed patients;

   f. The neurology/neurosurgery group is available for donor selection procedures necessary and to establish brain deaths;

g. The legal officer is familiar with transplantation laws and regulations; and

h. There are adequate logistical plans for organ procurement meeting legal and ethical criteria, as well as yielding viable transplantable organs in reasonable numbers;

6. The facility's commitment to research, development and transmission of knowledge is such that there is the capacity to conduct a systematic evaluation of clinical outcome and costs; and

7. The location of the hospital does not duplicate the availability of the HT service in a given geographic area, but rather, improves access to the service in other geographic areas.

8. For additional HT centers to be designated, the number of patients needing HT and for whom donor organs are available must exceed the capacity of existing HT center(s).

KIDNEY TRANSPLANT

Renal transplantation is available for individuals who have chronic irreversible renal insufficiency which limits life expectancy to a few weeks or months. Criteria for patient and facility selection are as follows:

Patient Selection Criteria:

1. The patient must be free of major infections and able to withstand the operational trauma after maximum improvement from preoperative care.

2. The patient must have a relatively normal lower urinary excretory tract.

3. There must be documentation that a satisfactory donor is available who has passed examination, renal function tests, and histocompatibility tests.

4. There must be evidence of chronic irreversible renal insufficiency such as evidence of azotemia, creatine clearance of less than 20 ml. per minute, findings from renal function tests or histocompatibility tests.

Facility Selection Criteria

Renal Transplant Centers must be a specialized unit of a hospital and be capable of providing acute dialysis, renal transplantation, and peritoneal dialysis or other means for removing toxic or excessive waste products from the blood.

The hospital shall meet the following requirements:

1. At least fifteen transplants should be performed per annum to demonstrate capability and high quality.

2. The hospital shall offer both living related donor and cadaver donor transplant services.

3. The hospital shall coordinate and with other facilities providing care for end-stage renal disease and accept referrals from those which do not.

4. The hospital must operate under a written hepatitis control program incorporating the recommendations of Report 33, January 1971, of the Hepatitis Surveillance Program of the Center for Disease Control, Public Health Services, Atlanta, GA 30333.

5. The hospital must also be equipped to directly provide respiratory therapy, angiography, nuclear medicine, and Immunofluorescence studies. It must also have a twenty-four hour laboratory capability of performing the following determinations: C.B.C., B.U.N., creatinine, platelet count, blood typing and cross matching, blood gas analysis, blood pH, electrolytes, serum glucose, coagulation tests, spinal fluid examination, and urinalysis.

CORNEA TRANSPLANTS

The Medi-Cal program covers cornea transplants when medically necessary. Patient selection is determined by a licensed Ophthalmologist and surgeon. Cornea transplantation can be done either on an inpatient or outpatient basis depending on the needs of the patient. Hospitals and clinics must meet federal and state licensing standards. Ophthalmologists and surgeons must be licensed in accordance with their respective state boards. Their practices are reviewed by the State Board of Medical Quality Assurance.

Citation		Condition or Requirement
1932(a)(1)(A)	A.	Section 1932(a)(1)(A) of the Social Security Act.

The State of **California** enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

The various models have been in operation as follows: Sacramento Geographic Managed Care (GMC) as of April 1, 1994, Two-Plan Model as of January 22, 1996, and Healthy San Diego Geographic Managed Care as of October 16, 1998.

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

__X__ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

This program is called Medi-Cal Managed Care (MMC). The program is being implemented in select counties and ZIP Codes throughout California. All Medicaid beneficiaries, depending on the beneficiaries' geographic location, and Medi-Cal eligibility-related aid code, as described in Section D, are required to enroll in a managed care organization (MCO). Those Medicaid beneficiaries as described in Section G, are not subject to mandatory enrollment, but are permitted to voluntarily enroll in a MCO. Regardless of model, all MCOs are risk-comprehensive contracts.

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____i. fee for service;
__X__ii. capitation;
____iii. a case management fee;

Citation		Condition or Requirement
		____iv. a bonus/incentive payment; ____ v. a supplemental payment, or __X_vi. other. (Please provide a description below). **Former Agnews Residents:** **The managed care health plans that the Department contracts with to provide services to Former Agnews Residents will paid under a non-risk arrangement as described in 42 CFR 438.2 and 42 CFR 447.362. The Department's payments to the health plans will not exceed what the Department would have paid on a fee-for-service basis for services furnished to health plan enrollees plus the net savings of administrative costs the Department achieves by contracting with the health plans instead of purchasing the services on a fee-for-service basis.**
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3.	For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. __X_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4.	Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* **On an ongoing basis, DHCS employs many methods to ensure public involvement:**

Citation	Condition or Requirement

- **The Medi-Cal Managed Care Advisory Group: DHCS Medi-Cal Managed Care Division (MMCD) Advisory Group was formed in December 1998, as a vehicle to facilitate active communication between the Medi-Cal managed care program and all interested parties and stakeholders. The MMCD Advisory Group membership consists of advocacy groups, health plan representatives, medical associations, and the State's enrollment broker. The Advisory Group meetings are held in Sacramento and are chaired by the MMCD Division Chief. This group is routinely advised about issues relevant to Medi-Cal managed care, and is often solicited for feedback on issues such as informing materials and the State Quality Strategy.**

- **Tribal input is/will be solicited by direct inquiry to tribal councils and the California Rural Indian Health Board (CRIHB) regarding any future changes to the managed care program.**

- **Public input is/will be solicited in the future through published news articles produced by DHCS Public Information Office.**

1932(a)(1)(A)

i. The state plan program will___/will not_X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_X_/ voluntary_____ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory)

Medi-Cal Managed Care/ Two-Plan Model:

- **Los Angeles, except (*see list of excluded ZIP Codes)**
- **Kern, except (**see list of excluded ZIP Codes)**
- **San Bernardino, except (***see list of excluded ZIP Codes)**
- **Riverside, except (***see list of excluded ZIP Codes)**
- **Tulare**
- **Fresno**
- **Santa Clara**
- **Stanislaus**
- **San Joaquin**
- **San Francisco**
- **Alameda**
- **Contra Costa**

Excluded ZIP Codes

***The Los Angeles Region includes Los Angeles County with the exclusion of the following ZIP Code, which covers Santa Catalina: – 90704.**

****Kern County---93555 and 93556 Ridgecrest.**

Citation | Condition or Requirement

***The San Bernardino/Riverside Region includes San Bernardino County and Riverside County with the exclusion of the following rural ZIP Codes in these counties:

ZIP CODE	PREFERRED CITY NAME	COUNTY
92225	Blythe	Riverside
92226	Blythe	Riverside
92239	Desert Center	Riverside
92275	Salton City	Riverside
92280	Vidal	Riverside & San Bernardino
92242	Earp	San Bernardino
92252	Joshua Tree	San Bernardino
92256	Morongo Valley	San Bernardino
92267	Parker Dam	San Bernardino
92268	Pioneer Town	San Bernardino
92277	Twenty-Nine Palms	San Bernardino
92278	Marine Base Corp	San Bernardino
92284	Yucca Valley	San Bernardino
92285	Landers	San Bernardino
92286	Yucca Valley	San Bernardino
92304	Amboy/Cadiz	San Bernardino
92305	Angelus Oaks	San Bernardino
92309	Baker	San Bernardino
92310	Fort Irwin	San Bernardino
92311	Lenwood/Barstow	San Bernardino
92312	Barstow	San Bernardino
92314	Big Bear City	San Bernardino
92315	Big Bear lake	San Bernardino
92317	Blue Jay	San Bernardino
92319	Cadiz	San Bernardino
92321	Cedar Glen	San Bernardino
92322	Cedarpines Park	San Bernardino
92323	Cima	San Bernardino
92325	Crestline	San Bernardino
92326	Crest Park	San Bernardino
92327	Daggett	San Bernardino
92332	Essex	San Bernardino
92333	Fawnskin	San Bernardino
92338	Ludlow (Newberry Springs)	San Bernardino
92339	Forrest Falls	San Bernardino
92341	Green Valley Lake	San Bernardino

Citation | Condition or Requirement

92342	Helendale	San Bernardin
92347	Hinkley	San Bernardin
92352	Lake Arrowhead	San Bernardin
92356	Lucerne Valley	San Bernardin
92363	Needles	San Bernardin
92364	Nipton	San Bernardin
92365	Newberry Springs	San Bernardin
92366	Mountain Pass	San Bernardin
92368	Oro Grande	San Bernardin
92372	Pinon Hills	San Bernardin
92378	Rimforest	San Bernardin
92397	Wrightwood	San Bernardin
92382	Running Springs	San Bernardin
92385	Skyforest	San Bernardin
92386	Sugarloaf	San Bernardin
92391	Twin Peaks	San Bernardin
92398	Yermo	San Bernardin
93528	Johannsburg	San Bernardin
93554	Johannsburg	San Bernardin
93558	Red Mountain	San Bernardin
93562	Trona	San Bernardin
93592	Trona	San Bernardin

Medi-Cal Managed Care/Geographic Managed Care (GMC):

- **Sacramento**
- **San Diego**

ii. county/counties (voluntary) **see Section B item 5 i above**
iii. area/areas (mandatory) **see Section B item 5 i above**
iv. area/areas (voluntary) **see Section B item 5 i above**

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. _X_The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)

2. ___The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

Not Applicable

Citation	Condition or Requirement
42 CFR 438.50(c)(2) 1902(a)(23)(A) 1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. _X_The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. _X_The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. _X_The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. _X_The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362	7. _X_The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met. **Former Agnews Residents:** **The managed care health plans that the Department contracts with to provide services to Former Agnews Residents will paid under a non-risk arrangement as described in 42 CFR 438.2 and 42 CFR 447.362. The Department's payments to the health plans will not exceed what the Department would have paid on a fee-for-service basis for services furnished to health plan enrollees plus the net savings of administrative costs the Department achieves by contracting with the health plans instead of purchasing the services on a fee-for-service basis.**
42 CFR 438.50(c)(6) 45 CFR 74.40	8. _X_The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.
	D. Eligible groups
1932(a)(1)(A)(i)	1. List all eligible groups that will be enrolled on a mandatory basis. **Title XIX of the Social Security Act applicable sections:** **A. 1925** **B. 1905 (u)(2)** **C. 1931** **D. 1902(a)(10)(A)(i)(III)**

Citation	Condition or Requirement

E. 1902(a)(10)(A)(i)(IV)
F. 1902(a)(10)(A)(i)(VI)
G. 1902(a)(10)(A)(i)(VII)

Enrollment will be mandatory for beneficiaries who meet the criteria for A-G above, and are not ineligible to participate because they fail to meet any of the following additional criteria listed in a-c below:

a. Are eligible to receive Medi-Cal services that are not limited in scope. If services are limited in scope, the beneficiary is not eligible to enroll. Limited scope means a subset of the scope of benefits as described in the state plan with or without a share-of-cost.
b. Have been determined to have a share-of-cost equal to zero. If the share of cost is greater than zero, the beneficiary is not eligible to enroll.
c. Have been found by their county welfare department to be eligible under one of the following programs (Section D 2i-2vii) and do not qualify for an exemption to mandatory enrollment.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. _X_Recipients who are also eligible for Medicare.

In the case of a beneficiary who is in a mandatory aid code whose eligibility is subsequently changed to a voluntary aid code, the individual would be allowed to exercise their right to disenroll from a managed care plan. Individuals are informed of their rights by the enrollment broker at the time they become eligible for Medicare.

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. _X_Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Members of Federally recognized tribes, Native American Indians, Alaskan Native, or qualified non-Indian (means the immediate family member), or a non-Indian who has been verified by the

Citation		Condition or Requirement
		Indian Health Service Center as receiving services there, may choose to disenroll and receive health care services from an Indian Health Service Center. Alternatively, American Indians and Alaskan Natives may choose to enroll on a voluntary basis.
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii.	_X_Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) **42 CFR 438.50(d)(3)(ii)**	iv.	___Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) **42 CFR 438.50(3)(iii)**	v.	_X_Children under the age of 19 years who are in foster care or other out-of-the-home placement. **For children who cannot be immediately identified as foster care by Medi-Cal's unique identifier, upon obtaining concurrence of the child's caretaker, a county director of social services, his/her designee in one of the designated counties, or the Probation Officer in the case of a foster child who is a ward of the court, a foster child may be enrolled voluntarily into an available managed care plan. Similarly, an adoptive parent may voluntarily enroll an Adoption Assistance Program (AAP) child into an available managed care plan.**
1932(a)(2)(A)(iv) **42 CFR 438.50(3)(iv)**	vi.	_X_Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. **See comment in Section D item v. above**
1932(a)(2)(A)(ii) **42 CFR 438.50(3)(v)**	vii.	___Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. **Children receiving services through the California Children's Services (CCS) program in geographic areas served by either the Two-Plan, San Diego GMC, or Sacramento GMC models of managed care will be mandatorily enrolled into a Two-Plan or GMC model MCO under a separate Section 1915(b) waiver.**
	E.	Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1.	Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services*

Citation	Condition or Requirement
	at a specific clinic or enrolled in a particular program.) **The State's definition includes all children receiving services through the CCS program.** **Children receiving services through the CCS program in geographic areas serviced by the Two-Plan , San Diego GMC, or Sacramento GMC models of managed care will be mandatorily enrolled into a Two-Plan or GMC model MCO under a separate Section 1915(b) waiver. Identification of this population is possible by:** • **A Medi-Cal unique identifier on the eligibility file.** • **CMS Net-an automated case management system that includes the CCS programs' demographic data, or** **For those counties not on CMS Net, a manual report is prepared by the county and distributed to each managed care plan the recipient is enrolled in.**
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: _X__i. program participation, ____ii. special health care needs, or ____iii. Both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. _X__i. yes ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; **By Medi-Cal or other unique identifier or by self identification** ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; **Not applicable**

Citation	Condition or Requirement
	iii. Children under 19 years of age who are in foster care or other out-of-home placement; **By Medi-Cal or other unique identifier or by self identification** iv. Children under 19 years of age who are receiving foster care or adoption assistance. **By Medi-Cal or other unique identifier or by self identification**
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* **Children not otherwise identified by unique identifiers are allowed to self-identify to the State and be exempt from mandatory enrollment.**
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* i. Recipients who are also eligible for Medicare. **There is a unique other health coverage code on the Medi-Cal Eligibility Data System (MEDS) record.** ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. **By self identification**
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment **1. The following populations may be excluded from mandatory enrollment upon filing an exemption with the State's enrollment broker, and receiving services through traditional Fee-For-Service (FFS).**

Citation	Condition or Requirement

A. Non-Medical:
Enrolled in a waiver for skilled nursing services in their home.

B. Medical:
Beneficiaries being treated for a complex condition from a physician, who is participating in the Medi-Cal program but is not a contract provider of themanaged care plans in the service area, may request exclusion from mandatory enrollment upon filing an exemption with the State's enrollment broker and receive services through traditional FFS. Complex conditions include:

1. **Pregnancy;**
2. **Cancer;**
3. **Organ transplant (except Kidney) – or are scheduled for one;**
4. **Renal disease and have dialysis at least two times a week;**
5. **A disease that affects more than one organ system (such as diabetes);**
6. **HIV positive;**
7. **A neurological disorder (such as multiple sclerosis); and**
8. **Other conditions as determined by the State.**

2. The following populations are excluded from enrollment in an MCO under this state plan:

A. If another health coverage code indicates Medicare coverage, the beneficiary will be excluded from enrollment unless they are enrolled in Medicare in the same plan or their plan partners approved Medicare Advantage Special Needs Plan.
B. Individuals eligible for Medicaid after paying a share of cost.
C. Individuals already residing in a Long Term Care (LTC) (includes: nursing facility, sub-acute, pediatric, and intermediate care facilities) facility at the time Medicaid is approved.
D. Individuals who have an eligibility period that is less than 3 months.
E. Individuals who have an eligibility period that is only retroactive.
F. Individuals eligible for Limited Services (See page 7).
G. Members of a commercial health plan through private insurance that are identified as having specific "other health coverage" at the time of initial enrollment eligibility. If an individual acquires other health coverage after enrollment in a plan, the State will allow the member to remain enrolled on a voluntary basis in the plan.

Citation	Condition or Requirement

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

1. **Enrollment in a plan shall be voluntary for eligible beneficiaries who meet all of the following criteria as described in section 2 of the California State Plan, including related attachments and supplements:**

   A. **Are eligible to receive services that are not limited in scope.**
   B. **Have been determined to have a share of cost equal to zero.**
   C. **Have been determined by their county welfare department to be eligible for one of the following programs:**

      Title XIX of the Social Security Act applicable sections:

      1. **1902(a)(10)(A)(ii)(XVIII)**
      2. **1902(a)(10)(A)(i)(I)**
      3. **1902(a)(10)(C)**
      4. **1902(a)(10) (A)(ii)(X)**
      5. **1902(a)(10)(A)(i)(II)**
      6. **1902(a)(10)(A)(ii)(XVII)**
      7. **1634**

   D. **Beneficiaries enrolled in one of the following forms of other health coverage, obtained after enrollment in a Medi-Cal managed care plan, shall be allowed to remain enrolled:**

      1. **Medicare HMO (subject to restrictions on Page 12, Section F 2-A).**
      2. **Tricare HMO.**
      3. **Kaiser HMO.**
      4. **Any other HMO, or prepaid health plan in which the enrollee is limited to a prescribed panel of providers for comprehensive services.**

H. Enrollment process.

Use of an enrollment broker:

Process:

The enrollment broker will conduct in-person enrollment sessions in each county with all Medicaid eligible beneficiaries that voluntarily choose to attend.

Citation	Condition or Requirement

Beneficiaries are informed of these sites through the presentation schedule included in the enrollment packets. Referrals are also made by eligibility workers and the enrollment broker's call center staff.

The State assures the information will be presented to non-English speaking participants in a culturally competent manner. Accommodations for the visually and hearing impaired, and the physically disabled are made available.

***GMC exception: In San Diego County, county employees will conduct in-person enrollment sessions with all Medicaid eligibles that voluntarily choose to attend.**

Content:

The content of the enrollment sessions includes information as follows:

- **A. Description of what is a Medi-Cal MCO;**
- **B. Who must vs. who may join a MCO;**
- **C. Those who are not eligible to join a MCO;**
- **D. Those who may be exempt from mandatory participation in a MCO;**
- **E. Service and items covered by the MCO;**
- **F. Benefits outside the managed care contract, and how participants may access these services;**
- **G. How to change Primary Care Providers (PCPs) or MCOs; and**
- **H. Grievance and appeal rights provided by the MCOs and the State Hearing process, and the procedures for using them.**

Enrollment Packets:

The population subject to the initial process includes those Medi-Cal beneficiaries in mandatory aid codes who are eligible for enrollment in a managed care plan.

Beneficiaries who are newly eligible for enrollment in a mandatory aid code managed care plan are mailed an Intent to Assign (IA) Packet. The IA process is as follows:

- **A. The enrollment broker receives the newly eligible list and an IA record is generated;**
- **B. The IA records are sent and received by the enrollment broker mail house, which has three days to process them;**
- **C. The enrollment broker prepares the IA packet and mails it to the newly eligible. Five days are allowed for mail time;**

Citation	Condition or Requirement

D. The newly eligible has 30 days to decide on a plan and respond with his/her decision; and

E. When the newly eligible's response is received, a transaction is processed and he/she is enrolled in the plan. The enrollment packet contains the directive that eligible beneficiaries may change plans at any time after this selection.

Annual Renotification Process:

Managed Care enrollees are again informed of their right to change health plans at any time during the Annual Renotification process. This process includes sending a notice to each enrollee that has been in the same plan for ten consecutive months. The notice includes a "tear off" postcard that can be mailed back requesting materials for changing health plans.

Should a beneficiary request disenrollment from their current plan during the renotification process or at any other time, the request will be processed no later than the end of the month following the month in which the request to disenroll is received by the enrollment broker.

(H. Enrollment Process Continued)

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Enrollment will be based upon maintaining a prior family-plan relationship, or where not possible, a default algorithm will be used. Assignments made for continuity of care are not considered to be default assignments.

Citation	Condition or Requirement

The State will use an enrollment broker, and the criteria for assigned enrollment are described below.

When a beneficiary is assigned to a plan, a weighted assignment method shall be used to determine the plan to be assigned. Considerations that apply include, but are not limited to, the following:

A. A beneficiary shall only be assigned to a managed care plan with a primary care service site in the same ZIP Code as the beneficiary's residence;
B. A beneficiary shall be assigned to the same managed care plan as:

1. that in which he/she was previously enrolled;
2. that in which a head of household (case head) is enrolled
3. if the case head is not enrolled in a plan, then that in which another family member is enrolled.

However, provided at least one family member has maintained managed care assignment history, and in order to preserve continuity of care, the following considerations shall be taken into account for each assignment:

A. Continuity of care is maintained at a case/household level;
B. At least one member of the household must remain continuously eligible within the county for continuity of care to be assigned to someone within that case;
C. If a member of the case loses eligibility for more than 120 days, the case history is archived; however, should the member re-establish eligibility, continuity of care will be restored based on the case;
D. If all members of the case lose eligibility for more than 120 days, the case is archived, and continuity of care is lost; and
E. If the entire case moves out of the county of eligibility, continuity of care is lost.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

Two-Plan and GMC plans are required to contract with traditional and safety net providers and they must make a reasonable effort to maintain the ongoing participation of these

Citation	Condition or Requirement
	types of providers. Plans are required to ensure that these providers are proportionately included in the assignment process for members who do not voluntarily select a primary care physician.
	ii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*
	A formula, based on eight performance measures, six of which come from Health Effectiveness Data and Information Set (HEDIS) and two safety net measures, determines the equitable distribution of Medi-Cal beneficiaries. The State's default process is based on health plan performance with a greater number of beneficiaries being assigned to higher performing Two-Plan and GMC health plans. A cap is placed on auto assignments preventing one plan from capturing a hundred percent of the defaults should one plan perform exceptionally well and another perform poorly.
	The two safety net measures ensure that plans are given credit for using traditional and safety net providers in their network. All distributions of beneficiaries to plans are checked by the State each month to determine that all auto-assignments are done correctly according to the formula. If a health plan is at capacity or cannot take enrollments for a particular period, the beneficiaries are distributed to the other health plans.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will____/will not_X_ use a lock-in for managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be within:
	30 days of receiving the enrollment packet.

Citation	Condition or Requirement
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* **Medicaid recipients who are subject to mandatory enrollment, but fail to make a choice within 30 days of receiving an enrollment packet, shall be automatically enrolled (defaulted) into a MCO as follows:** **A. If no response is received within 20 days of the mailing of the enrollment packet, an Intent to Default (ID) letter is mailed.** **o The ID letter will address:** **1. A reminder that unless the eligible responds to the IA packet, he/she will be assigned to a MCO by default, and the effective date of assignment, and;** **2. Reiterates the date in which he/she must respond by in order to preclude assignment.** **B. If still no response is received, a default transaction is created and sent to Medi-Cal Eligibility Data System (MEDS).** **C. Then a confirmation letter is generated and mailed to the beneficiary informing them of the name of the plan assigned and the effective date of the assignment.**
	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.) How are they notified of this right to change plans?* **If no response is received within 20 days of the mailing of the enrollment packet, an ID letter is mailed to the beneficiary. This letter informs the beneficiary that should they not be satisfied with the plan assigned to them, they are able to change plans by completing a choice form.** **The beneficiary may choose to change plans at any time after receiving the official default notification from the enrollment broker. If the beneficiary decides to change plans, the beneficiary may call the enrollment broker's toll-free telephone number for additional assistance.**

Citation	Condition or Requirement

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

The enrollment broker shall adhere to the State's algorithm for a performance-based auto-assignment of beneficiaries to the various managed care plans in Two-Plan and GMC Model counties, pursuant to State regulations (California Code of Regulations, Title 22, Section 53820), and written directives.

A description of the most significant parameters is as follows:

A. The distribution of auto-assignments will be determined based on an assessment of comparative plan performance on eight measures.

B. Six of the measures come from HEDIS: Childhood Immunizations: Combination 2, Well-Child Visits: 3rd – 6th Years of Life, Adolescent Well-Visits, Timeliness of Prenatal Care, Appropriate Medications for People with Asthma, and Cervical Cancer Screening. The DHCS used the first five measures for the first two years, and for Year three added one additional HEDIS measure, Cervical Cancer Screening. There are also two safety net provider support measures that were created through collaboration among MCOs and DHCS: Members Assigned to Safety Net Provider PCPs and Discharges at Disproportionate Share Hospital (DSH) Facilities.

C. For the HEDIS measures, a health plan will be awarded two points for a score that is statistically and significantly better than those of its competitor. If there is no statistical difference in rates, each plan will get one point.

D. For each of the safety net provider support measures, a plan will be awarded one point if its rate is 5 percent higher than that of its competitor, with an additional 0.25 (1/4) points awarded for each additional 5 percent difference, up to a maximum of two points being awarded for a difference of 25 percent or more.

E. For each of the first three years (Year three began on Dec 1, 2007 and ends November 30, 2008), the percentage of auto-assignments received by a plan will not change more than 10 percent from the prior year.

Citation	Condition or Requirement

F. Beginning in the second year, plans were awarded one point for demonstrating statistically significant improvement for each measure relative to prior year performance, with the possible loss of one point for a statistically significant decline in performance as well. Those plans determined by DHCS to have exceptionally strong performance automatically earn a point and are not required to demonstrate statistically significant improvement.

G. Eliminates the minimum enrollment level for LI.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The default rates are monitored through a reporting process. Health Care Options (HCO) receives daily, weekly, and monthly reports from the enrollment broker that are required for monitoring the default process. Monitoring is done as follows:

A. Review the Daily Status Report- provides a breakdown of enrollment into the Two-Plan and GMC plans in each managed care county and the default ratios for each county.

B. Review the Monthly Managed Care Maximum Enrollment Report – provides information on the maximum and minimum beneficiary enrollment capitations of all Two-Plan and GMC managed care plans.

C. Review the Monthly Enrollment Default Percentages Report –provides county specific default percentages for all managed care counties.

D. Review the MSC-B-M02 Monthly Enrollment summary – provides formula determined default percentage rates for the Two-Plan and GMC.

E. Review the Monthly Progress Report – provides a summary of the MSM-B-M22 Monthly Cumulative Medical Beneficiaries Assigned to Two-Plan and GMC plans.

F. Random sampling of the processed enrollment forms.

The default rates are monitored daily and determined on a monthly basis for plan accuracy.

Citation	Condition or Requirement

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _X__The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _X_This provision is not applicable to this 1932 State Plan Amendment.

4. ____The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

5. ____ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   _X_This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will___/will not_X_ use lock-in for managed care.
   Not Applicable

2. The lock-in will apply for ____ months (up to 12 months).

3. Place a check mark to affirm state compliance.

   _X__The state assures that beneficiary requests for disenrollment (with

Citation	Condition or Requirement
	and without cause) will be permitted in accordance with 42 CFR 438.56(c).
	4. Describe any additional circumstances of "cause" for disenrollment (if any). **The State does not limit disenrollment. The enrollee may request to switch plans at any time. However, actual disenrollment does not take effect until the first day of the following month.**
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	_X__The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM) **All services included in the approved California Medicaid State Plan are provided by the MCOs under this State Plan Amendment, with the following exceptions:** • **Services for major organ transplant procedures that are Medi-Cal benefits (except for kidney transplant).** • **Long Term care (LTC) services in a facility for longer than the month of admission plus one month.** o **For former Agnews residents, LTC is defined as care in a facility for longer than the month of admission plus three months.** • **Home and Community Based Services (HCBS) waiver program services authorized under section 1915 (c) of the Social Security Act, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver.** • **Services authorized by the California Children Services (CCS) program.** • **Mental health services which are outside the scope of PCPs. (Except in the cases of Western Health Advantage and Kaiser in Sacramento County. Kaiser is responsible for all mental health services (including inpatient and outpatient specialty mental health services) and Western Health Advantage is responsible for all outpatient mental health services).**

Citation	Condition or Requirement

- **Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health providers, with the exceptions listed above for Western Health Advantage and Kaiser in Sacramento County.**

- **Alcohol and substance abuse treatment services available under the Drug Medi-Cal program as defined in CCR, Title 22, Section 51341.1 and outpatient heroin detoxification services defined in CCR, Title 22, Section 51328.**

- **Fabrication of optical lenses provided through Prison Industry Authority optical laboratories.**

- **Directly observed therapy for treatment of tuberculosis provided by local health departments.**

- **Dental services as specified in CCR, Title 22, Section 51307 and Early Periodic Screening Diagnosis and Treatment (EPSDT) supplemental dental services as described in CCR, Title 22, Section 51340.1(a). However, Contractor is responsible for all Covered Services that are within the scope of the PCP regarding dental services.**

- **Acupuncture services as specified in CCR, Title 22, Section 51308.5 (Two-Plan model only).**

- **Chiropractic services as specified in CCR, Title 22, Section 51308 (Two-Plan model only).**

- **Prayer or spiritual healing as specified in CCR, Title 22, Section 51312 (Two-Plan model only).**

- **Local Education Agency (LEA) assessment services as specified in CCR, Title 22, Section 51360(b)(1) provided to a member who qualifies for LEA services based on CCR, Title 22, Section 51190.1(a).**

- **Any LEA services as specified in CCR, Title 22, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq., or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in CCR, Title 22, Section 51360.**

Citation	Condition or Requirement

- **Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of DHCS.**
- **Adult Day Health Care.**
- **Pediatric Day Health Care.**
- **Personal Care Services.**
- **State supported Services.**
- **Targeted case management services as specified in CCR, Title 22, Sections 51185(h) and 51351. Except that the MCO shall be responsible for: 1) coordinating health care with the Targeted Case Management (TCM) provider and for determining medical necessity of diagnostic and treatment services recommended by the TCM provider, and 2) ensuring access to services comparable to EPSDT TCM services for those members under age 21 who are not accepted for TCM services.**
- **Childhood lead poisoning case management provided by county health departments.**
- **Specific psychotherapeutic drugs and psychotherapeutic drugs classified as Anti-Psychotics and approved by the Federal Food and Drug Administration (FDA) after July 1, 1997.**
- **Specific Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) drugs and HIV/AIDS drugs classified as Protease Inhibitors, Nucleoside Reverse Transcriptase Inhibitors, Non-nucleoside Reverse Transcriptase Inhibitors, and Nucleoside Analog Reverse Transcriptase Inhibitor Combination approved by the FDA after July 1, 1997 and any future category of drugs for the treatment of HIV and AIDS, not previously classified and those classified as Fusion (Entry) Inhibitors, approved by the FDA after March 1, 2003.**

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will__X___/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

Citation	Condition or Requirement

2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

Two-Plan Model:

The State will contract with two MCOs in each county to provide services, and beneficiaries will have a choice between these two plans* (See exceptions below for Stanislaus, Tulare, and Fresno Counties).

In general, the State will contract with one MCO, referred to as the Local Initiative health plan and one MCO, referred to as the Commercial Plan. The Local Initiative is a locally developed comprehensive managed care system, developed under the leadership of the County Board of Supervisors. It is essentially a public-private partnership that will have a contractual obligation to include traditional and safety net providers in its network. If there is no Local Initiative in a particular county, the State may seek to contract with two Commercial Plans.

***In Stanislaus and Tulare, the County has designated a Commercial Plan to act as the Local Initiative. In Fresno County, there are two Commercial Plans.**

The Commercial Plan contractors in the Two-Plan Model are awarded through the competitive bid process in accordance with Title 22, CCR (California Code of Regulations), Section 53800(b)(1). The Request for Proposal (RFP) bidding method is used due to the highly complex nature of the services to be provided. The resulting contracts are generally entered into for a period of up to eight years, having an original term of five years with three one-year extensions. The average RFP process takes approximately 18 months to complete. Therefore, it should begin at least 18 months prior to end of the eight-year period. Since contracts for the Two-Plan contractors were executed at various dates, the RFP process is staggered so that various geographic areas are solicited during each proposal cycle.

For former Agnews residents: Services will be provided by the Medi-Cal managed care health plans that are operating as Local Initiatives in Santa Clara and Alameda counties, based on their networks' readiness to serve the health care needs of this population, if consumers, where applicable, choose to enroll.

Citation	Condition or Requirement
	GMC:
	The State will contract with multiple MCOs to provide services and beneficiaries will have a choice of no less than two plans.
	The selective contracting provision is not applicable to the GMC model
	4. __ The selective contracting provision is not applicable to this state plan.

CALIFORNIA MMIS
ALTERNATIVE CLAIMS PROCESSING ASSESSMENT SYSTEM

The California Claims Processing and Assessment System (CPAS) is designed to monitor the Contractor's claims processing system, and to evaluate the integrity of the Medi-Cal fiscal intermediary Contractor's Quality Control (QC) system. The California CPAS uses a select random sampling process to identify and review all claim types that are processed through the claims processing system. The QC plan, as specified within the contract, allows for the State, through the Department of Health Services, to conduct special studies of the Contractor's system.

The evaluation of the selected sample claims includes review of the following potential deficiency areas:

1. Payment for incorrect, inconsistent, or incomplete claims
2. Errors which result in incorrect, inconsistent, or incomplete data entries
3. Incorrect, inconsistent, or incomplete automated system programming
4. Payment to a provider not eligible to participate in the program
5. Payment for a service furnished to an ineligible individual
6. Payment for services not authorized by regulation or policy
7. Payments above allowable charges or costs
8. Payment for which an individual was responsible
9. Duplicate payment

Once deficiencies from the claims processing system are identified, they are transmitted to the Contractor in a Problem Identification Statement. The Problem Statement (Attachment 1) provides both the State and the Contractor with a standard method for identifying problems within the claims processing system. As required in the contract, the Contractor must respond to all problem statements and generate a Corrective Action Plan when a problem has been located.

The Corrective Action Plan (CAP) is a response to a Problem Statement concerning procedural or program problems which identifies the source of the problem within the system and provides a complete analysis. A written CAP must be received from the Contractor within 30 days from error identification and notification. The CAP is reviewed by the State and the Contractor will either be notified in writing that the CAP is approved for implementation or the CAP is disapproved and a corrected version must be resubmitted. Once written notification has been transmitted, the Contractor will have a 30 days to implement the CAP.

The Contractor is required to submit a correction notification letter to the State by the 30th day to assure compliance with the CAP and resolution of the problem.

To ensure full accountability of all Problem Statements, the State requires the Contractor to submit a complete index of all problem statements generated, in progress, and resolved. This report is prepared on a weekly basis by the Contractor's QC section. The State also prepares a weekly internal problem statement work sheet that encompasses all of the essential activities that the Contractor is required to perform. Both the Contractor's Problem Statement index and the State's Problem Statement Worksheet are used to compare information and to ensure accuracy of data reported. This Problem Statement Worksheet not only provides a thorough audit trail, it also reports the full range of activities such as start dates and completion dates on all Problem Statements submitted to the Contractor. At the end of the fiscal year period, a final "open" and "closed" report is prepared. The final assessment sorts the problem statements into two categories - "open" the listing of all Problem Statements that have not been resolved and "closed" the listing of all problem statements that have been resolved with corrective action (if deemed necessary) completed. The final Problem Statement report would satisfy the CPAS annual reporting requirement (Attachment 2).

When the State or the Contractor discovers a potential erroneous payment which may require an adjustment, a Problem Statement is generated. As a direct result of the Problem Statement process, the Contractor is obligated to submit a summary of findings to the State within 10 days, and a CAP (which includes the Erroneous Payment Correction plan) within the contracted 60 days. Once the potential adjustment has been identified, the Contractor is obligated to submit to the State for approval a CAP that will specify the Erroneous Payment Correction (EPC) plan that will be implemented. The EPC has five (5) specific phases (Attachment 3) which identify the degree of the overpayment, and makes all of the necessary adjustments within the contractual timeframes.

The EPC plan allows for dialogue between the State and Contractor to discuss how to coordinate any and all possible claim adjustments. If appropriate, targeted letters may be sent to affected providers of the computed adjustments. A Provider Bulletin may be used to inform providers of adjustments that will occur, including the proposed dates for adjustment, warrant numbers, and whether off-setting balances have been established.

To ensure that all adjustments have been made, the Contractor is bound by the contract to maintain a thorough audit trail through the CP-0-07B Report (Attachment 4). This report is submitted to the State weekly for review.

The Department of Health Services' CPAS coordinates with the California State Controller's Office (SCO) to actively perform a pre and post payment audit of the Contractor's automated and manual claims system. The principal activity of the SCO is to review the electronic payment tapes and determine legality and propriety of those payments made. If the SCO identifies possible payment errors, they will submit to the Department a listing of:

1. claims in question
2. potential error amount
3. the adjusted amount
4. total of the potential overpayment

The State submits a Problem Statement that incorporates the SCO findings, thereby, notifying the Contractor of the deficiency. The Contractor has a total of 10 days to respond to the State with an analysis of the problem, and a total of 45 days to make all necessary adjustments. The Contractor is not obligated to submit an EPC plan; however, the Contractor is required to submit a CAP if deemed appropriate. The contract provides that SCO related adjustments be made within 45 days regardless of any circumstances. Once the State receives the Contractor's final summary of findings, it is reviewed for accuracy and forwarded to the SCO for information. In addition to the warrant reviews, the State will also conduct a post payment review of medical claims, professional/supplier. A random select sample is drawn and examined for propriety of payment. The objective of this study is to ascertain if any excessive dollar payments and/or duplicate payments have been made. If there are any deficiencies discovered or adjustments required, a Problem Statement is submitted, and the normal SCO/Problem Statement process is in effect.

The State compares the Contractor's data against an internal audit tracking worksheet. If there are any deficiencies within the report, the State notifies the Contractor in writing (with documentation) pointing out any and all identified deficiencies. Incorporated within the EPC worksheet is the specific dollar amount adjustment. This data is an ongoing report; therefore, at the end of the fiscal year an annual total is computed, along with those accounts that have not been resolved by year's end that will be carried over to the next fiscal period.

The EPC worksheet not only provides an audit trail on all accounts being reported, it also serves as a resource to monitor the Contractor's activities in this specific area.

CALIFORNIA DENTAL MMIS
ALTERNATIVE CLAIMS PROCESSING ASSESSMENT SYSTEM

This document adds the Alternative Claims Processing Assessment System (CPAS) Plan for California's Dental Medicaid Management Information System (CD-MMIS). The purpose of the addition is to include the State's process for monitoring the claims processing activities of its Fiscal Intermediary (FI) responsible for paying claims for dental services covered under California's Medicaid Program (Medi-Cal).

CPAS for the Medi-Cal dental program's (Denti-Cal) claims processing system assimilates the CPAS designed to monitor and evaluate the integrity of the claims processing and Quality Control (QC) systems used by the FI responsible for paying claims for the remainder of the Medi-Cal Program (all services other than dental).

Similar to the CPAS used for assessing the propriety of claims payment activities for claims paid for all other services covered by the Medi-Cal program, CPAS for Denti-Cal uses a select random sampling process to review claims which are identified through the FI's adjudicated claims monthly QC reports. The claims listed on these reports are those which have gone through an audit as part of the FI's QC system. Currently, only claims which require professional adjudication are included in the State's random sample. Approximately 90% of the dental claims fall under this category. The State is currently exploring a means by which the remaining claims can routinely be included into the sample.

In addition to the monthly random sample of claims, the Denti-Cal program relies on special studies which the Denti-Cal FI is contractually required to conduct when requested by the State. These studies provide an additional means by which the State evaluates the efficiency of the claims processing system.

RANDOM SAMPLE OF CLAIMS

The evaluation of the selected sample of claims processed by the State's Denti-Cal FI involves a review of the following potential deficiency areas:

1. Payment for incorrect, inconsistent or incomplete claims.
2. Errors which result in incorrect, inconsistent or incomplete claims.
3. Incorrect, inconsistent or incomplete automated system programming.
4. Payment to a provider not eligible to participate in the program.
5. Payment for a service furnished to an ineligible individual.
6. Payment for services not authorized by regulation or policy.

7. Payments above allowable charges or costs.

8. Payment for which an individual was responsible (share of costs).

9. Duplicate payment.

10. Appropriate professional adjudication.

ON-SITE CLAIMS AUDIT FOR APPROPRIATE PROFESSIONAL ADJUDICATION

The evaluation of appropriate professional adjudication, listed as Item 10 above, represents a review element which is unique to Denti-Cal due to the program's reliance on x-rays in determining whether a claim is payable. Prior to payment of any claim for which an x-ray is required (approximately 90% of all claims processed), the claim and accompanying x-ray are reviewed by a dental professional to determine if the x-ray adequately documents the need for the service(s) for which payment is requested.

In accordance with its contract, the Denti-Cal FI is required to make available to the State dental consultants an ongoing sample of contractor-processed claims which have undergone professional adjudication by the FI's dental professionals. The sample includes all supporting documentation, including x-rays as submitted by the provider. The sample includes approximately 200 claims per quarter.

State dental consultants perform a quarterly review of this randomly selected sample of fully adjudicated claims and present their findings to the FI within 15 calendar days of completion of their review. This audit is done to establish whether there is a discrepancy between what was approved by the FI's dental consultants and what should have been approved by their State counterparts. The State employs statistical definitions, procedures and formulas to compute the precision of the discrepancy between what the FI approved and paid and what the State would have approved and paid. The "Protocol for State Audit on the CD-MMIS System" describes this State audit process in more detail.

PROBLEM STATEMENT PROCESS

When deficiencies are identified in the manual or automated portion of the claims processing system, they are transmitted to the FI in a problem identification statement. The Problem Statements provide both the State and the FI with a standard method of identifying problems within the claims processing system.

CORRECTIVE ACTION PLAN

The FI is required to respond to all Problem Statements and generate a Corrective Action Plan (CAP) when the cause of the problem has been located. The CAP is a response to a Problem Statement concerning procedural or program problems and must identify the source of the problem within the system as well as provide a complete analysis of how

to resolve that problem. The FI is required to provide a written CAP within 30 days of the time that the error was identified and notification provided. If the problem relates to an error in provider payment or is identified as a priority, the CAP is required within 10 days of error identification and notification.

Upon receipt, the CAP is reviewed by the State after which the FI will be notified in writing that the CAP is either approved for implementation or disapproved, in which case, a revised version must be submitted. Once written notification of the State's approval is transmitted, the FI will have 30 calendar days to confirm correction with a written report to the State. The entire process of original notification or the FI's problem identification, must not exceed 60 days. Extensions of the 60-day time period are only granted by the State under special circumstances and on a request-by-request basis.

To ensure full accountability of all Problem Statements, the State requires the FI to submit a list of all Problem Statements generated, in progress and resolved. This report is prepared on a weekly basis by the FI's QC section. The State also prepares a weekly internal Problem Statement listing that encompasses all of the essential activities that the FI is required to perform.

FEDERAL REPORTING REQUIREMENT

At the end of the fiscal period, a final assessment of the Problem Statement activity is prepared. The final assessment sorts the Problem Statements into two categories - "open", the listing of all Problem Statements that have not been resolved, and "closed", the listing of all Problem Statements that have been resolved with corrective action (if deemed necessary) completed. This final Problem Statement report would satisfy the CPAS annual reporting requirements.

ERRONEOUS PAYMENTS

When the State or FI discover a potential erroneous payment which may require an adjustment, a Problem Statement is generated. When a Problem Statement is generated which involves potential erroneous payment, the FI is obligated to submit a CAP within 10 days of submittal of the Problem Statement and the correction notification letter within 60 days thereafter.

The Erroneous Payment Correction (EPC) plan allows for dialogue between the State and the FI to discuss how to coordinate any and all possible claim adjustments. If appropriate, letters may be sent to affected providers informing them of the computed adjustments. A provider bulletin may be used to inform providers of adjustments that will occur, including the proposed dated for adjustments, warrant numbers and whether off-setting balances have been established.

To ensure that all adjustments have been made, the FI is contractually obligated to maintain a thorough audit trail and to provide a status report to the State on a weekly basis.

SPECIAL STUDIES

Edits/Audits Review. The State's contract with the Denti-Cal FI requires the contractor to produce monthly reports on the accuracy of four different edits and audits, which will be identified by the State.

Systems' Development Group. The State's contract with the Denti-Cal FI required the contractor to establish a Systems Development Group (SDG). The primary purpose of the SDG is to design, develop, test and install State required modifications to the system. This includes all modifications or enhancements initiated by the State and, with the prior approval of the State, changes initiated by the contractor. Another responsibility of the SDG is to perform testing and simulation studies to assess the impact of proposed changes to the management information and claims processing system. Such studies include, but are not limited to, the impact of incurred benefit costs, administrative costs, and automated and/or manual procedures resulting from a change in edits, audits, benefits coverage or the surveillance parameters used in the advanced Surveillance and Utilization Review System (S/URS). The State exercises full control over the work to be performed by the SDG.

State of California—Health and Welfare Agency

Attachment 1

Department of Health Se

MMIS PROBLEM STATEMENT
(STATE INITIATED)

Control No. P89??2443

USE TYPEWRITER ONLY

PS Type: 17

MMIS USER ORGANIZATION'S USE

1. Originated by: Mary Goodman	3. Originating Unit: Case Development Section	5. Originator's Manager Signature:
2. Telephone: 322-1071	4. Mailing Address: 713 K Street, 1 Floor	6. Performance Analysis Approval:
7. Contract Reference:		8. ☐ New PS ☐ Reopen PS ☐ Addendum
		9. User Priority: ☐ Low ☐ Medium ☒ High
		10. Erroneous Payment Correction Plan Due: ☒ Yes

11. Title: [illegible]

12. System:	13. Overpayment (Recoup)	14. Underpayment
	$	$

15. Problem: (Use additional pages when necessary.)

Dr. Bernard Goetz was placed on Special Claims Review on Julian Date 9345. The following claims were incorrectly denied with Denial code 238.

1) 9838302611502 Date of Service Nov. 13, 1989
2) 9838302611402 Date of Service Nov. 29, 1989
3) 9838302611102 Date of Service Nov. 25, 1989
4) 9838343009002 Date of Service Nov. 30, 1989

also 9260420414402 - code 82565-24 was read incorrectly as 82505-24 and denied with EOB 262 (Date of service 11-11-89) and 0022420815101 - a claim for an office visit 90050 charge $50.00 was reimbursed at $5.00 (see attachment) please have these claimslines paid since they were incorrectly denied.

FOR FI's USE

Summary of Findings: (Use additional pages when necessary.)

Completed by	Date	Approved by	Date

FI—White FIMD—Yellow Originator—Pink Other—Goldenrod

DHS 6031 (1/89)

Attachment 2

REPORT-NO. PC-0-850 CALIFORNIA DEPARTMENT OF HEALTH SERVICES- MEDI-CAL ASSISTANCE PROGRAM PAGE 0001
REPORT-DATE 03/23/90 PROBLEM CORRECTION ONLINE REPORTS — PLOG MASTER LIST PRIOR UPDATE RUN 03/16/90

PROBLEM STATEMENT SUMMARY REPORT

WEEKLY TOTALS	P/S OPEN THIS WEEK STATE	CONTRACTOR	INTERM RESPONSE	CAPS GENERATED	CCRR GENERATED	OPEN PROBLEM STATEMENTS SMG	Q/C	TOTAL	CLOSED ITEMS WEEK	TOTAL	TOTAL P/S
01	009	005	003	000	003	337	052	389	000	608	997
02	005	001	010	000	003	329	057	386	008	617	1003
03	005	001	000	000	004	328	061	389	003	620	1009
04	004	004	000	000	010	323	061	384	012	631	1015
05	000	000	000	000	000	000	000	000	000	000	000
MTD	023	011	013	000	020	323	061	384	023	631	1015
MAR 90	023	011	013	000	020	323	061	384	023	631	1015
FEB 90	007	014	031	000	036	327	054	381	001	608	989
JAN 90	015	024	026	001	038	317	047	364	027	608	972
DEC 89	021	037	054	001	062	315	046	361	037	579	940
NOV 89	022	020	024	000	044	311	054	365	024	535	900
OCT 89	018	013	020	000	057	299	057	356	030	513	869
SEPT 89	020	027	062	002	054	307	059	366	043	479	845
AUG 89	021	025	028	000	033	290	078	368	038	439	807
JULY 89	014	014	069	000	043	284	070	354	028	409	763
JUNE 89	057	029	057	000	045	285	069	354	045	385	739
MAY 89	029	046	055	000	050	279	041	320	016	342	662
APR 89	015	021	022	000	033	246	028	274	038	325	599
MAR 89	017	025	021	000	053	246	040	286	036	283	569

CLAIM CONTROL NO.	RECIPIENT NUMBER	CLAIM TYPE	PROVIDER NUMBER	ADJ TYPE	ADJ RSN	ORIG. CLAIM CONTROL NO.	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
0014770101600	5460157343101	INPATIENT	HSP30327G	DEBIT	912	9156501500500	$2,524.45+	$10,842.71+	$8,318.26+
0014770102400	3910155760160	INPATIENT	ZZR00084F	DEBIT	912	9156501502800	$7,654.73+	$6,694.70+	$960.03-
0014770104200	4369564748859	INPATIENT	ZZR00038F	DEBIT	912	9156501507300	$2,936.34+	$6,666.92+	$3,730.58+
0014770104:00	3469479227813	INPATIENT	ZZR00108F	DEBIT	912	9156501400700	$1,067.76+	$6,230.26+	$5,162.50+
0014770104600	1969489263441	INPATIENT	HSP30571G	DEBIT	912	9156501507200	$2,135.52+	$2,994.84+	$859.32+
0014770104800	0469548235289	INPATIENT	ZZR00030F	DEBIT	912	9156501502600	$5,245.83+	$9,300.82+	$4,054.99+
0014770105600	3729553102629	INPATIENT	ZZT30447G	DEBIT	912	9156501402300	$3,523.20+	$5,109.82+	$1,586.62+
0014770106400	3460707130701	INPATIENT	ZZR00599G	DEBIT	912	9156501400900	$3,524.50+	$4,284.50+	$760.00+
0014770106700	2419564529310	INPATIENT	ZZR00179F	DEBIT	912	9156501502400	$5,822.45+	$14,510.90+	$8,688.45+
0014770107800	5069454646989	INPATIENT	HSP30464G	DEBIT	912	9156501502200	$8,542.08+	$25,089.85+	$16,547.77+
0014770108100	3030749856711	INPATIENT	ZZT31404F	DEBIT	912	9156501400600	$3,309.57+	$4,887.32+	$1,577.75+
0014770108200	4510092456001	INPATIENT	HSP30312H	DEBIT	912	9156501502100	$3,593.60+	$4,332.60+	$739.00+
0014770108800	2980023960101	INPATIENT	ZZR00033F	DEBIT	912	9156501501800	$704.90+	$5,770.77+	$5,065.87+
0014770112300	1966869764102	INPATIENT	ZZT30116F	DEBIT	912	9156501400500	$4,229.40+	$9,419.12+	$5,189.72+
0014770114500	5069547142851	INPATIENT	ZZR00154F	DEBIT	912	9156501501400	$9,022.72+	$16,577.72+	$7,555.00+
0014770114600	0169424245827	INPATIENT	ZZR00305F	DEBIT	912	9156501400400	$3,947.44+	$5,820.66+	$1,873.22+
0014770115400	5660377888060	INPATIENT	ZZT30082F	DEBIT	912	9156501501300	$2,402.46+	$7,971.56+	$5,569.10+
0014770115800	3730799644202	INPATIENT	ZZT30141F	DEBIT	912	9221505800900	$4,004.10+	$6,372.21+	$2,368.11+
0014770116500	1966897300101	INPATIENT	ZZT30116F	DEBIT	912	9156501400300	$3,242.54+	$11,728.33+	$8,485.79+
0014770116600	4360807525001	INPATIENT	ZZR00215F	DEBIT	912	9156501501100	$4,229.40+	$17,484.19+	$13,254.79+
0014770117100	3460726053702	INPATIENT	ZZR00599G	DEBIT	912	9156501400200	$4,229.40+	$7,042.90+	$2,813.50+
0014770118600	1969557190614	INPATIENT	HSP30571G	DEBIT	912	9156501500900	$3,665.48+	$7,326.48+	$3,661.00+
0014770118800	1915473661102	INPATIENT	ZZT30116F	DEBIT	912	9156501500800	$4,088.42+	$10,956.20+	$6,867.78+
0014770119400	3469518222289	INPATIENT	ZZR00599G	DEBIT	912	9156501400100	$4,229.40+	$8,938.40+	$4,709.00+
0014770119800	0429497347035	INPATIENT	ZZR00030F	DEBIT	912	9156501503400	$5,958.00+	$8,366.20+	$2,408.20+
0014770120000	4329586383148	INPATIENT	ZZR00125F	DEBIT	912	9156501500100	$3,965.13+	$5,[illegible]+	$[illegible]3.80+

0014770120800 **C 01**

REPORT NO. CP-0-09A
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-C L ASSISTANC. PROGRAM
PROCESSED ERRONEOUS PAYMENT CORRECTION REPORT

RUN ON 02/04/90 AT 10 39

CLAIM CONTROL NO.	RECIPIENT NUMBER	CLAIM TYPE	PROVIDER NUMBER	ADJ TYPE	ADJ RSN	ORIG. CLAIM CONTROL NO.	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
0014770120800	1965903617101	INPATIENT	HSP30581G	DEBIT	912	9156501501 0	$4,229.40+	$11,972.50+	$7,743.10+
0014770121600	1969557190614	INPATIENT	HSP30571G	DEBIT	912	9156501500 0	$1,973.72+	$6,079.02+	$4,105.30+
0014770121700	1969557190614	INPATIENT	HSP30571G	DEBIT	912	915650150020C	$4,229.40+	$7,009.40+	$2,780.00+
0014770121800	1969557190614	INPATIENT	HSP30571G	DEBIT	912	9156501 00 0	$4,229.40+	$7,269.71+	$3,040.31+
ADJ RSN TOTAL		912 ADJ RSN RC	30				$122,490.74+	$262,679.54+	$140,188.80+
FINAL TOTALS		ADJ RSN RC	30				$122,490.74+	$262,679.54+	$140,188.80+

D 01

REPORT NO. CP-O-09A
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
PROCESSED ERRONEOUS PAYMENT CORRECTION REPORT

RUN ON 02/04/90 AT 10 39

CLAIM CONTROL NO.	RECIPIENT NUMBER	CLAIM TYPE	PROVIDER NUMBER	ADJ TYPE	ADJ RSN	ORIG. CLAIM CONTROL NO.	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT

TOTAL ACTIVITY RECORDS READ	2,483,843		
TOTAL ADJUSTMENTS	4,803		
TOTAL DEBIT ADJUSTMENTS PROCESSED	1,748		
RETROACTIVE DEBITS	29	DOLLAR VALUE	$141,148.83+
RETROACTIVE CREDITS	01	DOLLAR VALUE	$960.03-
TOTAL PROCESSED VOIDS	00		
STANDARD	00	DOLLAR VALUE	$00.00+
RETROACTIVE	00	DOLLAR VALUE	$00.00+
TOTAL APPROVED BILLABLE LINES	5,614		

0014770108800 **H 01**

REPORT NO. CP-0-09B
REPORT DATE 02/04/90
PROVIDER NUMBER ZZR00033F

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION PROVIDER REPORT

RUN ON 02/04/90 AT 10 39

CLAIM CONTROL NO	CLAIM TYPE	ORIG. CLAIM CONTROL NO.	DATE OF SERVICE	ADJ TYPE	WARRENT DATE	AMOUNT BILLED	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
0014770108800	INPATIENT	9156501501800	86/10/21	912	87/01/20	$15,945.48+	$704.90+	$5,770.77+	$5,065.87+
** ADJ RSN TOTALS	912		CLAIMS R/C		1	$15,945.48+	$704.90+	$5,770.77+	$5,065.87+
** PROVIDER TOTALS			CLAIMS R/C		1	$15,945.48+	$704.90+	$5,770.77+	$5,065.87+

912 B 01

REPORT NO. CP-0-09C
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOU" PAYMENT CORKECTION ADJUSTMENT REPORT

RUN ON 02/04/90 AT 10 39

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
912	30	$714,650.25	$122,490.74	$262,679.54	$140,188.80
* TOTALS	30	$714,650.25	$122,490.74	$262,679.54	$140,188.80

B 01

REPORT NO. CP-0-09D
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION RESUB REPORT

PAGE
RUN ON 02/04/90 AT 10

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
CP-0-09D	NO TRANSACTIONS THIS REPORT				

B 01

REPORT NO. CP-O-09E
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION INTERNAL DENIAL RPT

RUN ON 02/04/90 : 10 39

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
CP-O-09E	NO TRANSACTIONS THIS REPORT				

B 01

REPORT NO. CP-0-09F
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION PROVIDER TOTAL REPORT

RUN ON 02/04/90 AT 10 10

PROVIDER NUMBER	PROVIDER NAME	CLAIMS	AMOUNT BILLED	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
HSP30312H	REDDING MEDICAL CENTER	1	$8,066.20	$3,593.60	$4,332.60	$739.00
HSP30327G	LOMA LINDA UNIVERSITY	1	$29,852.73	$2,524.45	$10,842.71	$8,318.26
HSP30464G	DOCTORS MEDICAL CENTER	1	$61,789.53	$8,542.08	$25,089.85	$16,547.77
HSP30571G	CHARTER SUBURBAN HOSPIT	5	$114,328.76	$16,233.52	$30,679.65	$14,445.93
HSP30581G	DOCTORS HOSP OF LAKEWOOD	1	$35,478.10	$4,229.40	$11,972.50	$7,743.10
ZZR00030F	ORGVILLE HOSPITAL	2	$36,599.49	$11,203.83	$17,667.02	$6,463.19
ZZR00033F	MT ZION HOSPITAL	1	$15,945.48	$704.90	$5,770.77	$5,065.87
ZZR00038F	SANTA CLARA VLY MED CEN	1	$14,246.58	$2,936.34	$6,666.92	$3,730.58
ZZR00084F	ST JOSEPHS HOSPITAL	1	$26,773.75	$7,654.73	$6,694.70	$960.03-
ZZR00108F	SUTTER GENERAL HOSPITAL	1	$12,452.50	$1,067.76	$6,230.26	$5,162.50
ZZR00125F	ALEXIAN BROTHERS HOSP	1	$18,850.63	$3,995.13	$5,628.93	$1,633.80
ZZR00154F	MEMORIAL HOSP CERES	1	$39,127.00	$9,022.72	$16,577.72	$7,555.00
ZZR00179F	EMANUEL MEDICAL CENTER	1	$37,906.85	$5,822.45	$14,510.90	$8,688.45
ZZR00215F	SAN JOSE HOSPITAL	1	$34,865.59	$4,229.40	$17,484.19	$13,254.79
ZZR00305F	ALTA BATES HOSPITAL	1	$27,826.22	$3,947.44	$5,820.66	$1,873.22
ZZR00599G	U C DAVIS MEDICAL CENTER	3	$41,966.50	$11,983.30	$20,265.80	$8,282.50
ZZT30082F	ST JOHNS HOSPITAL	1	$12,677.45	$2,402.46	$7,971.56	$5,569.10
ZZT30116F	NORTHRIDGE HOSP FOUNDATI	3	$93,436.49	$11,560.36	$32,103.65	$20,543.29
ZZT30141F	AMI CLAIREMONT COMM HOSP	1	$13,494.11	$4,004.10	$6,372.21	$2,368.11
ZZT30447G	VILLA VIEW COMM HOSPITAL	1	$25,635.54	$3,523.20	$5,109.82	$1,586.62
ZZT31404F	CHILDRENS HOSP OF ORANGE	1	$18,330.75	$3,309.57	$4,887.32	$1,577.75
*** TOTAL		30	$714,650.25	$122,490.74	$262,679.54	$140,188.80

B 01

REPORT NO. CP-0-09G
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION PROVIDER TOTAL REPORT

RUN ON 02/04/90 AT 10 10

PROVIDER NUMBER	PROVIDER NAME	CLAIMS	AMOUNT BILLED	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
ZZRU0084F	ST JOSEPHS HOSPITAL	1	$26,773.75	$7,654.73	$6,694.70	$960.03-
HSP30312H	REDDING MEDICAL CENTER	1	$8,066.20	$3,593.60	$4,332.60	$739.00
ZZT31404F	CHILDRENS HOSP OF ORANGE	1	$18,330.75	$3,309.57	$4,887.32	$1,577.75
ZZT30447G	VILLA VIEW COMM HOSPITAL	1	$25,635.54	$3,323.20	$5,109.82	$1,586.62
ZZR00125F	ALEXIAN BROTHERS HOSP	1	$18,850.63	$3,995.13	$5,628.93	$1,633.80
ZZR00305F	ALTA BATES HOSPITAL	1	$22,826.22	$3,947.44	$5,820.66	$1,873.22
ZZT30141F	AMI CLAIREMONT COMM HOSP	1	$13,494.11	$4,004.10	$6,372.21	$2,368.11
ZZ 00038F	SANTA CLARA VLY MED CEN	1	$14,246.55	$2,936.34	$5,666.92	$3,730.58
ZZR00033F	MT ZION HOSPITAL	1	$15,945.48	$704.90	$5,770.77	$5,065.87
ZZR00108F	SUTTER GENERAL HOSPITAL	1	$12,452.50	$1,067.76	$6,230.26	$5,162.50
ZZT30082F	ST JOHNS HOSPITAL	1	$12,677.45	$2,402.46	$7,971.56	$5,569.10
ZZR00030F	OROVILLE HOSPITAL	2	$36,599.49	$11,203.83	$17,667.02	$6,463.19
ZZR00154F	MEMORIAL HOSP CERES	1	$39,127.00	$9,022.72	$16,577.72	$7,555.00
HSP30581G	DOCTORS HOSP OF LAKEWOOD	1	$35,478.10	$4,229.40	$11,972.50	$7,743.10
ZZR00599G	U C DAVIS MEDICAL CENTER	3	$41,966.50	$11,983.30	$20,265.80	$8,282.50
HSP30327G	LOMA LINDA UNIVERSITY	1	$29,852.73	$2,524.45	$10,842.71	$8,318.26
ZZR00 79F	EMANUEL MEDICAL CENTER	1	$37,906.85	$5,822.45	$14,510.90	$8,688.45
ZZR00215F	SAN JOSE HOSPITAL	1	$34,865.59	$4,229.40	$17,484.19	$13,254.79
HSP30571G	CHARTER SUBURBAN HOSPIT	5	$114,328.76	$16,233.52	$30,679.45	$14,445.93
HSP30464G	DOCTORS MEDICAL CENTER	1	$61,789.53	$8,542.08	$25,089.85	$16,547.77
ZZT30116F	NORTHRIDGE HOSP FOUNDATI	3	$93,436.49	$11,560.36	$32,103.65	$20,543.29
*** TOTAL		30	$714,650.25	$122,490.74	$262,679.54	$140,188.80

L 08

REPORT NO. CP-0-07B
REPORT DATE 03/17/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
RETROACTIVE RATE CHANGE IMPACT

RUN ON 03/17/90 AT 20 04

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
829	1	$1,145.23	$988.25	$1,145.23	$156.98
* TOTALS	1	$1,145.23	$988.25	$1,145.23	$156.98

Standard - Setting Authority for Institutions

The standards established for private or public institutions in which recipients of medical assistance under this plan may receive care or services are enumerated in Title 22 of the California Administrative Code. This title sets forth both health standards and other non-health standards for providers participating in the program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

INTERAGENCY AGREEMENTS OF THE DEPARTMENT OF HEALTH SERVICES REGARDING MEDI-CAL SERVICES.

The California State Department of Health Services, as the single state agency, is responsible for administering the California Medical Assistance Program. The Department of Health Services maintains the following interagency agreements:

1) An agreement with the California State Department of Mental Health for the provision of Short/Doyle Medi-Cal mental health services. Short/Doyle Medi-Cal services are not to be confused with those mental health services administered by the Department of Health Services. The mental health services administered by the Department of Health Services are commonly referred to as "Fee-for-Service" mental health services.

2) Two agreements with the California State Department of Aging for:

   A) The Multipurpose Senior Services Program (MSSP)--a 1915 (c) waiver.

   B) Adult Day Health Care services.

3) Three agreements with the California State Department of Developmental Services for:

   A) Home and Community Based Services for the Developmentally Disabled--a 1915 (c) waiver.

   B) Community Support Living Arrangement Program.

   C) Delegating a fiscal agent role to DDS for payment for certain services.

4) Two agreements with the California State Department of Social Services for:

   A) Payment for the health related services provided by county workers.

   B) Personal Care Services Program.

5) An agreement with the California State Department of Alcohol and Drug Programs for the provision of Medi-Cal funded drug treatment services.

6) An agreement with the California State Department of Rehabilitation for the provision of coordination of services between the two departments.

7) An agreement between the California Children Services Program and the Maternal and Child Health Program of DHS for establishing mutual goals and objectives, operationalizing the relationship of the respective parties in the system of title V and title XIX services, and establishing the fiscal relationship of the two parties in the provision of services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

INTERAGENCY AGREEMENTS OF THE DEPARTMENT OF HEALTH SERVICES REGARDING MEDI-CAL SERVICES.

The above mentioned agreement meets the following requirements:

1. It specifies the responsibilities and duties of each party to the agreement.

2. It specifies the cooperative and collaborative relationship at the State level.

3. It specifies the kinds of services to be provided by providers.

4. It specifies the system of payment or reimbursement.

5. It specifies the system for monitoring of service usage at the provider level and other utilization review and quality assurance elements.

The mentioned agreements are on file at the California State Department of Health Services office and are available for review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   The beneficiary or his or her representative declare that the institutionalized individual cannot reasonably be expected to be discharged and return home. The beneficiary has been given a 30-day notice of the Department of Health Services' intent to impose a lien and has an opportunity for a hearing in accordance with state established hearing procedures. The notice to the beneficiary must include an explanation of the proposed lien and the effect on an individual's ownership interest.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

   A son or daughter of the individual residing in the home, who has resided there for at least two years immediately before the date of the individual's admission to the institution, has resided there on a continuous basis since that time, and can establish to the agency's satisfaction that he or she has been providing care which permitted the individual to reside at home rather than in an institution. (A statement from a licensed health care provider(s) clearly indicating that the level and duration of care provided prevented or delayed the decedent from being placed in a medical or long-term care institution will satisfy this provision.)

3. The State defines the terms below as follows:

   - estate – For individuals who die on or after October 1, 1993, and for payments made on or after October 1, 1993, "estate" is defined as all real and personal property and other assets in which the decedent had any legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a dependent, heir, survivor, or assignee of the decedent through joint tenancy, tenancy in common, survivorship, life estate, living trust, annuities purchased on or after September 1, 2004, life insurance policy that names the estate as the beneficiary or reverts to the estate, or any retirement account that names the estate as the beneficiary or reverts to the estate.

   - individual's home – An individual's principal domicile.

   - equity interest in the home – The fair market value of the property to which the decedent held legal title or interest at the time of death (to the extent of such interest), less the amount owed in deeds of trust, mortgages, and liens on record at the time of death.

   - residing in the home for at least one or two years on a continuous basis —To live in the beneficiary's principal domicile, for an extended or prolonged period and without interruption or cessation, for one year in the case of a sibling and two years for a son or daughter.

   - discharge from the medical institution and return home – To leave a medical facility and return to the individual's principal residence.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

- lawfully residing – To live in a place for an extended or permanent period of time with the authorization of the owner(s), and within the bounds of law or public policy.

4. The state defines substantial hardship as follows: A. An applicant can demonstrate through submission of a written application or, if applicable, at an estate hearing, that enforcement of the applicant's proportionate share of the Department's claim would result in a substantial hardship to the applicant based on the factors listed below. B. A substantial hardship does not exist when the decedent or applicant created the hardship by using estate planning methods to divert or shelter assets in order to avoid estate recovery. C. To the extent that there currently is, or later becomes any conflict between the following criteria and the standards that may be specified by the Secretary of the Department of Health and Human Services, the federal standards shall prevail.

   The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause a substantial hardship, and when recovery is not cost-effective.

   In determining the existence of a substantial hardship, the Department shall waive an applicant's proportionate share of the claim if one of more of the following factors apply:

   A. When allowing the applicant to receive the inheritance from the estate would enable the applicant to discontinue eligibility for public assistance payments and/or medical assistance programs; or,

   B. When the estate property is part of an income-producing business, including a working farm or ranch, and recovery of medical assistance expenditures would result in the applicant losing his or her primary source of income; or,

   C. When an aged, blind, or disabled applicant has continuously lived in the decedent's home for at least one year prior to the decedent's death and continues to reside there, and is unable to obtain financing to repay the State. The applicant shall apply to obtain financing, for an amount not to exceed his or her proportionate share of the claim, from a financial institution as defined in Probate Code Section 40. The applicant shall provide the Department with a denial letter(s) from the financial institution; or,

   D. When the applicant provided care to the decedent for two or more years that prevented or delayed the decedent's admission to a medical or long-term care institution. The applicant must have resided in the decedent's home during the period care was provided and continue to reside in the decedent's home. The applicant must provide written medical substantiation from a licensed health care provider(s), which clearly indicates that the level and duration of care provided prevented or delayed the decedent from being placed in a medical or long-term care institution; or,

   E. When the applicant transferred the property to the decedent for no consideration; or,

   F. When equity in the real property is needed by the applicant to make the property habitable, or to acquire the necessities of life, such as food, clothing, shelter or medical care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

The Department shall provide written notification to the applicant of its decision regarding the hardship waiver application within 90 days of the applicant's submission. If an application for hardship waiver is denied, the Department shall provide the applicant with notice of the right, the address, and the timeframe to request an estate hearing, at the time it provides notice of its decision. The Department shall issue its decision on an applicant's hardship waiver application prior to and independent of its consideration of a voluntary post death lien.

If it is determined that enforcement of the State's claim would result in a substantial hardship to one or more of the dependents, heirs, or survivors of the individual against whose estate the claim exists, the Department shall waive the proportionate share of its claim against any applicant who qualifies for a waiver due to a substantial hardship, as specified in Section 50963(a). The Department shall not enforce collection of the proportionate share of an estate claim for any applicant who is awaiting the resolution of a hardship waiver request or an estate hearing. However, the Department shall enforce collection of its claim from the remaining dependent(s), heir(s), or survivor(s) for his or her proportionate share of the claim.

If the asset is an income producing business, the State will not recover from any heir if collection from one heir would cause a substantial hardship to another heir.

5. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

   Because of the volumes of cases and available resources, the Department has determined that it is not cost-effective to file claims/liens if the potential net collection amount is under $500. However, when the administrative costs to process a case and effect collections is very low, usually with cases handled by public administrators/guardians and with some attorneys' formal probates (where there may be unreported assets), the Department may file for any amount. Additionally, in certain circumstances when the debtor has excessive allowable expenses or obligations, when the heir(s) live out of state and is not responsive to collection efforts, etc., we may determine that it is not cost-effective to litigate or otherwise pursue recoveries, even though the net assets are over the normal $500 threshold.

6. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

   A. Advance Notice Procedure

   Beneficiaries are notified of the Medi-Cal Estate Recovery program, during their initial application process and during annual redetermination, via the Rights and Responsibilities form (MC219) and Statement of Facts (MC210), which they read and sign. Our program also sends beneficiaries notices twice a year, informing them of any updates or changes in laws/procedures affecting estate recoveries. In addition, the Department publishes a Medi-Cal Pamphlet and

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

places them in all of California's county welfare offices, which explains that property/assets are allowable for eligibles and indicates under what circumstances Medi-Cal may bill the estate of a deceased beneficiary. Heirs, or their representatives, are notified any time the Department intends to claim against a deceased beneficiary's estate or place a lien against an institutionalized beneficiary's real property (if beneficiary or personal representative has indicated no intent to return home), are informed of our legal authority to do so, and are given the opportunity to apply for a hardship waiver or otherwise appeal our decision.

B. Collection Procedures

The Department may be notified of a Medi-Cal beneficiary's death in several different ways. The majority of our cases are set up as a result of a monthly data search of the Medi-Cal Eligibility System to check the eligibility status codes on each Medi-Cal beneficiary's file. If the eligibility status shows that the beneficiary was terminated by reason of death, a system-generated questionnaire is sent to the estate, at the last known address. In addition, Probate Code Sections 215, 9202, and 19202 require the estate attorney or personal representative of a deceased Medi-Cal beneficiary to notify the Department within 90 days of the date of death. Notice must be provided in writing to the Director of the Department of Health Services at his or her Sacramento office, or, Estate Recovery Unit, Mail Stop 4720, P.O. Box 997425, Sacramento, CA 95899-7425. The Department also receives referrals of the death of a person who may have been receiving Medi-Cal benefits from various other private and public sources.

When notice of a Medi-Cal client's death is received by the Department, research is necessary to verify the Medi-Cal eligibility periods, the beneficiary's assets at the time of death, and that the case meets the criteria of law to pursue recovery. Cases which pass this screening are established on the program's Automated Collection Management System (ACMS), claim details are requested and an itemized list of payments to providers, health plans, etc., is prepared. This itemization is used to file a claim in formal probate with the county recorder and/or with the heirs of the decedent's property.

Once a case is established, and accounts receivable (AR) entered into the ACMS, cases are monitored quarterly. Status requests may be sent to the responsible party(ies) and case notes track the progress of the claim. Payments received are deposited daily and the ACMS AR adjusted (making sure that the correct amount was paid). Failure of payments to be made, claims honored, attorneys (or other responsible party) cooperating in closing probate, etc., may result in collection action against the heir(s), attorney, or other responsible persons, by litigating in small claims court, or referring to the Attorney General's Office for filing a complaint with the courts.

C. Collection Procedures – Voluntary Post Death Liens

Voluntary post death liens may be utilized to secure and satisfy the Department's claim when one or more of the dependents, heirs, or survivors of the deceased Medi-Cal client are living in and not willing to sell the real property, are unable to pay the State's claim in full, and can demonstrate that they are unable to obtain financing to pay off the claim. A voluntary post death lien is only utilized as a means to secure the Department's claim and is voluntary in nature.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

If a hardship waiver has been requested, a decision will be issued on the waiver request prior to and independent of the Department introducing a voluntary post death lien.

Once it has been determined that one or more of the dependent(s), heir(s), or survivor(s) are unable to pay or obtain financing to pay their proportionate share of the estate claim, the Department may offer to accept a voluntary post death lien. The dependent(s), heir(s), or survivor(s) must provide the Department with a letter(s) from a financial institution defined in Probate Code Section 40, which denies financing for an amount not to exceed the dependent(s), heir(s), or survivor(s) proportionate chare of the claim.

The Department may request monthly payments, based on the dependent(s), heir(s), or survivor(s) financial ability to pay, in addition to the placement of a lien on the estate property. These payments would be based on the dependent(s), heir(s), or survivor(s) financial ability to pay, and be adjusted as needed. Monthly payments would continue until the lien amount owed to the Department by the lienee, plus interest, is paid in full.

The lien will accrue simple interest at the rate of seven percent per annum, and becomes due and payable, including all interest accrued, upon: 1) the death of the dependent(s), heir(s), or survivor(s); or 2) the sale, refinance, transfer, or change in title to the real property; or 3) escrow funding; and/or 4) default in payments.

In the event of a transfer of an interest in, or title to, real property subject to the voluntary post death lien without payment of the lien, the lienee shall provide notification of the transfer, with the identity and address of the new titleholder(s), by mail to the Department, within 30 days of the transfer. The lienee shall notify the new titleholder(s) of the voluntary post death lien prior to the transfer of title, and the obligation to satisfy the lien. The new titleholder must make arrangements for full satisfaction of the Department's lien with the Estate Recovery Program.

When the dependent(s), heir(s), or survivor(s) agree to a voluntary post death lien, the Department will prepare and mail the lien documents to the dependent(s), heir(s), or survivor(s) for notarized signature(s). Once the lien documents are returned to the Department, the Department forwards the documents on to the County Recorder's Office where the property is located for recording of the lien. The Department will issue a release of lien to the County Recorder's Office after full payment of the lien with accrued interest is received.

D. Collection Procedures – Imposing Liens Against the Real Property of Institutionalized Beneficiaries

At the time of their initial application for Medi-Cal benefits and during their annual redetermination process, institutionalized beneficiaries who own real property are asked if they intend to return home to live in that real property at any time in the future. If the beneficiary or personal representative indicates no intent to return home (and if there is no spouse or dependent relative residing in the home), the County Department of Social Services may send a Notice of Action (NOA) to the institutionalized beneficiary. The NOA informs beneficiaries that if the property is listed for sale (and Medi-Cal eligibility is established or continues), a lien will be recorded against the property to cover the cost of medical care received under the Medi-Cal program. The notice also advises the clients of their right to request further county review

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

and/or a state hearing, within 30 days of the date of the notice, in order to present additional information/evidence for consideration. No action is taken during this 30-day period or pending further review and/or a hearing.

If, after the 30 days has elapsed, the Department will research the referral from the county to determine if the case meets the criteria of law to impose a lien against the property. That is, there is no surviving spouse, child under age 21, blind or disabled child, or a sibling with an interest in the home, living in the home. Cases that pass this screening are established on the program's ACMS, claims details are requested, and an itemized list of payments made thus far to providers, health plans, etc., is prepared to determine the preliminary amount of the lien. The Department then sends a lien to the appropriate county recorder's office and a copy to the beneficiary. The transmittal letter, which accompanies the beneficiary's copy of the lien, gives the preliminary amount of the lien, informs that the lien amount may increase monthly (as services are paid), and provides the name of the person to contact if an escrow is ready to close or a sale is finalized for the final balance due.

Once a case is established and an accounts receivable is entered onto ACMS, cases are monitored quarterly. Status requests may be sent to the beneficiary and case notes track the progress of the pending sale/lien. If at any time prior to the sale of the property, the Medi-Cal beneficiary is discharged from the medical institution and resumes use of the property as principal residence, the lien is removed. If and when the property is sold, the amount of the lien will be recovered from the proceeds of the sale.

E. Procedures for Waiver of a Claim Based Upon Substantial Hardship

California law and regulations require the Department to waive a dependent(s), heir(s), or survivor(s) (applicant) proportionate share of its claim against the estate of a deceased Medi-Cal beneficiary, when the Department determines that enforcement of the Department's claim would result in a substantial hardship to the applicant. The Department provides written notice informing the person handling the decedent's estate of the right to seek a waiver of or to contest the Department's claim. The notice and attachments include the basis for the estate claim; the specific statutes and regulations supporting the claim; the right to seek a waiver of the Department's claim; the right to contest the Department's claim; the right to request an estate hearing if dissatisfied with the waiver decision; the timeframes for requesting a waiver or estate hearing; and the basis for the applicant to seek a waiver or estate hearing due to substantial hardship. The Department shall attach to the notice a copy of the itemized Medi-Cal payments that constitute the basis for the claim. In addition, the Department shall provide an Application for Hardship Waiver, form DHS 6195 (1/06). The person handling the estate of the decedent shall notify all dependents, heirs, or survivors of the Department's claim and their right to seek a waiver of or to contest the Department's claim against the estate. An applicant has 60 days from the date stated on the Department's notice in which to submit an application for waiver due to substantial hardship.

The actual criteria used in determining substantial hardship are listed in (4) above. An applicant may challenge the Department's hardship waiver decision by submitting a written request for an estate hearing to the Director of the department through his or her designee, the Office of Administrative Hearings and Appeals, within 60 days of the date of the Department's decision

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

inscribed at the top of the Department's notice. The Department shall provide the applicant at least 30 days notice of the date, time, and place of the hearing. The hearing shall be conducted within 60 days from the date of the request, and may be continued for good cause, such as illness, injury, or incarceration of the applicant.

For an applicant who lives in the State, the Department shall conduct the hearing within the California Court of Appeal district where the applicant resides. In the case of an applicant who lives out of the State, the hearing shall be conducted in Sacramento, California.

At the estate hearing, the applicant and/or applicant's representative shall have the opportunity to be heard, offer evidence, and present witnesses in support of the request for a waiver. All testimony shall be submitted under oath, affirmation, or penalty of perjury. The proceedings at the estate hearing shall be electronically recorded. The applicant and/or the applicant's representative shall be prepared to leave copies of all documents which support the applicant's request for waiver with the hearing officer.

The hearing shall be conducted in an impartial manner by a hearing officer appointed by the Department's Director. A proposed decision, stating the applicable law, evidence, and reasoning upon which the decision is based, shall be submitted to the Director no more than 30 days after the hearing record is closed. Any errors or omissions in the information provided by the applicant that would affect the Department's decision may be a basis for denial of the request for a hardship waiver.

Within 30 days after the proposed decision is received by the Director, the Director may adopt the proposed decision, reject the proposed decision and have a decision prepared based upon the record, or refer the matter to the hearing officer to take additional evidence. If the Director takes no action within 30 days after receipt of the proposed decision, the decision shall be deemed adopted. The decision shall be final upon adoption by the Director and no further administrative appeal shall occur. Copies of this decision shall be mailed by certified mail to the applicant or his or her designated representative.

Judicial review of the final decision of the Department may be made by filing a petition for a writ of administrative mandate in accordance with the provisions of Section 1094.5, et seq., Code of Civil Procedure.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
Clinic			X	$1 per visit
Surgical center			X	$1 per visit
Optometric			X	$1 per outpatient visit
Chiropractic			X	$1 per outpatient visit
Psychology			X	$1 per outpatient visit
Podiatric			X	$1 per outpatient visit
Occupational therapy			X	$1 per outpatient visit
Physical therapy			X	$1 per outpatient visit
Speech therapy			X	$1 per outpatient visit
Audiology			X	$1 per outpatient visit
Acupuncture			X	$1 per outpatient visit
Drug Prescriptions			X	$1 per outpatient drug prescription
Dental			X	$1 per outpatient dental visit
Nonemergency services in an emergency room.			X	$5 per visit (average payment for nonemergency services in an emergency room is greater than $50.00)

Exceptions:

1. Any service for which the State payment is $10 or less.
2. Any family planning service.
3. Any service provided to a person age 18 or under.
4. Any woman receiving perinatal care.
5. Any person who is an inpatient in a health facility.
6. Any children under 21 living in boarding homes or institutions for foster care.

* (other) (besides nonemergency services in an emergency room)
All amounts meet the definition of nominal.

TN No. 85-18
Supersedes
TN No. 85-4

Approval Date FEB 18 1986

(* Note: Annotated) 3/4/86 tc to Benefits Branch to clarify waiver status)

Effective Date OCT 1 1985

HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

B. The method used to collect cost sharing charges for categorically needy individuals:

/X/ Providers are responsible for collecting the cost sharing charges from individuals.

/ / The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The individual determines whether he/she can pay the copayment and informs the provider accordingly. Providers have been instructed that they may not refuse to provide services based solely on the individual's inability to copay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers are instructed, via provider bulletins, of those services which are not subject to copayment and of those individuals who are exempt from copayment requirements. Notices are also sent to beneficiaries informing them of the conditions under which they will be asked to copay.

Enforcement is accomplished by contacting individual providers when complaints of noncompliance are brought to the attention of the state agency.

E. Cumulative maximums on charges:

/X/ State policy does not provide for cumulative maximums.

/ / Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge: Deduct.	Coins.	Copay.	Amount and Basis for Determination
Physician			X	$1 per visit
Clinic/outpatient			X	$1 per visit
Surgical center			X	$1 per visit
Optometric			X	$1 per outpatient visit
Chiropractic			X	$1 per outpatient visit
Psychology			X	$1 per outpatient visit
Podiatric			X	$1 per outpatient visit
Occupational therapy			X	$1 per outpatient visit
Physical therapy			X	$1 per outpatient visit
Speech therapy			X	$1 per outpatient visit
Audiology			X	$1 per outpatient visit
Acupuncture			X	$1 per outpatient visit
Drug Prescriptions			X	$1 per outpatient drug prescription
Dental			X	$1 per outpatient dental visit
Nonemergency services in an emergency room.			X	$5 per visit (average payment for non-emergency services in an emergency room is greater than $50.00)
				* (other) besides nonemergency services in an emergent room
				All amounts meet the definition of nominal.

Exceptions:

1. Any service for which the State payment is $10 or less.
2. Any family planning service.
3. Any service provided to a person age 18 or under.
4. Any woman receiving perinatal care.
5. Any person who is an inpatient in a health facility.
6. Any children under 21 living in boarding homes or institutions for foster care.

TN No. 85-18
Supersedes
TN No. 85-4

Approval Date FEB 1 8 1986 Note: Annotated per t.c. to Benefits Branch 2/14/86 to clarify re: waiver.)

Effective Date OCT 1 1985

HCFA ID: 0053C/0061E

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

B. The method used to collect cost sharing charges for medically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The individual determines whether he/she can pay the copayment and informs the provider accordingly. The providers have been instructed that they may not refuse to provide services based solely on the individual's inability to copy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers are instructed via a provider bulletin of those services which are not subject to copayment, and of those individuals who are exempt from copayment requirements. Notices are also sent to beneficiaries informing them of the conditions under which they will be asked to copay.

Enforcement is accomplished by contacting individual providers when complaints of noncompliance are brought to attention of the state agency.

E. Cumulative maximums on charges:

[X] State policy does not provide for cumulative maximums.

[ ] Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /_/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

Optional Sliding Scale Premiums Imposed on
Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /_/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

State: California

I. DEFINITIONS

The following definitions are applicable to this Plan only unless otherwise specified in a section of a regulation:

(1) Administrative Adjustment (AA) means the adjustment to a provider's PIRL in response to a provider's administrative adjustment request (AAR).

(2) Administrative Adjustment Request (AAR) means the provider's request for changes to the PIRL, which includes both the all-inclusive rate per discharge limitation (ARPDL) and peer grouping rate per discharge limitation (PGRPDL).

(3) Aligned ARPDs means the modified ARPDs which have been adjusted to estimate their value as of a common fiscal period ending for the purpose of computing the 60th percentile ARPD for each peer group which is then used to calculate the PGRPDL.

(4) All-Inclusive Rate Per Discharge (ARPD) means the per discharge dollar limit on Medi-Cal reimbursable costs prior to the application of the peer grouping inpatient reimbursement limitation (PIRL). The ARPD excludes return on owner's equity, disproportionate share payments and reductions for third-party liability (TPL) as referenced in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(5) All-Inclusive Rate Per Discharge Limitation (ARPDL) means a Medi-Cal inpatient reimbursement limit (MIRL) which is the all-inclusive rate per discharge (ARPD) multiplied by the number of Medi-Cal discharges. The ARPDL excludes return on owner's equity, disproportionate share payments and reductions for TPL, as referenced in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(6) Allowable Rate Per Discharge (ARPD) means all-inclusive rate per discharge (ARPD).

(7) Atypical Case means Cost Outlier or Day Outlier.

(8) Base Period shall be for fiscal periods which begin on or after May 23, 1992, the fiscal period end (FPE) immediately prior to the settlement period.

(9) Base Year means Base Period.

(10) Burden of Going Forward means the responsibility of a party to be the first one to present its evidence with respect to a particular issue.

(11) Burden of Proof means the responsibility of proving, by a preponderance of the evidence, the existence or nonexistence of each fact which is essential to demonstrate that a party's position regarding a disputed issue is correct.

(12) Case Mix means the mix in terms of the diagnostic related groups (DRGS) of the Medi-Cal patients served by the provider.

(13) Case Mix Index means an index that measures the average level of health care needed by a provider's Medi-Cal patients.

(14) Charitable Research Hospital means a provider which accepts catastrophically ill patients by referral only, has over 33 percent of their Gross Operating Expense (GOE) as charity care, over 1 percent of their GOE for research and has no obstetrics or nursery.

(15) Children's Hospital means in accordance with Section 14087.2 of the W&I Code, those hospitals where 30 percent of the infants and children served by the single institution qualify for Medi-Cal payment systems and the institution serves primarily children.

(16) Contract Services Costs means costs related to services provided that are covered by a contract with the Department for care of Medi-Cal inpatients, per W&I Code Section 14081.

(17) Contract Hospital means a provider that contracts with the Department, based on negotiations with the California Medical Assistance Commission (CMAC) in accordance with W&I Code Section 14081.

(18) Cost Outliers means those patients who have extraordinarily higher inpatient costs as identified by the cost outlier formulas in Section VII of this Plan.

(19) Cost Report means a report required by the Department and completed by the provider to determine the Medi-Cal Program's share of the provider's reasonable costs in accordance with applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(20) County Appropriations means the amount appropriated to the provider from the county general fund or other county sources for operating deficits or other operating needs. If a county hospital repays the county any portion of the appropriations, the repayment must be abated against current fiscal period appropriations.

(21) Customary Charges, as specified in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1, means those uniform charges allowed by Medi-Cal which are listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement.

(22) Crossover Patients means hospital inpatients who are eligible for both Medi-Cal and Medicare.

(23) Current Fiscal Settlement Period means the provider's accounting year for which a peer group inpatient reimbursement limitation (PIRL) is being determined.

(24) Day Outliers means those patients whose stay in the hospital is extraordinarily longer as identified by the day outlier formulas in Section VII. of this Plan.

(25) Department means the California State Department of Health Services.

(26) Depreciation and Amortization means those amounts which represent portions of the depreciable or amortizable asset's cost or other basis which is allocable to a period of operation.

(27) Diagnosis Related Group (DRG) means a group identified by certain clinically coherent types of patients who should have similar resource consumption within each of the universe of DRGs used in the Medicare Prospective Payment System (PPS) (or as modified by the Department), in accordance with applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(28) Discharge means the termination of lodging and a formal release of an inpatient by a provider. Deaths are counted as inpatient discharges. See Medi-Cal Discharge.

(29) Disproportionate Share Hospital means a provider whose Medicaid inpatient utilization rate (as defined in Section 1923(b)(2) of the Social Security Act) is at least one standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in the State, or where the providers's low income utilization rate (as defined in Section 1923(b)(3) of the Social Security Act) exceeds 25 percent.

(30) Economically and Efficiently Operated Providers means providers whose costs do not exceed the PIRL except for those costs that are otherwise found allowable by an AA or Formal Appeal process.

(31) Employee Benefits means the direct operating costs related to employee benefits consisting of FICA; State Unemployment Insurance

and Federal Unemployment Insurance; vacation, holiday, and sick leave; group health insurance; group life insurance; pension and retirement; workers' compensation insurance; other payroll related employee benefits; and, other non-payroll related employee benefits.

(32) Employee Benefits Index means the factor resulting from the adjusted comparison of settlement fiscal period employee benefits expense to prior fiscal period employee benefits expense.

(33) Exempt Reimbursement means reimbursement not included in, or subject to limitation by the PIRL. These costs are limited to return on owner's equity and disproportionate share payments.

(34) Extraordinary and Unusual Events means an event of a sudden, unexpected, or unusual nature; e.g., avalanche, floods, earthquakes or other similar events whose circumstances are unavoidable regardless of the level of prudence exercised by the provider.

(35) Factor Input Price means the same as the Input Price Index.

(36) Final Peer Group Inpatient Reimbursement Limitation (PIRL) Settlement means a Departmental determination of liabilities owed resulting from a PIRL calculation based upon data audited or otherwise considered true and correct by the Department for the final settlement fiscal period pursuant to the W&I Code Section 14170.

(37) Fiscal Period Ending (FPE) means the last day of a provider's fiscal period. A fiscal period is an accounting period established by the provider. The fiscal period is generally a twelve (12) consecutive month period, however, in some instances it may be less than or exceed 12 months.

(38) Fixed Costs means an operating expense or a class of operating expenses that does not vary with patient volume. Fixed costs are not fixed in the sense that they do not fluctuate or vary, but fluctuate or vary from causes independent of patient volume.

(39) Food Service Expense means those expenses for services and supplies related to the food service categories of: kitchen, dietary, and cafeteria.

(40) Formal Appeal means the provider's appeal of the Department's decision on an AAR concerning a final PIRL calculation.

(41) Formula Relief means changes in the ARPD that will carry forward into the next fiscal period's ARPD calculation.

(42) Gross Operating Expense (GOE) means the total operating expenses of the provider. This includes all expenses incurred in conducting the ordinary major activities of the provider inclusive of daily hospital services, ancillary services, research, education, general services, fiscal services and administrative services, including the physician professional component.

(43) Initial Base Period means the last fiscal period for each provider ending prior to the providers fiscal period that begins on or after May 23, 1992.

(44) Input Price Index (IPI) means the weighted computation resulting in the reimbursable change in the prices of goods and services purchased by the providers (except for pass throughs). The input price index shall consist of a market basket classification of goods and services purchased by providers, a corresponding set of market basket weights derived from each provider's own mix of purchased goods and services, and a related series of price indicators.

(45) Interim Payment Rate means the rate paid to a provider, expressed as a percentage, derived by the PIRL divided by Medi-Cal charges.

(46) Interest on Working Capital means a cost representing all interest incurred on borrowings for working capital purposes or interest on an unpaid tax liability.

(47) Interest All Other means a cost representing all interest incurred for borrowings other than interest on working capital.

(48) Leases and Rents Costs means costs representing lease and rental expenses relating to occupying or using buildings, leasehold improvements and fixed assets not owned by the provider and not directly assignable to another cost center.

(49) Length of Stay Outliers means Day Outliers.

(50) Licenses and Taxes Costs means costs representing all license expenses and all taxes (other than tax on income).

(51) Malpractice Insurance (Hospital and Professional) Costs means costs representing liability insurance expenses, including premiums paid for physicians, the deductibles paid on claims, or the actuarially determined cost of self-insurance.

(52) Maximum Inpatient Reimbursement Limitation (MIRL) means the lowest of the following:

(A) Customary charges.

(B) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(C) ARPD limitation.

(53) Medi-Cal discharges means those discharges where the inpatient services provided were covered by Medi-Cal for a Medi-Cal eligible beneficiary. This includes deaths, and eligible beneficiaries whose Medi-Cal covered services were paid in full or in part by third parties, if Medi-Cal was also billed for the services. Late paid claims where the patients statistics were not included in the cost or audit report used to derive the PIRL and well newborns shall not be counted as Medi-Cal discharges. However, a well newborn whose mother is not eligible for Medi-Cal shall be counted as a discharge if the newborn is eligible for Medi-Cal. Medicare crossover patients are not counted as Medi-Cal discharges if Medi-Cal paid only for any applicable deductibles and co-payments.

(54) MIRL Reimbursement Rate Per Discharge means the per discharge reimbursement amount under the MIRL, which has not been reduced for third-party liability, excluding any one-time relief, return on owner's equity and any disproportionate share payments. It is calculated by dividing the MIRL by the number of Medi-Cal discharges.

(55) New Hospital means any hospital: (A) which has a complete new physical plant that is less than three years of age and is not on the same or an adjacent property as the old physical plant; or (B) Under new ownership, or resuming operations for the first time after a 12-month period (i.e. was closed for at least 12 months prior to being reopened under new ownership); or (C) Which has operated under present and all previous ownerships for less than three years.

(56) New Service means an additional service developed and implemented by a Medi-Cal provider, to furnish and maintain quality inpatient hospital care to a patient population inclusive of Medi-Cal recipients.

(57) Newborn means an infant born in the hospital or delivered outside the hospital and admitted to the hospital shortly after birth.

(58) Noncontract Hospital means a provider that does not have a negotiated contract with the Department to provide medical care for Medi-Cal beneficiaries pursuant to W&I Code Section 14108.

(59) Noncontract Service Costs means costs related to services provided to Medi-Cal inpatients, which are excluded from the provider's contract with the Department.

(60) Non-Pass-Through Costs means costs which are subject to the hospital cost index as found in Section V. of this Plan.

(61) OSHPD means the Office of Statewide Health Planning and Development.

(62) One-Time Relief means changes in the ARPDL which only affect the settlement period and are not carried forward into the next settlement period ARPDL.

(63) OSHPD Accounting and Disclosure System means a uniform accounting and disclosure system designed by OSHPD.

(64) Outliers means Cost Outliers and Day Outliers.

(65) Partial Period Contracting Hospital means a contract hospital with a contract which covers only a partial fiscal period.

(66) Partially Contracting Hospital means a contract hospital with a contract that does not include all Medi-Cal services.

(67) Pass-Through Costs means cost categories for purposes of the ARPDL that are not subject to the hospital cost index. The categories are limited to: depreciation, rents, leases, interest, property tax, license fees, utilities and malpractice insurance as defined in Section V. of this Plan.

(68) Per Diem means a daily rate paid for hospital services provided to Medi-Cal beneficiaries.

(69) Peer Group means a group of hospitals with similar characteristics that are grouped together for purposes of determining reimbursement limitations.

(70) Peer Grouping Inpatient Reimbursement Limitation (PIRL) means the lowest of the following:

(A) Customary charges.

(B) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1.

(C) ARPDL.

(D) PGRPDL. If a provider is exempt from the peer group limits, the Medi-Cal reimbursement limitation will be the lowest of (A), (B) or (C), identified above. All references to PIRL include MIRL.

(71) Peer Grouping Rate Per Discharge Limitation (PGRPDL) means a Medi-Cal inpatient reimbursement limit. The PGRPDL excludes return on owner's equity, disproportionate share payments and reductions for third-party liability. The PGRPDL is the 60th percentile ARPD of each provider's peer group multiplied by the provider's number of Medi-Cal discharges.

(72) Pharmacy Expense means those expenses for services and supplies related to the pharmacy. The cost of drugs dispensed to inpatients are also included in this category.

(73) Primary Health Service Hospital means a provider that is either (1) located outside of a standard metropolitan statistical area, and located at least 15 miles from another licensed acute care hospital, and has 60 or fewer acute care beds: or (2) is located at least 20 miles from any other licensed acute care hospital in the county, and has fewer than 100 acute care beds as defined by Health and Safety Code Section 1339.9.

(74) Prior Fiscal Period means any fiscal period ending prior to the fiscal period for which a PIRL is being determined.

(75) Productive Hours means the total paid hours less hours not on the job. Hours not on the job include: vacation time; sick time; holidays; and other paid time off.

(76) Productive Salaries means the total direct payroll costs for productive hours related to a given classification.

(77) Professional Fees means fees for professional services consisting of medical (therapist and others); consulting and management fees; legal; audits; registry nurses and contracted services.

(78) Provider means an institution in California that furnishes inpatient hospital services to Medi-Cal beneficiaries.

(79) Purchased Services means costs related to services purchased from outside contractors.

(80) Rate Per Discharge means ARPD.

(81) Reasonable Costs means reimbursable costs as defined by 42 CFR, Part 413 and HCFA Publication 15-1.

(82) Recalculated Final PIRL Settlement means a final PIRL settlement which has been recalculated.

(83) Reimbursable Costs means those costs that are reimbursed as determined by the PIRL.

(84) Replacement Service means a newly implemented service which replaces another service in whole or in part.

(85) Rural Hospitals means consistent with the Health and Safety Code and those hospitals described in Appendix C of the DHS Hospital Peer Grouping Report dated May 1991.

(86) Salaries and Wages means the direct operating costs related to salaries and wages, consisting of: management and supervision; technicians and specialists; registered nurses; licensed vocational nurses; aides and orderlies; clerical and other administrative; environmental and food services; non-physician medical practitioners; and other salaries and wages. Those salaries and wages related to students from the medical education centers as well as physicians are not included here.

(87) Salary and Wage Index means the factor which is defined as part of the calculation in Section V G. and Section V I. 1) (a).

(88) Second Level Appeal means Formal Appeal.

(89) Service Intensity means changes in the character of the services provided to each patient including but not limited to: changes in applicable technology; qualitative and quantitative changes in: personnel; supplies; drugs; and other materials. Service intensity does not include changes in the types of patients and illnesses treated.

(90) Settlement Fiscal Period means the provider's accounting period for which a PIRL settlement is being or has been conducted.

(91) Sixtieth Percentile means the point at which sixty percent (60%) will be below in any given group arrayed in order.

(92) Sixtieth Percentile ARPD means the maximum reimbursement per discharge under the PGRPDL system. It is the sixtieth percentile rate per discharge for each peer group.

(93) Sole Community Hospital is defined in 42 USC, Section 1395ww(d) (5).

(94) Student and Physician Professional Fees means fees charged for the professional services provided to patients by hospital-based physicians and students. These do not include those fees related to the education, research and administrative duties performed by the hospital-based physicians.

(95) Student and Physician Salaries and Wages means the compensation, (exclusive of in-service education), of students in teaching programs and physicians including such items as research, education program activities, general hospital administration, patient care and supervision.

(96) Tentative PIRL Settlement means the Department's determination of liabilities owed, resulting from a PIRL or MIRL calculation using unaudited cost report data provided by a provider.

(97) Third-Party Liability (TPL) means amount owed for hospital inpatient services on behalf of a Medi-Cal eligible beneficiary by any payor other than Medi-Cal.

(98) Total Hospital Gross Revenue means the amount of total charges for services rendered to all patients.

(99) Total Medi-Cal Gross Revenue means the amount of charges to Medi-Cal for services rendered to Medi-Cal eligible patients.

(100) Total Paid Hours means the sum of the productive hours and the vacation time, sick time, holidays, and other paid time off for all employee classes related to daily hospital services, ancillary services, general services; fiscal services; and admin services.

(101) Utilities means the direct expenses, excluding telephone and telegraph expenses, incurred in the operation of the hospital plant and equipment, such as, but not limited to: electricity, gas and water.

(102) Variable Costs means operating costs that vary or fluctuate with changes in patient volume.

(103) Volume Adjustment means the adjustment for changes in patient volume that applies to the provider's specific all-inclusive rate per discharge for a given fiscal period.

(104) Well Newborn means those newborns who have no major medical problems who are not counted as Medi-Cal discharges. This includes newborns classified in Medicare PPS DRGs 390 and 391.

(105) Working Capital means the difference between total current assets and total current liabilities.

II. REIMBURSEMENT LIMITS

A. Reimbursement for in-state hospital inpatient services provided to Medi-Cal program beneficiaries for provider fiscal periods beginning on or after May 23, 1992 and not fully covered by a negotiated contract as allowed in the Welfare and Institution Code (W&I) Section 14081, shall be the lowest of the following four items except as stated in B., D., F., G., and H., for each provider:

1) Customary charges;

2) Allowable costs determined by the Department, in accordance with applicable Medicare standards and principles of cost based reimbursement, as specified in applicable parts of 42 Code of Federal Regulations (CFR), Part 413 and HCFA Publication 15-1.

3) All-inclusive rate per discharge limitation (ARPDL). This is detailed in Section V. of this Plan.

4) The peer grouping rate per discharge limitation (PGRPDL). This is detailed in Section IX. of this Plan.

B. The following adjustment should be made to items 1) through 4) above:

1) Providers shall also be reimbursed for disproportionate share payments if applicable.

2) The least of the four items listed in A. 1) - 4) above shall be reduced by the amount of TPL.

C. Amounts determined under 3) or 4) above may be increased only by an AA or formal appeal.

D. New hospitals and rural hospitals shall be exempt from the provisions of this part of the Plan relating to the MIRL and PIRL. New and rural hospitals shall be reimbursed in accordance with the lessor of A. 1) or A. 2) above, and subject to any limitations provided for under federal law and/or regulation.

E. Reimbursement for hospital inpatient services provided by State Hospitals under the jurisdiction of the State Department of Developmental Services and Mental Health will be exempt from Section I. through XVI. of this Plan. Payment for services to these providers will be under Medicare retrospective reimbursement principles; audit, administrative and appeal procedures; and applicable cost ceiling limitations.

F. Each provider shall be notified of the ARPDL and PGRPDL at the time of tentative and/or final PIRL settlements. If only a final PIRL settlement is issued, it shall take the place of both the tentative and final PIRL settlement.

G. Payments for Medicare covered services provided to Medicare/Medi-Cal crossover patients shall not be subject to the limitations specified in this part of the Plan. These services shall be reimbursed only for the Medicare deductibles and co-insurance amounts. The deductibles and co-insurance amounts shall not exceed the state reimbursement maximums. State reimbursement maximums shall be the interim rate times Medi-Cal charges after consideration of the Medicare payment.

H. Payment for skilled nursing facility services shall be made in accordance with Section 51511.

I. Payment for intermediate care facility services shall be made in accordance with Section 51510.

J. Hospitals that elect to provide transitional inpatient care services by voluntarily entering into a transitional inpatient care contract will receive a reimbursement rate that is modeled on the distinct-part nursing facility reimbursement rates, and includes increases for components of the transitional inpatient care program that are not part of the distinct-part nursing facility rate. (For details about the payment methodology, refer to Supplement 2 to Attachment 4.19D for the "Study to Determine Rates for Transitional Inpatient Care".)

K. Hospitals that do not elect to voluntarily enter into a transitional inpatient care contract, but are located in a geographic area where a transitional inpatient care contractor(s) exists, may transfer a TC patient to a contract facility. Until the patient is transferred, the hospital will be reimbursed in the same manner and at the same rate as a hospital that has voluntarily entered into a transitional inpatient care contract. This rate is higher than that paid for nursing facility services alone, but lower than the acute inpatient hospital rate.

L. 1) Allowable costs, as that term is used in Section II.A.2, and elsewhere in this Attachment 4.19-A, shall not include provider expenditures to assist, promote,or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph L are set forth below in subparagraphs 2) and 3).

2) "Assist, promote, or deter union organizing" means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:

(a) Whether to support or oppose a labor organization that represents or seeks to represent employees.

(b) Whether to become a member of any labor organization.

3) "State funds" means California State Treasury funds or California State special or trust funds received by the provider on account of the provider's participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.

4) Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

5) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(a) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(b) Allowing a labor organization or its representatives access to the provider's facilities or property.

(c) Performing an activity required by federal or state law or by a collective bargaining agreement.

(d) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

III. METHODS OF PAYMENT

A. The methods of payment for inpatient hospital services under the MIRL shall include the following:

1) An ARPD that shall be retrospectively established for each provider's tentative and final settlement fiscal period. The ARPD shall:

(a) Apply to all non-contract Medi-Cal inpatient covered services provided by the provider during its settlement fiscal period. It shall be based upon the statistics included in the providers Medi-Cal cost or audit report.

(b) Be updated annually to reflect reimbursable changes in factor input prices, service intensity, technology, productivity, patient volume, and other items as allowed through the AA and appeals process.

2) An interim payment rate based upon an actual or projected reimbursable cost to charge ratio.

(a) The current interim payment rate shall be based on the lower of the following:

1. The latest tentative settlement fiscal period for which a final settlement has not been issued.

2. The latest final (which also includes recalculated finals) settlement fiscal period reimbursable cost-to-allowable customary charge ratio expressed as a percentage, rounded to the nearest whole integer, up or down.

(b) Interim payment rates calculated under A. may use data from settlements that have been previously issued if needed to determine the lower of 1) and 2) above.

(c) When newly-established providers do not have cost experience which to base a determination of an interim rate of payment the Department will use the following methods to determine an appropriate rate:

1. If there is a provider or providers comparable in substantially all relevant factors to the

provider for which the rate is needed, the Department will base an interim rate of payment on the reimbursable costs and customary charges of the comparable provider.

2. If there are no substantially comparable providers from whom data are available, the Department will determine an interim rate of payment based on the budgeted or projected reimbursable costs and customary charges of the provider.

3. Under either method, the Department will review the provider's cost and charge experience and adjust the interim rate of payment in line with the provider's cost and charge experience.

4. The Department may prohibit ~~in~~creases in the accommodation rates, as defined in applicable parts of 42 CFR, Part 413 and HCFA Publication 15-1, charged by the provider if the Department projects that such increases would cause their interim payments to exceed the PIRL.

5. Newly established providers may appeal their interim rate if it is based upon the criteria in A. 2) (c) 1. through 4., in accordance with the AAR procedures specified in Section VI. of this Plan.

IV. OVERPAYMENTS

A. Interim payment rate adjustments and recovery of overpayments to providers shall be made at tentative or final settlement based upon the application of this Plan.

1) Such overpayments shall be collected and such interim payment rates shall be adjusted whether or not appeals of any audit, MIRL or PIRL for the current or any prior fiscal period have been filed by the provider.

2) Interim payment rates calculated after May 23, 1992 for Sections I. through XIII. of this Plan and applied to services provided after May 23, 1992, shall comply with Sections III. and IV. of this Plan even if the actual settlement upon which the new interim rate is based, is not subject to the Plan.

B. Within the time specified in 42 CFR 433.316 - 433.320, the State will refund to HCFA the federal share of the provider overpayments, unless the overpayment debt has been discharged in bankruptcy or is otherwise uncollectable as specified in 42 USC Section 1396 b(d) (2) (D).

V. REIMBURSEMENT FORMULA

A. A hospital cost index (HCI) shall be established for each provider. This index shall consist of an input price index (IPI) and shall contain an allowance for changes in scientific and technological advancement; service intensity and productivity. The allowance shall be called the Service Intensity, Productivity, Scientific and Technological Advancement Factor (SIPTF). The HCI shall be calculated:

1) To account for actual changes in the IPI after the close of each provider's accounting period.

2) By multiplying the HCI by the non-pass-through portion of the provider's MIRL reimbursement rate per discharge (tentative or final) for the prior fiscal period to determine the non-pass-through portion of its ARPD for the settlement fiscal period.

B. The prior period shall always be the base period for each settlement.

C. For the initial base period only, the non-pass-through portion of the ARPD shall be calculated as follows:

1) Step 1, add the amount of TPL for the initial base period to the MIRL (lowest of 51536(a)(1)-(3)) which includes amounts reimbursed under the AA and appeals process for the initial base period.

2) Step 2, recalculate Medi-Cal discharges for any initial base period in accordance with the definition of Medi-Cal discharges contained in Section II. of this Plan.

(a) The Department shall notify the provider of the revised count of Medi-Cal discharges for the initial base period.

(b) The provider may file an AAR on the count of Medi-Cal discharges for the initial base period only and only as it is used in the settlement period MIRL. The AAR

must be filed within 60 days of notification of the number of Medi-Cal discharges for the initial base period.

(c) The provider may file an appeal of the Department's response to the AAR in accordance with Section VIII. of this Plan.

3) Step 3, divide the result of step 1 by the result of step 2.

4) Step 4, multiply the percentage of non-pass-through costs for the initial base period by the result of step 3.

5) Use the result of step 4 in place of the PNPARPD in the ARPD formula in D. below.

D. The ARPD shall be calculated as follows:

ARPD = PASPD + NPARPD.
= PASPD + (PNPARPD * HCI)
= (TPTC/THD) + (PNPARPD * ((AIPI * CMAF) + SIPTF))

Where ARPD = All-inclusive Rate Per Discharge.
PASPD = Pass through per discharge = TPTC/THD
TPTC = Total pass through costs in the settlement fiscal period.

THD = Total hospital discharges in the settlement fiscal period.

NPARPD = Non-Pass-through All-inclusive Rate Per Discharge.

NPARPD = PNPARPD * HCI.

PNPARPD = Prior year Non-Pass-through portion of the MIRL reimbursement rate per discharge which is, ((PMIRL - (PMCDIS * (PTPTC/PTHD)))/PMCDIS)

Where:

PMIRL = Prior fiscal period MIRL.
PMCDIS = Prior fiscal period number of Medi-Cal discharges.
PTPTC = Prior fiscal period total pass through costs.
PTHD = Prior fiscal period total hospital discharges

HCI = Hospital Cost Index =

((AIPI) ** (Days/730))* CMAF) + (SIPTF. **(Days/730))

If the prior or settlement fiscal period is long (over 370 days) or short (under 360 days). If both fiscal periods are over 359 days and under 371 days HCI = (AIPI * CMAF) + SIPTF.

Where:

AIPI = Adjusted Input Price Index.

SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological Advancement Factor.

Days = Sum of days in the current and prior fiscal periods.

CMAF = Case mix adjustment factor.

* = Multiplication.
** = Exponentiation.

E. An annual allowance for service intensity, productivity and scientific and technological advancement shall be added to the allowable increase in the non-pass-through portion of the ARPD, as detailed in the formulas in this part of the Plan. This allowance shall be in addition to reimbursement for pass-through categories and shall be the net amount of changes for scientific and technological advancement, productivity improvement and service intensity, if any (excluding case mix), as recommended annually by the Prospective Payment Assessment Commission for the Medicare PPS for all FPEs during the PPS effective dates of the recommended allowance.

F. The pass-through categories are those hospital cost categories which, for purposes of tentative and final settlement, are not subject to the HCI.

1) Each pass-through category is listed below:

(a) Depreciation.
(b) Rents and Leases.
(c) Interest.
(d) Property Taxes and License Fees.
(e) Utility Expenses.
(f) Malpractice Insurance.

G. An IPI shall be established to compute the reimbursable change in the prices of goods and services purchased by the providers (except for pass-throughs). The IPI shall consist of a market basket classification of goods and services purchased by providers, a corresponding set of market basket weights derived from each provider's own mix of purchased goods and services, and a related series of price indicators.

H. Weights corresponding to market basket categories shall be derived and updated for each settlement fiscal period. These weights shall be computed using the latest available information from each provider's Medi-Cal cost report. If information from this source is not sufficient to establish a hospital specific weight for a particular market basket category, the Department shall assign a weight based on information from the United States National Hospital Input Price Index published by the Department of Health and Human Services, or other available sources.

I. The IPI shall be calculated after the close of each hospital's FPE, to account for actual and/or estimated changes in the:

1) Hospital specific wage and benefit rates.

(a) The index for allowable increases in wages shall be computed as follows:

Salary and Wage Index (SWI) = CLSA/ACSA.

Where:
CLSA = Summation of (PYHx * CYHRx) for all x.

ACSA = Summation of all Actual Prior Fiscal Period Salaries for all x categories.
x = The following categories:

a. Technicians and Specialists.
b. Registered Nurses.
c. LVNs.
d. Aides and orderlies.
e. Clerical and other administrative.
f. Environmental and food service.

PYHx = Prior Fiscal Period Productive Hours.

CYHRx = Current (Settlement) Fiscal Period Hourly Rate
= CYSx/CYHx.

CYSx = Current (Settlement) Fiscal Period salary Expense for each category.

CYHx = Current (Settlement) Fiscal Period productive Hours.

(b) The Employee Benefits Index (EBI) shall be computed as follows:

EBI = (PYHT X CYBR)/PYB.

Where:

PYHT = Prior Year (Prior Fiscal Period) Paid Labor Hours for All Labor Categories.

CYBR = Current Year (Settlement Fiscal Period) Benefit Rate = CYB/CYHT.

PYB = Prior Year (Prior Fiscal Period) Benefits Costs.

CYB = Current Year (Settlement Fiscal Period) Benefits costs.

CYHT = Current Year (Settlement Fiscal Period) Labor Hours for All Labor Categories.

(c) The SWI and EBI shall be annualized for any provider which has a short or long (under 360 or over 370 days) prior or current fiscal period.

1. The SWI shall be adjusted using the following formula:

ASWI = SWI ** (730/Days).
ASWI = Adjusted SWI.
Where Days = Total days in the current and prior fiscal periods.

2. The EBI shall be adjusted using the following formula:

AEBI = EBI ** (730/Days).
Where:
AEBI = Adjusted EBI.
Days = Total days in the current and prior fiscal periods.

3. If the SWI and EBI are not annualized, then the ASWI = SWI and AEBI = EBI.

2) Price indicators for other non-pass-through categories.

3) Market basket weights for the following categories:
   (a) Salary and wages.
   (b) Benefits.
   (c) Professional fees, medical.
   (d) Professional fees, other.
   (e) Food.
   (f) Drugs.
   (g) All other non-pass-through costs.

4) The non-pass-through costs "all other" category shall be weighted using the following weights for purposes of calculating the price indicator:

Category	Weight
Chemicals	12.16%
Surgical and Medical Instruments and Supplies	10.59%
Rubber and Miscellaneous Plastics	9.02%
Travel	4.71%
Apparel and Textiles	4.31%
Business Services	14.90%
All other miscellaneous	44.31%

5) The weights for the seven market basket categories shall be the percentage of costs for each category as calculated from the Medi-Cal cost report.

6) Each market basket weight shall be multiplied by the corresponding price indicator. The results will be summed to obtain the unadjusted non-pass-through price index.

7) The price indicators for items under I. 3) (c through g) will be established for the end of each calendar quarter (March 31, June 30, September 30 and December 31). Any FPE other than on a calendar quarter shall use the price indicators under 3) above for the quarter in which the provider's FPEs.

   (a) The following five market basket categories and price indicators to be used in developing each provider's IPI are shown in the following table.

NON-PASS THROUGH MARKET BASKET CLASSIFICATION
(Excluding Wages and Benefits)

MARKET BASKET CATEGORIES	PRICE INDICATORS	
	VARIABLE	SOURCE
(1) Professional Fees for Physicians	Physicians' services component	Consumer Price Index, Urban Consumers
(2) Other Professional Fees	Hourly earnings production or non supervisory, private nonagricultural employees	U.S. Department of Labor, Bureau of Labor Statistics
(3) Food	Average of processed foods and feeds component of PPI and food and beverages component of CPI	Producer Price Index Consumer Price Index All Urban Consumer
Drugs	Pharmaceuticals and ethicals component	Producer Price Index
(5) Other costs:		
(a) Chemicals	Chemicals and allied products component	Producer Price Index
(b) Surgical & Medical Instruments and Supplies	Special industry machinery and equipment component	Producer Price Index
(c) Rubber and Plastics	Rubber and plastics	Producer Price Index
(d) Travel	Transportation component	Consumer Price Index All Urban Consumers
(e) Apparel and Textiles	Textile products and apparel component	Producer Price Index
(f) Business Services	Services component	Consumer Price Index All Urban Consumers
(g) All Other	All items	Consumer Price Index All Urban Consumers

b) The price index shall be 1.0 + the percentage increase in each price category as measured by the price indicator, expressed as a proportion.

8) The formula for the hospital IPI shall be:

IPI = (PX1 * PGE1) + (PX2 * PGE2) +
(PX3 * PGE3) + (PX4 * PGE4) +
(ASWI * PGE5) + (AEBI * PGE6) +
(PXO * PGE7)

Where:

IPI = Input Price Index.
PX1 = Price Index for Medical Professional Fees.
PX2 = Price Index for Other Professional Fees.
PX3 = Price Index for Food Costs.
PX4 = Price Index for Drug Costs.
ASWI = Adjusted Salary and Wage Index.
AEBI = Adjusted Employee Benefit Index.
PXO = Price Index for Other Costs.
PGE1 = Proportion of non-pass-through GOE which is for Medical Professional Fees for the prior fiscal period.
PGE2 = Proportion of non-pass-through GOE which is for Other Professional Fees for the prior fiscal period.
PGE3 = Proportion of non-pass-through GOE which is for Food Costs for the prior fiscal period.
PGE4 = Proportion of non-pass-through GOE which is for Drug Costs for the prior fiscal period.
PGE5 = Proportion of non-pass-through GOE which is for Salary and Wages for the prior fiscal period.
PGE6 = Proportion of non-pass-through GOE which is for Employee Benefits for the prior fiscal period.
PGE7 = Proportion of non-pass-through GOE which is for Other Costs for the prior fiscal period.
non-pass-through GOE = GOE minus total of all pass-through costs for the prior fiscal period.

9) Providers that do not supply the data needed to calculate the IPI, shall have an IPI equal to the hospital market basket increase as calculated by HCFA, for the closest corresponding time period. For hospitals with short FPEs, the closest corresponding time period shall be the one with the closest mid-point.

J. A volume adjustment shall be made to the provider's non-pass-through portion of the ARPD for the settlement fiscal period if the number of annualized total hospital discharges in the provider's settlement fiscal period differs from the number of

annualized total hospital discharges in its prior fiscal period. The volume adjustment is used to allocate fixed costs on a per discharge basis. Provider fiscal periods (both settlement and prior) under 360 or over 370 days shall be annualized to a 365 day period based on the following formula:

ATHD = (365/DFP) * THD.

Where:

ATHD = Annualized total hospital discharges.
DFP = Days in fiscal period.
THD = Total hospital discharges.

1) The volume adjustment shall be calculated using the following formula which adjusts the rate per discharge for estimated changes in average costs resulting from changes in volume.

VOLUME ADJUSTMENT FORMULA

AIPI = IPI * VAF

Where:

AIPI = Allowable change in the prior year non-pass-through portion of the APRD after volume adjustment, expressed as a proportion. This is the adjusted IPI, which has not been annualized and does not include any CMAF or SIPTF.

IPI = Hospital Input Price Index.

$$VAF = \frac{DIS_P + (VC * (DIS_F - DIS_P))}{DIS_F}$$

VAF = Volume Adjustment Factor

DIS_P = Total hospital discharges in the prior fiscal period (annualized if needed).

VC = Variable cost as a proportion of total cost for the prior fiscal period.

* = Multiplication.

DIS_F = Total hospital discharges in the settlement fiscal period (annualized if needed).

2) Each provider's total costs, except for pass-through costs, shall be divided into the fixed and variable components shown in the following table. Data from the provider's Medi-Cal cost report or in the event it is unavailable, other direct report of expenses, shall be used to estimate the percentage of a provider's cost which varies with volume. A fixed to variable cost ratio of 50:50 shall be used when sufficient data from the provider are not available.

Approach: Reimbursement to Out-of-State Hospitals for Inpatient Services Provided to Medi-Cal Beneficiaries

Out-of-state hospital inpatient services which have been certified for payment at the acute level and which are either of an emergency nature or for which prior Medi-Cal authorization has been obtained, shall be reimbursed the current statewide average of contract rates for acute inpatient hospital services provided by hospitals with at least 300 beds or the hospital's actual billed charges, whichever is less. Contract rates are negotiated by the California Medical Assistance Commission (CMAC), which annually reports to the California Legislature the average of such rates as of the preceding December 1. The term "current" in this paragraph refers to the most recent average of the contract rates for hospitals with at least 300 beds that CMAC has reported to the Legislature. The average of the contract rates for hospitals with at least 300 beds as of December 1 in a particular calendar year will be the maximum rate paid to out-of-state hospitals for dates of service beginning January 1 of the following calendar year.

CLASSIFICATION OF FIXED AND VARIABLE COSTS

FIXED COSTS	VARIABLE COSTS
SALARIES AND WAGES	SALARIES AND WAGES
Management and supervision	Registered nurses
Technician and specialist	Licensed vocational nurses
Clerical and other administrative	Aides and orderlies
Physicians	Environmental and food Services
Nonphysician medical practitioners	Other salaries and wages
EMPLOYEE BENEFITS-Distributed proportionately according to salaries and wages	EMPLOYEE BENEFITS-Distributed proportionately according to salaries and wages
FICA	FICA
Unemployment insurance	Unemployment insurance
Vacation, holiday, and sick leave	Vacation, holiday, and sick leave
Group insurance	Group insurance
Pension and retirement	Pension and retirement
Workers' compensation	Workers' compensation
Other employee benefits	Other employee benefits
OTHER DIRECT EXPENSES	PROFESSIONAL FEES
Insurance	Medical
Other direct expenses	Consulting and management
	Legal
	Audits
	Other professional fees
	SUPPLIES
	Food
	Surgical supplies
	Pharmaceuticals
	Medical care materials
	Minor equipment
	Nonmedical supplies
	PURCHASED SERVICES
	Medical
	Repairs and maintenance
	Management services
	Other purchased services

3) A provider may submit additional data on the classification of fixed and variable costs for review by the Department with the AAR. If these alternative classifications and/or data are accepted by the Department, the provider shall continue to:

(a) Utilize these accepted classifications of fixed and variable costs in all FPEs.

(b) Submit to the Department, along with their filed cost report, any required data on fixed and variable costs necessary to do the alternative calculations for all subsequent FPEs. If the provider fails to supply the data with the cost report, they shall have their interim payments reduced by 20 percent. If the data has not still been supplied 60 days after the 20 percent reduction in interim payments begins, the provider shall have their interim payments reduced by 100 percent until the data are supplied. The provider shall be given 30 days advance notice to supply the required data before any reductions in interim payments are applied under this part of the Plan.

4) All providers must supply the data items for each FPE necessary to do the PIRL calculations. The data must be supplied as part of each provider's Medi-Cal cost report.

K. Summary of ARPDL formula for provider with full settlement and full prior fiscal periods:

(1) ARPDL = MCDIS *
(2) (((RENTS + LIC + PTAX + DEP + LEAS + INT + UTL + MPI) / THD) +
(3) (((PMIRL - (PMCDIS * (TPTCPP / PTHD))) / PMCDIS) *
(4) (((((PX1 * (MPFP / (GOEPP - TPTCPP))) +
(5) (PX2 * (OPFP / (GOEPP - TPTCPP))) +
(6) (PX3 * (FOODP / (GOEPP - TPTCPP))) +
(7) (PX4 * (DRUGP / (GOEPP - TPTCPP))) +
(8) (($\sum_{k=1}^{6} (PYH_k * CYHR_k)$ / $\sum_{k=1}^{6} (PYH_k * PYHR_k)$) *
(9) (SWP / (GOEPP - TPTCPP))) +
(10) (((PYHT * CYBR) / PYB) *
(11) (PYB / (GOEPP - TPTCPP))) +
(12) (PXO * (OTCP / (GOEPP - TPTCPP)))) *
(13) ((DIS$_p$ + (VC * (DIS$_f$ - DIS$_p$)))/DIS$_f$)) *
(14) ((($\sum_{i=1}^{n} DRGC_i$) / MCDIS) / (($\sum_{j=1}^{n} DRGP_j$)/ MCDISP))) +
(15) (STA + PI + SI))))

Where:

ARPDL = All-Inclusive Rate Per Discharge Limitation.
MCDIS = Medi-Cal discharges in the settlement fiscal period.
RENTS = Rental costs for the settlement fiscal period.
LIC = License fees for the settlement fiscal period.
PTAX = Property Tax expenses for the settlement fiscal period.
DEP = Total allowable Depreciation expenses for the settlement fiscal period.
LEAS = Lease expenses for the settlement fiscal period.
INT = Allowable Interest expense for the settlement fiscal period.
UTL = Allowable utility expenses for the settlement fiscal period.
MPI = Total Malpractice Insurance costs for the settlement fiscal period.
THD = Total hospital discharges for the settlement fiscal period.
PMIRL = MIRL (Lowest of rate, costs and charges) for the prior fiscal period.
PMCDIS = Medi-Cal discharges in the prior fiscal period.
TPTCPP = Total allowable pass-through costs for the prior fiscal period.
PTHD = Total hospital discharges for the prior fiscal period.
PX1 = Price index for medical professional fees.
MPFP = Allowable Medical Professional Fees for the prior fiscal period.
GOEPP = Gross Operating Expenses (GOE) for the prior fiscal period.
PX2 = Price index for Other Professional Fees.
ODFP = Allowable Other Professional Fees for the prior fiscal period.
PX3 = Price Index for Food costs.
FOODP = Allowable food costs for the prior fiscal period.
PX4 = Price Index for Drug costs.
DRUGP = Allowable costs for Drugs for the prior fiscal period.
PYH_k = Prior fiscal period hours paid for employee classification k.
$CYHR_k$ = Settlement Fiscal Period Hourly Wage rate for employee classification k.
$PYHR_k$ = Prior fiscal period Hourly Wage Rate for employee classification k.
SWP = Allowable costs for salaries and wages for the prior fiscal period.
PYHT = Prior fiscal period paid hours.
CYBR = Settlement fiscal period hourly benefits rate.
PYB = Prior fiscal period benefits.
PXO = Price Index for Other Costs.
OTCP = Other allowable costs for the prior fiscal period.
DIS_p = Total hospital discharges for the prior fiscal period.
VC = Variable cost proportion for the prior fiscal period.
DIS_f = Total hospital discharges for the settlement fiscal period.
$DRGC_i$ = DRG weight for patient i in the settlement fiscal period.
n = Number of DRG weights in the settlement fiscal period.
$DRGP_j$ = DRG weight for patient j in the prior fiscal period.
m = Number of DRG weights in the prior fiscal period.
MCDISP = Medi-Cal discharges in the prior fiscal period.

STA = Adjustment factor for Scientific and Technological Advancement.
PI = Adjustment factor for Productivity Improvement.
SI = Adjustment factor for Service Intensity.

Lines 2 through 15 are the ARPD = All-Inclusive Rate Per Discharge.
Line 2 is the PASPD = Pass-through cost per discharge.
Line 3 is the PNPARPD = Prior fiscal period Non-pass through MIRL Reimbursement Rate Per Discharge.
Lines 4 through 12 are the IPI = Input Price Index.
Lines 4 through 13 are the AIPI - Adjusted Input Price Index.
Lines 4 through 15 are the HCI = Hospital Cost Index.
Line 8 is the SWI = Salary and Wage Index.
Line 10 is the EBI = Employee Benefits Index.
Line 13 is the VAF = Volume Adjustment Factor.
Line 14 is the CMAF = Case Mix Adjustment Factor.
Line 15 is the SIPTF = Allowance for Service Intensity, Productivity, and Scientific and Technological Advancement Factor.

VI. ADMINISTRATIVE ADJUSTMENT PROCESS

A. A provider may request an AA to the ARPDL or PGRPDL established for that provider if the provider's cost based allowable reimbursement for the settlement fiscal period as defined by the lower of Section II A. 1) and 2) of this Plan, exceeds or are expected to exceed the PIRL by over $100. Expected to exceed only refers to the settlement period being issued and not any future settlement fiscal periods. The burden shall be on the provider to estimate, using the PIRL settlement information provided by the Department and any other information they may have, if they will expect to exceed the PIRL by over $100.

B. Items that are not subject to an AA or appeal include the following:

1) The use of Medicare standards and principles of reimbursement.

2) The reimbursement amounts determined in Section II A. 1) and A. 2) of this Plan.

3) The method for determining the IPI.

4) The use of all-inclusive reimbursement rates.

5) The use of a volume adjustment formula.

6) Disproportionate share payments (these are not reduced by application of the PIRL).

7) Data reported on the cost report which has been audited or reviewed by the Department or considered true and correct pursuant to W&I Code Section 14170. Data that was incorrectly transferred from the providers Medi-Cal cost or audit report and used to calculate the MIRL is subject to appeal.

8) The methodology used to calculate the interim rate.

9) Any prior fiscal period issues, including the base period.

10) Higher costs due to low occupancy.

11) Items not reimbursed as part of the Medi-Cal cost report process as determined in Section II A. 1) and A. 2) of this Plan.

12) Increased costs. Only the cause for the increased costs may be appealable, and then only if it is otherwise an appealable item.

13) Any issue raised in a previous formal appeal for which a decision was made by the Department for the same provider. The only exception is to incorporate into the settlement fiscal period PIRL the prior decision in the same manner as it was previously decided by the Department. These only include decisions made for FPEs affected by Parts I through XIII of this Plan. This does not include issues withdrawn by the provider and thus not determined on their merits in the formal decision.

14) Increases in average length of stay.

15) Changes in the Cost-Based Reimbursement System as determined under Section II A. 1) and A. 2) of this Plan.

16) Increased costs incurred by entering into a contract which did not contain reasonable cost increase limitations.

17) Increases due to increased costs or charges of a related party.

18) Any issues involving labor cost increases except for those allowed in Section VII B. of this Plan.

19) New services.

C. Issues involving the following MIRL (or ARPDL but not PGRPDL) items may be resolved through an AA under the procedures in Section VII of this Plan.

1) Changes in Medi-Cal case mix and outliers.

2) Inappropriate calculation of fixed and variable costs.

3) An error in the calculations.

4) Determination of whether or not a provider is exempt from the ARPDL.

5) Extraordinary and unusual events.

6) Labor costs as allowed under Section VII B. of this Plan.

7) Other causes of cost increases for costs which were economically and efficiently incurred for the necessary care of Medi-Cal inpatients, that are an increase on a per-discharge basis over the prior fiscal period and are not listed under B. as not being subject to an AAR.

8) The interim rate as it may be affected by changes resulting from items appealed under 1) through 7) above.

D. If a provider's cost based reimbursement is the lower of Section II A. 1) and A. 2) of this Plan and exceeds both the ARPDL and the PGRPDL, the providers' AAR and any subsequent appeal of the AA, must address both limitations in order to obtain relief for both limitations. If only the ARPDL is appealed, no further appeal rights will exist for the PGRPDL at any later date, except for an AAR on a tentative PIRL settlement that is issued later as a final PIRL settlement.

E. The procedures for requesting an AA of an ARPDL shall be as follows:

1) A request for an AA of the ARPDL or PGRPDL, which the

Department deems acceptable, shall be submitted within 90 days after notification of that limitation. These AARs must be postmarked or hand delivered on or before the 90th day after the postmark on the settlement notification letter. No extensions shall be granted. If a settlement letter from the Department contains settlements for more than one fiscal period, 120 days shall be allowed to file the AAR.

2) The AAR shall be submitted in writing to the Department and shall specifically and clearly identify each issue, the total dollar amount involved for each issue and the dollar amount of overlap among each issue. If the Department determines that additional data are needed, the provider shall have 60 days after written notification of the Department's request to supply it to the Department. No extension shall be granted.

3) The AAR need not be formal, but it shall be in writing and specific as to each issue in dispute, setting forth the provider's specific contentions as to those issues and the estimated amount each issue involves. If the Department determines that the request for any issue fails to state the specific grounds upon which objection to the specific issue is based, including the estimated dollar amount involved, the provider shall be notified that it does not comply with the requirements of this regulation and the issue cannot be accepted. If an issue is not accepted on this basis, the provider may not submit this issue as a formal appeal.

4) All AARs must be signed by an employee of the provider authorized by the provider to do so or by an authorized representative.

   (a) If the AAR is signed by an authorized representative, a signed statement of such authorization for each fiscal period must accompany the AAR signed by an appropriate employee of the provider.

   (b) Each AAR must have a declaration attesting to the validity of all statements contained in the AAR. The declaration shall be signed by an appropriate employee of the provider or an authorized representative.

5) For each issue other than those covered by one of the specific formulas in this Plan the provider must demonstrate either (a), (b) or all parts of (c) below:
   (a) Data that was incorrectly transferred as specified in Section VI B. 7) of this Plan.

   (b) An error was made in the rate calculation.

   (c) All costs for which additional reimbursement are being requested were:

      1. economically and efficiently provided for the necessary care of Medi-Cal inpatients.

      2. not already included in the ARPDL and/or PGRPDL, whichever limitation(s) is being appealed.

      3. not overlap with any other AAR issue, or if there were, all such overlap must be used to reduce any additional reimbursement which would otherwise have been granted.

6) The request shall contain all the appropriate data to allow the Department to determine if relief is needed and to do the relief calculation.

   (a) This may include, but is not limited to:

      1. All internal/external reports concerning each issue;

      2. All material presented to the hospitals' Governing Board concerning this issue;

      3. Medical records for Medi-Cal patients;

      4. Bank statements and canceled checks;

      5. All financial statements;

      6. Copies of contracts.

      7. Copies of proposed and/or actual budgets.

      8. The provider's suggested calculation for relief except for each issue specifically listed under Section VII below, the formula in this Plan must be used.

(b) All data submitted must be accompanied by one or more statements attesting that the data are true and correct signed by an individual with knowledge of the submitted data. More than one statement may be required if more than one data source is utilized.

(c) All data submitted may be audited by the Department.

7) One-time relief may be granted for extraordinary and unusual events.

(a) The criteria for one-time relief is any item which occurred in one fiscal period and is not normally expected to apply to all future fiscal periods and therefore the ARPDL is not adjusted each future fiscal period for this issue.

(b) Formula relief shall only be granted for issues which are expected to carry on to every future fiscal period.

(c) Any relief granted for allowable increases in employee hours per discharge shall be one-time relief for the first two fiscal periods and then formula relief during the third fiscal period.

8) The following steps are required by the Department for calculating relief:

(a) The provider shall clearly identify each issue and the estimated dollar amount of relief for each issue.

(b) The provider shall identify the specific cause of the increased costs.

(c) The provider shall calculate what reimbursement is already included in the ARPDL due to this issue (such as pass-throughs) and/or overlap from other AAR issues.

(d) The Department shall review the providers' figures on (a) and make any necessary corrections.

(e) The Department shall determine whether to grant one-time or formula relief or no relief.

9) If data or other items requested by the Department for evaluation of an AAR are not supplied within 60 days, the Department shall suspend further consideration of this issue. After written notification if the requested data are not supplied within 120 days, the Department shall deem the AAR rejected for all issues for which the Department requested data or other items, and the provider shall be precluded from raising the issues in a formal appeal.

10) The provider shall be notified of the Department's decision in writing within 90 days of receipt of the provider's written request for an AA or within 60 days of receipt of any additional documentation or clarification which was required by the Department, whichever is later. The request for an AA shall be deemed denied if no decision is issued within these time frames.

11) A change in cost based reimbursable costs as defined in Section II A. 1) and A. 2) of this Plan whether or not as a result of an audit appeals process, shall result in a redetermination of the PIRL, and shall not give rise to any additional appeal rights.

VII. SPECIFIC ADMINISTRATIVE ADJUSTMENT ISSUES

A. AAs for year-to-year changes in case mix and/or outliers under the ARPD (not the PGRPD) shall be resolved in the following manner:

1) The case mix adjustment factor (CMAF) shall be calculated using the following steps:

(a) the provider shall supply a listing for every Medi-Cal discharge that occurred during both the settlement fiscal period and the prior fiscal period, sorted in admission date order, and shall include as a minimum:

1. The patient's last name and first initial.

2. Medi-Cal I.D. Number.

3. The admission date.

4. The discharge date.

5. The principal diagnosis code.

6. The total amount of billed charges.

7. The DRG number.

8. The DRG weight. The same set of DRG groups and weights must be used for both settlement fiscal period and prior fiscal period data. If charges for a newborn were billed together with its mother, the newborns and the mother must be listed separately on this listing, each with their own DRG and weight.

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

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

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

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

(e) Once a CMA is granted, each subsequent fiscal period ARPDL shall include a CMA (even if the adjustment is negative) and the provider shall supply all required data necessary to do the CMA calculation to the Department within 9 months after the end of each subsequent FPE. Failure to do so will result in a 20 percent reduction to the provider's current interim payments. If the data

is not received within 12 months of the end of the FPE, the interim payment reduction shall be increased to 100 percent, resulting in an interim payment rate of zero percent. If a provider does not supply the data prior to the issuance of the final settlement, the CMAF shall be calculated so as to remove the affect of all previous CMAFs by compounding the previous CMAFs and applying the result to decrease the settlement fiscal periods ARPD. The provider shall not be eligible for a CMAF for any fiscal period. However, if the tentative PIRL settlement is issued within 9 months of the end of the FPE and the case mix data has not yet been supplied, then a CMAF of 1.0 shall be used for the tentative PIRL settlement only.

The provider shall be given 30 days advance notice prior to applying any reductions in interim payments under this part of the plan.

(f) For noncontract hospitals, the DRG weights shall be modified by one of the following two methods:

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

2. All DRG weights for patients transferred to other acute care hospitals after being stabilized shall be adjusted as follows:

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

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

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

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

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

2) Additional reimbursement shall be granted to approximate a hospital's increases, on a per discharge basis, in the marginal cost of care beyond specified thresholds that are not already reimbursed for in the ARPDL, including the CMAF. AARs for additional reimbursement due to outliers (both cost and day outliers) shall be determined as follows:

(a) If the provider has received a CMAF for the settlement fiscal period, then the outlier relief shall be calculated by:

1. the hospital shall also include on the listing required under A. 1) above the following additional items:

a. The length of stay for each patient.

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

c. If a patient qualifies as a day outlier under the Medicare prospective payment definitions, or using the alternative cutoff when the alternative DRG weights are used, then the amount of allowable outlier payments shall also be listed. This amount shall be the MIRL

divided by the number of Medi-Cal patient days, times 80 percent, multiplied by the number of days over the day outlier threshold for each patient.

d. For patients that do not qualify as a day outlier, but do qualify as a cost outlier, the amount of costs over the threshold shall be listed and shall be calculated as follows:

(1) The outlier cost cutoff shall be the greater of:

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

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

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

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

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

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

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

(3) Relief shall be calculated by subtracting the prior fiscal period result of (2) from the settlement fiscal period result of (2).

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

The provider shall be given 30 days advance notice prior to applying any reduction on interim payments under this part of the Plan.

(b) If a provider has not elected a CMA, then relief for outliers shall be calculated as follows:

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

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

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

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

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

settlement fiscal periods.

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

7. Calculate the amount of day outlier payments by:

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

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

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

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

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

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

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

8. For patients who do not qualify as a day outlier, additional relief shall be provided as a cost outlier as follows:

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

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

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

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

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

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

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

h. For each FPE, list the following items for each Medi-Cal patient, in admission date order, over the charge threshold as calculated in g. above:
   (1) Last name and first initial.

   (2) Admission date.

   (3) Length of stay.

   (4) Charges.

   (5) Amount of charges over the threshold.

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

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

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

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

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

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

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

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

B. AAs for changes in labor costs shall be resolved in the following manner:

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

2) The Department will be authorized to grant relief if the provider meets the criteria for relief. Any relief granted shall be based upon an analysis of labor costs both prior and subsequent to the effective date of the

adherence to the requirements. Any request for relief will require the following:

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

(b) Additional hours and staff required to adhere to the governmental requirements. The request will specify:

1. The exact title(s) of the added staff;

2. The appropriate employee cost category; and

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

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

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

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

4) The Department shall evaluate the submitted data to determine any changes in the following areas for each effected cost center:

(a) Labor hours per discharge;

(b) Labor costs per discharge;

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

5) The unit measure of change shall be the ARPD. Any relief granted shall be on a per discharge basis by adjusting the ARPD to incorporate the increased, if any, labor costs per discharge which were not reimbursed in the ARPD and which do not overlap with any

other issues. Any adjustments necessitated by the application of relief shall impact the base rate per discharge and will be carried forward into future settlements.

6) The only basis for relief under Section VII. of this Plan shall be:

   (a) Increased employee hours per discharge; or

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

7) Requests for relief on the basis of increased patient acuity will be deferred to Section VII. A. of this Plan. Patient acuity or service intensity shall not be entertained under Section VII. B. of this Plan.

8) Relief sought on the basis of labor disputes shall not be granted. Labor disputes are inclusive of, but not limited to, strikes, arbitration, and/or labor issues where employees in an organized, collective, or unified movement refrained from physically reporting to perform their routine duties or physically reported but refrained from performing their routine duties.

9) Relief shall not be granted under Section VII. B. of this Plan as the result of circumstances created when the provider switched to or from nursing services instead of salaried personnel.

C. The following steps will be used for calculating relief, if any, for any ARPDL issues not otherwise specified in this regulation:

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

2) The provider shall determine what is the specific underlying cause of the increased costs. If the underlying cause of the increased costs is not clearly stated, the AAR shall not be accepted by the Department.

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

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

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

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

VIII. AA FORMAL APPEALS PROCESS

A. A provider may appeal the Department's decision on the AAR for a final PIRL settlement only. There shall be no appeal on an AAR for a tentative PIRL settlement. The appeal shall be filed and conducted in accordance with the applicable procedural requirements of the provisions of the Plan, except as modified by Section VIII., including the following:

1) The appeal shall be submitted within 30 days after notification of the Department's decision on the AAR,

2) The provider shall present its issues and evidence first at the hearing, as they shall have the burden of going forward.

3) The provider has the burden of proof of demonstrating by a preponderance of the evidence, that the provider's position regarding disputed issues is correct.

4) In order to demonstrate that it is entitled to relief from the PIRL and that the AA decision should be overturned, the provider has the burden of demonstrating by a preponderance of the evidence that the Department's AA decision is inconsistent with the applicable regulatory provisions and that the provider's alternative is consistent with the applicable regulatory provisions.

5) If the Department's AA decision is proved, by a preponderance of evidence, inconsistent with the applicable regulatory provisions, and the provider has not proved by a preponderance of the evidence that its position is consistent with the applicable regulatory provisions, then the Administrative Law Judge (ALJ) may fashion whatever relief is necessary to obtain consistency with the applicable regulatory provisions.

6) Items that are not subject to an AA as specified in Section VII. of this Plan, shall not be subject to appeal.

7) The provider shall be paid at the PIRL initially determined by the Department pending determination of a formal appeal.

8) Any underpayments, identified in the appeal decision, shall be repaid to the provider, together with interest computed at the legal rate of interest beginning the later of the date the payment is received by the Department or the date the appeal is formally accepted by the Department.

9) The evidence to be submitted by the provider at a formal appeal hearing that was not provided to the Department nor specifically and individually identified as available to the Department, during the AA process excluding oral testimony, must be submitted to the Department 30 days before the scheduled date of the hearing. The only exception, is when a hearing is scheduled within 45 days from the date notice is given. In this latter case, evidence must be submitted 15 days before the scheduled date of the hearing. Failure to submit this information within the specified time frames shall result in its exclusion from the formal appeal hearing and record.

10) Recalculation of the PIRL due to an appeal decision shall not give rise to any further appeal rights.

11) If results of an audit appeal of the cost report or any prior fiscal period PIRL, AA or appeal, change data used in the settlement fiscal period PIRL, the PIRL shall be recalculated. The recalculation shall not give rise to further appeal rights.

12) If an issue in an AAR is not accepted pursuant to Section VI. E. 2) and 3), the ALJ may only consider the evidence that was presented in the AAR and not any additional information or testimony. If the ALJ determines that the issue should have been accepted, the issue shall be remanded for a response to the merits.

13) Only those issues that were clearly identified in a timely filed AAR, including an estimated dollar amount for each issue may be accepted as issues on a formal appeal.

IX. PEER GROUPING

A. Hospital reimbursement shall, unless exempted from or modified by the provisions of this Part, be payable at no more than the 60th percentile aligned ARPD of the peer group to which the hospital is assigned by the Department. This limit is the Peer Group Rate Per Discharge Limitation (PGRPDL). The peer groups shall be based on a classification of hospitals as determined in the 1991 Hospital Peer Grouping Report (Appendix C) published by the Department, that combines individual hospitals in a unit on the basis of similar or common characteristics. The following peer group classifications will be used:

1) University Teaching Hospitals.

2) Major (non-university) Teaching Hospitals.

3) Large Teaching Emphasis Hospitals.

4) Medium/small Teaching Emphasis Hospitals.

5) Extremely Large Sized Hospital.

6) Large Sized Hospitals.

7) Moderately Sized Hospitals.

8) Medium Sized Hospitals.

9) Moderately Small Sized Hospitals.

10) Very Small Sized Hospitals.

11) Acute Psychiatric Hospitals.

12) Alcohol-Drug Rehabilitation Hospitals

13) Combination Psychiatric/Alcohol/Drug Rehabilitation Hospitals.

14) Psychiatric Health Facilities.

15) Psychiatric Teaching Hospitals.

16) Psychiatric Children's Hospitals.

17) Moderate Alcohol-Drug Rehabilitation Emphasis Hospitals.

18) Moderate Psychiatric Emphasis Hospitals.

19) State Hospital-Veterans Home.

20) State Hospital-Mental Health.

21) State Hospital-Developmental Services

22) Children's Hospitals.

23) Crippled Children's Hospitals.

24) Rehabilitation Hospitals.

25) Large Rehabilitation Emphasis Hospitals.

26) Respiratory Specialty Hospitals.

27) Student Health Centers.

28) Charitable Research Hospitals.

29) Rural Hospitals.

30) Specialty Teaching Hospitals.

31) Prepaid Health Plan-Psychiatric/Alcohol-Drug Rehabilitation Hospitals.

32) Prepaid health Plan-Teaching Emphasis.

33) Eye Hospitals.

34) Women Hospitals.

35) Dental/Outpatient Hospitals.

B. The Department may review and change the number and definitions of peer groups and the peer group placement of individual providers.

1) Providers shall be notified of all such reviews and resultant changes to the peer groups.

2) For purposes of peer group placement, license beds shall be average licensed beds excluding any beds in suspense in accordance with Section 1271.1 of the Health and Safety Code.

3) All peer group assignments will be for all FPEs between July 1st and June 30th for each fiscal year.

C. Providers exempted from application of the PGRPDL shall consist of new hospitals, rural hospitals, sole community hospitals, children's hospitals, crippled children's hospitals, charitable research hospitals, primary health service hospitals and hospitals in peer groups with less than five Medi-Cal providers.

D. Providers with less than 15 Medi-Cal discharges in any FPE that covers over 360 days, shall be exempt from the PGRPDL for that FPE.

E. The peer group 60th percentile ARPD for each July 1-June 30 FPE shall be calculated by:

1) Obtaining the ARPD for each provider for the FPE during the state's fiscal period (or use the latest available if one is not yet available for the selected time period).

2) Using actual or estimated rates of inflation, align the ARPD for each hospital to a July 1 to June 30 FPE.

3) Locating the 60th percentile, by multiplying 0.6 times one more than the number of ARPDs in the peer group.

4) Starting from the bottom of a list of ARPDs, ordered from the lowest ARPD at the bottom, up to the highest ARPD at the top, count up the number of ARPDs using the result of E. 3) above.

5) Interpolate if necessary.

F. The 60th percentile ARPD shall be updated quarterly.

G. Once a final PIRL settlement is issued for a provider, the 60th percentile ARPD established in that Providers FPE shall not change, even though the final PIRL settlement may be reissued as a "recalculated final PIRL settlement" as a result of any appeal as well as other reasons for recalculation.

X. PEER GROUP ADMINISTRATIVE ADJUSTMENTS

A. A provider may request an AA of the reimbursement limits specified in this Section of the Plan and their peer group placement at the time of tentative and final PIRL settlement.

1) The request shall be made within 90 days after notification of the reimbursement limits and shall be made in accordance with the procedures specified in Section VI. of this Plan.

2) The burden of proof shall be on the provider to prove that the additional reimbursement sought meets all of the requirements under Section VI. and that except where a specific formula in Section XI. exists, the provider's cost per discharge of the item being appealed, exceeds the 60th percentile cost per discharge of the item being appealed.

3) In addition to the items listed under Section VI. B. of this Plan, the following items shall not be subject to an AA of the PGRPDL:

(a) The use of hospital peer groups.

(b) The use of 60th percentiles and the methods used to compute them.

(c) Changes in case mix.

(d) Costs associated with strikes other labor stoppages or slow downs.

(e) The addition of new services.

(f) Costs due to low occupancy.

(g) Difference in the type, nature, or scope of items or services available whether or not provided, between the provider and other providers in its peer group since differences in the actual services needed to be rendered are accounted for in the CMA as specified in Section XI. of this Plan.

(h) Any other issue that is not a difference between the provider and other providers in their peer group.

4) A provider may appeal the Department's decision on the AA for final PIRL settlements only. The appeal shall be in accordance with Section VIII. of this Plan.

XI. PEER GROUP SPECIFIC ADMINISTRATIVE ADJUSTMENT ISSUE

A. Differences in case mix (including outliers) between the provider and other providers in its peer group shall be determined for the PGRPDL using the following formula, but subject to reduction for overlapping issues as specified in D. below:

MARD=PGL * CMA

Where: MARD=Maximum Allowable Rate Per Discharge under the PGRPDL.

CMA=Case mix adjustment factor, which is the providers case mix index divided by the peer group 60th percentile case mix index.

PGL=Peer grouping reimbursement limit per discharge (60th percentile ARPD for the peer group if no adjustments have been made).

1) Case mix indexes shall be based on DRGs and shall be computed using OSHPD patient discharge data for providers. Providers with an ARPD CMAF shall use data they are required to supply for the ARPD CMAF. However, the set of DRG weights used must be consistent for all providers in the peer group and shall be determined by the Department for each FPE.

2) Providers shall be allowed to submit more accurate diagnosis and disposition data used to calculate the DRG case mix index. Any such patient discharge data must be submitted with the AAR. The data cannot be used until it is verified by the Department. The Department shall not accept data that it determines may not accurately reflect the provider's Medi-Cal patients.

3) If OSHPD patient discharge data does not correspond with all provider's FPE the closest FPE shall be used. Indices will be developed for a calendar year and for a July 1 through June 30 FPE. The period which most closely corresponds to the providers' FPE shall be used. Calendar year data snall be used for FPEs from October 1 through March 31 inclusive. July 1 through June 30 fiscal period data shall be used for all other FPEs.

4) CMAs may be applied to any provider with a case mix index greater than the 60th percentile case mix index of its peer group.

5) In addition to case mix relief, a provider shall be granted relief for outliers if the provider's outlier relief per discharge is greater than the computed 60th percentile outlier relief per discharge for all providers in the provider's peer group. The methodology used shall be as follows:

   (a) Using OSHPD patient discharge data, and Medicare criteria for DRG outlier relief as specified in 42 CFR, Part 412, compute the total outlier relief for all providers in each peer group (using the same formula as listed in Section VII. ARPD case mix and outliers). However, the cost outlier cutoff shall not vary within any one FPE worth of data.

   (b) Convert the results under 1) above to outlier relief per Medi-Cal discharge.

   (c) Align the results of (b) above, in order from lowest at the bottom up to the highest at the top, and by counting up from the bottom to the n + 1 provider (n = # of providers in the peer group), compute the 60th percentile outlier relief per discharge for each peer group.

   (d) If the requesting providers outlier relief per discharge is greater than the 60th percentile outlier relief per discharge, the provider's MARD shall be increased by the difference of the two figures.

6) These formulas shall be subject to the following limitations:

   (a) Only those providers with 30 or more Medi-Cal discharges shall be included in the calculation of the 60th percentile outlier and case mix index per discharge. However, providers with under 30 Medi-Cal discharges may still receive relief using the formulas in this Part.

   (b) Providers whose Medi-Cal discharge count per their OSHPD patient discharge data has more than a 50 percent variance from the appropriate Medi-Cal discharge figure from the cost report, after

adjusting for well newborns who are included in the OSHPD patient discharge data but not counted as Medi-Cal discharges, shall be excluded from the 60th percentile calculation. Cost report figures shall be adjusted to estimate the calendar or fiscal period OSHPD data.

(c) If the provider requesting outlier relief has more than a 10 percent variance in Medi-Cal discharge figures (OSHPD patient discharge data vs. Medi-Cal cost report), or under 30 Medi-Cal discharges, the provider shall be required to submit its own data for use in the calculation. Such data must be for all Medi-Cal patients and include the patient's last name, ICD-9 primary diagnosis code, admission date, discharge date, DRG number, charges, patient's age, and OSHPD disposition code. The list shall be in admission date order.

(d) Providers may submit additional data to replace the OSHPD data. Any such data must be supplied with the AAR. Providers must supply a list in admission date order, containing each Medi-Cal patient's last name, ICD-9 code, admission date, discharge date, DRG number, charges, patient's age, and OSHPD disposition code.

7) For noncontracting hospitals that do not keep a patient for the full episode of care, the CMA formula will be modified by one of the following formulas:

(a) Use only 40 percent of the appropriate DRG case mix weight for patients treated by noncontract hospitals, or

(b) (1) Track each patient's record to the contract hospital they were transferred to, and

(2) Sum the charges from both providers, and

(3) Apply the percent of total charges from the noncontract hospital to the DRG weight.

B. Differences in labor costs, caused by factors such as differences in location, between the provider and other providers in its peer group shall be calculated using the following formula, subject to reduction for overlapping issues as specified in D. below:

MARD = (LRCAF * WRR * PGL) + ((1-WRR) * PGL))

Where:

MARD = Maximum Allowable Rate Per Discharge under PGRPDL

LRCAF = Labor Related Cost Adjustment Factor, which is the minimum of (WI / PGWI), (HWR / PGWR) and (HWD / PGWD).

WRR = Wage Related Reimbursement Proportion of PGRPD (and ARPD) Reimbursement limitation for this hospital, which is: (TWRC / GOE) * (36LIMIT - %PASS * NETCOST)) / (36LIMIT * %NON).

PGL = Peer group limit, which is the 60th percentile ARPD.

WI = The wage and benefit index for the area in which the hospital is located.

PGWI = Peer group 60th percentile WI.

HWR = Hospital aligned wage and benefit rate per hour.

PGWR = Peer group 60th percentile HWR.

HWD = Hospital aligned wage related items per discharge.

PGWD = Peer Group 60th percentile HWD.

TWRC = Total wage related costs (sum of wages, benefits, and professional fees).

GOE = Gross operating expenses.

36 LIMIT = Maximum reimbursement under MIRL (lesser of costs, charges, and the ARPD multiplied by the number of Medi-Cal discharges).

%PASS = Proportion of GOE which are pass throughs from Report E, Part II, Line 3.

NETCOST = The lesser of net cost of covered services and charges.
%NON = 1 - %PASS, which is the proportion of GOE which are not pass-through costs.

NOTE: * = Multiplication

1) The labor adjustment formula starts by determining the portion of the MIRL that was allowed for Wage Related Reimbursement (WRR). Only this amount is adjusted by the minimum of:

(a) A ratio based on an area (Metropolitan Statistical Area (MSA)) index developed by the Department of Health and Human Services, calculated using aligned average hourly rates for all hospital employees. The provider's area index is divided by the peer group 60th percentile wage index.

(b) A ratio based on comparing the provider's aligned hourly rate to the 60th percentile aligned hourly rate of the peer group.

(c) A ratio based on comparing the providers aligned wage related items per discharge to the 60th percentile aligned wage related items per discharge for the peer group.

2) The first ratio is calculated as follows:

(a) Use Medi-Cal cost report data to determine the statewide average employee composition among all employee classifications.

(b) Adjust the wage and benefit rates for each provider to the adjusted rate using the statewide distribution of employees.

(c) Align the adjusted wage and benefit rate for each provider using OSHPD disclosure data. The alignment factors shall be a Department estimate of increases in salary levels.

(d) Sum the adjusted wages and benefits for each MSA and statewide.

(e) Sum productive hours by MSA and statewide.

(f) Divide the sum of wages and benefits by the sum of productive hours for each MSA and the statewide totals.

(g) Divide each MSA average aligned hourly wage rate by the statewide average to obtain an MSA index.

(h) Assign the index for each MSA to all hospitals in the MSA.

(i) Determine the 60th percentile index for each Peer Group.

(j) Divide the hospital's area index by the 60th percentile index of its peer group.

3) The second ratio is calculated by:

(a) Total the wages and benefits for all employees for each provider.

(b) Divide (a) above by the corresponding total productive hours for each provider.

(c) The Department shall estimate increases in employee hourly wage and benefit costs, and align the data in (b) above to a common FPE for all providers.

(d) Align all of the results of (c) above ordered from lowest at the bottom to the highest at the top for each peer group.

(e) Count (0.6 * (n + 1)) places up from the bottom of the list in each peer group to find the 60th percentile.

(f) N is the number of hourly rates in the peer group.

(g) Interpolation will be used whenever (0.6 * (n + 1)) is not a whole number.

4) The last ratio is calculated by:

(a) Total the wages and benefits for all employees for each provider.

(b) Using Department estimates of rates of increase in employee hourly wages and benefit costs, align the data in (a) above to a common FPE for all providers.

(c) Divide the result of (b) above by the number of total hospital discharges.

(d) For each peer group, order from lowest at the bottom to the highest at the top the results of (c) above.

(e) Count (.6 * (n + 1)) places up from the bottom of the list in each group to find the 60th percentile.

(f) N is the number of wage and benefit rates per discharge in the peer group.

(g) Interpolation will be used whenever (.6 * (n + 1)) is not a whole number.

C. Differences in capital costs between the provider and other providers in its peer group shall be resolved using the method specified in this subsection. Approval by the OSHPD of a capital expenditure shall be evidence of the need for the capital expenditure; however, such approval shall not, per se, compel additional reimbursement. The following methods shall be used to calculate relief under this issue:

1) Using data from the Medi-Cal cost report, compute relief by:

(a) Removing the 60th percentile capital cost per discharge from the 60th percentile allowable rate per discharge,

(b) Computing the allowable provider Medi-Cal capital expense per discharge subject to the limitations in (e) below, and

(c) Adding the result of (a) above to the result of (b) above.

(d) The resulting figure from (c) above will be used in place of the 60th percentile rate per discharge, but to avoid overlap with any other issue, this adjustment shall be made last.

(e) The result of 1) (b) above shall be subject to the following adjustments:

1. A hospital which has had a change of ownership (CHOW) on or after July 18, 1984, must submit data showing what its capital costs would have been had the CHOW not occurred except for any additional costs allowed under the Deficit Reduction Act of 1984. This capital cost

amount shall be used when computing the provider's capital per discharge figure above.

2. If a provider has had its capital costs reduced by Medicare, the provider's capital expense per discharge (CEPD) shall be reduced by the Medicare capital cost reduction percentage.

   The formula for relief would then be:

   MPGRPD = (PGRPD - 60th percentile CEPD) + (X * hospital CEPD)

   Where: X = 1 minus the Medicare payment reduction percentage

3. If a provider's capital expense per discharge is above the 60th percentile, it shall not be entitled to automatic relief. The provider must still prove that the capital expenses are necessary for the care of Medi-Cal patients.

D. Providers which are eligible for any multiple adjustments under Sections X. through XI. of this Plan shall have relief computed using the following methodologies:

1) For providers which are eligible for case mix, labor and capital adjustments, relief shall be computed as follows:

   MPGRPD = MAX(CMA,LRCAF,MIN ((CMA*(WI/PGWI)),(HWD/PGWD))) * WRR * PGRPD) +

   (CMA * (1 - CRC - WRR) * PGRPD) + CEPD

   Where: CRC = Capital related cost percentage (CEPD/GOE)
   MIN= Minimum of the items in parentheses
   MAX= Maximum of the items in parentheses

   If the provider's CEPD has been modified per Section XI. C. 2. above, that revised figure shall be substituted into the formula above.

2) For providers which are entitled to a CMA but whose capital and/or labor costs per discharge are below the 60th percentile, those cost components shall not be adjusted by the CMF. The formula for relief shall be:

MPGRPD = ((PGRPD - 60th percentile CEPD - 60th percentile
labor per discharge) * CMA) + hospital CEPD +
hospital labor per discharge

(a) This formula shall be modified to remove only those costs (labor and/or capital) which are below the 60th percentile limit.

(b) A provider's reimbursement, pursuant to the above, shall not be adjusted below the 60th percentile rate per discharge.

(c) All other multiple adjustments shall have their overlapping relief calculated using the basic PGARPDL principles.

E. Differences in costs between the provider and other providers in its peer group due to extraordinary events beyond the provider's control such as fire, earthquake, flood, or similar unusual occurrences with substantial cost effects shall be an appealable item;

F. Differences in costs between the provider and other providers in its peer group caused by other items or circumstances affecting provider costs which meet all of the following criteria:

1) The item is a difference, on a per discharge basis, between the hospital and the 60th percentile of the peer group.

2) The item can be measured or estimated for all providers in the peer group.

3) The costs were necessary for the provision of quality medical care to Medi-Cal beneficiaries.

4) There is no overlap with other issues or the overlap can be measured.

G. Relief for any issue shall be reduced for any overlap between issues.

H. Any additional reimbursement granted pursuant to this part of the Plan shall not result in a recalculation of the 60th percentile limit under Section IX. of this Plan.

XII. CONTRACTS

A. The reimbursement limitation for the noncontract service costs of contracting hospitals which had a valid contract during the entire settlement fiscal period shall be determined by the following method:

Noncontract Reduction = NMCN - TCL

Where:

NMCN = Noncontract Medi-Cal net cost of covered services including third-party liability amounts

TCL = PYNCPD * PDL * SYND
PYNCPD = PYNC/PYND

TCL = Total cost limit exclusive of any reductions for third-party liability

PYNCPD = Prior fiscal period noncontract cost per day

PYNC = Prior fiscal period noncontract costs

PYND = Prior fiscal period noncontract days

PDL = Per diem limit increase which shall be the target as specified in federal regulation CFR 42, Section 413.40(c)(3).

SYND = Settlement fiscal period noncontract days

1) All AA and appeal issues must pertain to the reason for the increase in the average noncontract costs per day from the prior fiscal period to the settlement fiscal period.

2) Contracting hospitals with noncontract service costs will also have an ARPDL calculation performed each FPE. The calculation will be used to determine the base period for the next FPE in the event the provider discontinues the contracting program.

B. The noncontract reimbursement reduction, if any, for partial FPE contracting hospitals those hospitals which have gone on or off contracting during their settlement fiscal period, shall be determined as follows:

Noncontract Reduction = PRNC * FYR

Where:

PRNC = NMCN/TMCN

PRNC = Proportion of reimbursement not under contract

FYR = Full fiscal period all services reimbursement reduction as determined by the PIRL.

NMCN = Noncontracting Medi-Cal net cost of covered services

TMCN = Total Medi-Cal net cost of covered services for the entire fiscal period for all services.

XIII. DISPROPORTIONATE SHARE

A. Disproportionate share payments shall be paid in accordance with the provisions of the existing State Plan (pages 18 to 37).

XIV. REIMBURSEMENT LIMITS FOR OUT-OF-STATE HOSPITALS

See Attachment 4.19-A, page 16. Provisions for Out-of-State reimbursement will remain in place on page 16.

XV. REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL ACUTE INPATIENT SERVICES

Reimbursement for Short-Doyle/Medi-Cal (SD/MC) acute inpatient hospital mental health services is either on a retrospective or prospective basis, based on determinations by the Department of Mental Health of individual county operations, and the preference of individual providers. Reimbursement shall be based on the lesser of:

1) Each provider's customary charges.

2) Depending on which reimbursement method the provider is under, each provider's allowable cost or negotiated rate (NR) or negotiated net amount (NNA), both of which are expressed by the established service function and unit of service (i.e., patient day) for providers contracting on an NR or NNA basis pursuant to Section 5705.2 of the

Welfare and Institutions Code.

3) A per diem rate established annually by the Department based on 125 percent of the statewide average of the costs of services as reflected in the most recent provider's cost reports. This rate shall be adjusted annually to reflect any cost of living allowance provided for in the Budget Act.

If application of this per diem rate would result in a substantial inability to provide SD/MC mental health services, the computed rate may be waived by the Department of Mental Health pursuant to Section 5705.1 of the Welfare and Institutions Code, subject to approval by the Department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

INCREASE IN MEDICAID PAYMENT AMOUNTS FOR CALIFORNIA DISPROPORTIONATE SHARE HOSPITALS

This segment of the State Plan sets forth the manner in which Medi-Cal payments for acute inpatient hospital services take into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs, as required by Sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code.

A. Disproportionate Share Hospitals

1. Hospitals shall be deemed disproportionate share hospitals if for a calendar year ending 18 months prior to the beginning of a particular State fiscal year:

   a. the hospital's Medicaid inpatient utilization rate as defined in Section 1396r-4(b)(2) of Title 42 of the United States Code and computed pursuant to pages 30-37B of this Attachment 4.19-A, is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or

   b. the hospital's low income inpatient utilization rate as defined in Section 1396r-4(b)(3) of Title 42 of the United States Code and computed pursuant to pages 30-37B of this Attachment 4.19-A, exceeds 25 percent;

   and in each case,

   c. the hospital has at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This requirement does not apply to a hospital (1) the inpatients of which are predominantly individuals under 18 years of age; or (2) which does not offer non-emergency obstetric procedures as of December 22, 1987; and

   d. the hospital's Medicaid inpatient utilization rate, as computed under paragraph a, above, is at least one percent.

2. A hospital will be considered to have disproportionate share hospital status regardless of whether it meets the requirements set forth in paragraphs A.1.a and A.1.b, above, if, during the payment adjustment year, the hospital is licensed to

the University of California and meets the requirements set forth in paragraphs A.1.c and A.1.d, above.

3. With respect to those disproportionate share hospitals that meet the requirements of subsection A.1 which are non-government operated hospitals, that is, hospitals that are licensed to entities *other than* a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state, the requirements of Sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code shall be satisfied through the provision of payment adjustments as described in paragraphs a and b below. The hospitals described in this subsection will not be eligible for payment adjustments provided for in Sections D through F below.

   a. An amount totaling **[one-hundred sixty dollars]** (**$ [160.00]**) will be paid as disproportionate share hospital payment adjustments to hospitals described in this subsection. The federal share of these payment adjustments will be subject to and drawn against the federal DSH allotment described in Section 1396r-4(f) of Title 42 of the United States Code.

   b. Each hospital described in this subsection shall receive a proportionate share of the total amount established in paragraph a, relative to the amounts calculated for the hospital pursuant to Appendix 2 to this Attachment 4.19-A. The proportionate share for each hospital meeting all other program requirements shall in no case be zero. Notwithstanding the provisions of Appendix 2, the amounts calculated thereunder for such hospitals are used solely for the determination of each hospital's proportionate share of disproportionate share hospital payment adjustments established under this subsection.

B. Definitions

The following definitions apply for purposes of this segment of Attachment 4.19-A.

1. "Disproportionate share list" means an annual list of disproportionate share hospitals that provide acute inpatient services that is issued by the State in tentative and final form with respect to the subject payment adjustment year, for purposes of this segment of Attachment 4.19-A.

2. "DSH" means disproportionate share hospital.

3. "Eligible hospital" or "eligible disproportionate share hospital" means a hospital that is eligible, pursuant to Section C, below, to receive payment adjustments with respect to the subject payment adjustment year.

4. "Government-operated hospital" means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

5. "High DSH facility" or "high DSH status" means a government-operated hospital that is an eligible hospital that meets the criteria set forth in paragraph A.1.a or A.1.b, pursuant to Section 1396r-4(g)(2)(B) of Title 42 of the United States Code and Section 4721(e) of the Balanced Budget Act of 1997 (P.L. No. 105-33), as amended by Section 607(a)(3) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (as incorporated into the Omnibus Consolidated Appropriations Act, 2000 (P.L. No. 106-112).

6. "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the California Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

7. "Payment adjustment" or "payment adjustment amount" means an amount paid or payable pursuant to Sections D through F, below, for acute inpatient hospital services provided by an eligible disproportionate share hospital.

8. "Payment adjustment year" means the state fiscal year (commencing July 1) with respect to which payment adjustments are to be made to eligible hospitals.

9. "Applicable federal fiscal year" means the federal fiscal year that commences on October 1 of the particular, or subject, payment adjustment year.

10. "Federal DSH allotment" means the maximum allotment of federal financial participation for DSH payment adjustments for California, as determined under Section 1396r-4(f) of Title 42 of the United States Code, for the applicable federal fiscal year.

11. "Finalized Medi-Cal 2552-96 cost report" means the cost report that is settled by the California Department of Health Services, Audits and Investigations (A&I) with the issuance of a Report On The Cost Report Review (Audit Report).

12. "Filed Medi-Cal 2552-96 cost report" means the cost report that is submitted by the hospital to A&I and is due five months after the end of the cost reporting period.

13. "OBRA 1993 limit" means the hospital-specific limitation on the total annual amount of DSH payment adjustments to each eligible hospital that can be made with federal financial participation under the provisions of Section 1396r-4(g) of Title 42 of the United States Code, as implemented pursuant to Section F, below.

14. "Uninsured individuals" means individuals with no source of third party insurance coverage for the hospital services they receive.

15. "Demonstration funding" means Medicaid funding for medical care services rendered to uninsured individuals, which is in addition to DSH payment adjustments, that is made available under the terms and conditions of a federal Medicaid demonstration project authorized by Section 1115(a) of the Social Security Act.

C. Eligibility For Disproportionate Share Hospital Payment Adjustments

1. Disproportionate share hospitals, as determined under subsections A.1 and A.2, that are government-operated hospitals shall be eligible to receive payment adjustments provided for under Sections D through F, below.

2. The eligible hospitals described in subsection C.1 will be categorized into one of the following DSH groups:

a. Cost-based DSH facilities – government-operated hospitals eligible for reimbursement of inpatient hospital services pursuant to page 46 et seq. of this Attachment 4.19-A, as specified in Appendix 1 to this Attachment, and any other government-operated hospitals receiving approval of the Centers for Medicare & Medicaid Services.

b. Non cost-based DSH facilities – government-operated hospitals that do not meet the description set forth in paragraph C.2.a, above.

D. Disproportionate Share Hospital Payment Adjustments

1. Payment adjustments for non cost-based DSH facilities shall be determined as follows:

a. For each subject payment adjustment year, the State will continue to perform all computations pursuant to the DSH provisions of the State Plan in effect as of the 2004-05 payment adjustment year, set forth in Appendix 2 to this Attachment 4.19-A ("the prior DSH methodology"). The State will use all data that would have been applicable for the subject payment adjustment year as if the prior DSH methodology was in effect for that year. The resulting determinations shall be used for purposes of the calculations set forth below.

b. For each individual non cost-based DSH facility, the State will determine the sum of the hospital's non-supplemental payment adjustment amount pursuant to subsection P.2 of the prior DSH methodology, and the hospital's supplemental lump-sum payment adjustment amount pursuant to subsection P.3 of the prior DSH methodology.

c. For all hospitals meeting the definition of a public hospital eligible under the prior DSH methodology, the State will determine the aggregate total of the non-supplemental payment adjustment amounts pursuant to subsection P.2 of the prior DSH methodology, and the supplemental lump-sum payment adjustment amounts pursuant to subsection P.3 of the prior DSH methodology.

d. For each non cost-based DSH facility, the individual sum for the hospital determined under paragraph D.1.b will be divided by the aggregate public hospitals total determined under paragraph D.1.c. The resulting fraction shall be used for purposes of paragraph D.1.i, below.

e. For all hospitals meeting the definition of a nonpublic/converted hospital, a converted hospital or a nonpublic hospital eligible under the prior DSH methodology, the State will determine the aggregate total of the non-supplemental payment adjustment amounts pursuant to subsection P.2 of the prior DSH methodology, and the supplemental lump-sum payment adjustment amounts pursuant to subsection P.3 of the prior DSH methodology.

f. The aggregate public hospitals total determined under paragraph c. shall be added to the aggregate total for the nonpublic/converted hospitals, converted hospitals and nonpublic hospitals determined under paragraph D.1.e.

g. The State will determine that fraction which is the number 1.00, minus the federal medical assistance percentage, expressed as a fraction, that is applicable for federal financial participation purposes for the applicable federal fiscal year. The resulting fraction shall be used for purposes of paragraph D.1.h, below.

h. The total sum determined under paragraph f. shall be multiplied by the fraction determined under paragraph g. The product shall be increased by the amount of $85,000,000, and the resulting amount used for purposes of paragraph D1.i, below.

i. For each non cost-based DSH facility, the individual fraction for the hospital determined under paragraph D.1.d will be multiplied by the amount determined under paragraph D.1.h. The resulting product shall be subtracted from the individual sum for the hospital determined under paragraph D.1.b, yielding the maximum DSH payment adjustment amount for the hospital for the subject payment adjustment year.

j. Commencing October 1 of each payment adjustment year, the State will make interim distributions of payment adjustment amounts to the non

cost-based DSH facilities, which will be subject to interim and final adjustments as may be necessary.

k. Payment adjustments under this subsection will be subject to the OBRA 1993 hospital-specific DSH limits determined and applied pursuant to Sections E and F, below.

2. Payment adjustments for cost-based DSH facilities will be of one or both of the following types:

a. Direct DSH payments – these payments are available only to cost-based DSH facilities that meet the requirements for high DSH status. Direct DSH payments will be paid to hospitals in amounts as determined by the State, but in no event shall the payment to a hospital exceed an amount equal to 75% of the hospital's uncompensated care costs, as determined under Section E. below. These payments will be made on an interim basis, commencing October 1 of the subject payment adjustment year, subject to interim and final adjustments as may be necessary.

b. Cost-based DSH claims – the State will claim amounts from the federal DSH allotment based on hospital cost data for the state fiscal year in which the federal fiscal year commences, as determined under Section E, below.

(1) The total amount of the federal DSH allotment to be claimed under this paragraph for the subject payment adjustment year, in combination with that portion of the federal DSH allotment associated with the payment adjustments described under subsection A.3, payments to non cost-based DSH facilities under subsection D.1, and the direct DSH payments under paragraph D.2.a for the subject payment adjustment year, will not exceed the federal DSH allotment.

(2) The State will determine the amount to be claimed from the costs of each cost-based DSH facility, but no such claim, in combination with the payments received by the hospital under paragraph D.2.a, will exceed the OBRA 1993 DSH limit for that hospital, as determined under Section F, below.

(3) Once claimed and received by the State, the amounts received will be distributed to hospitals in amounts as determined by the State. Interim distributions will be made from the amounts that are made available on the basis of the interim determinations of uncompensated care costs described in subsection E.1, below. The State will make subsequent adjustments to the distribution amounts as may be necessitated by any interim and final reconciliations that

affect the total amount available for distribution. Amounts distributed to the hospitals pursuant to this subparagraph will not be used for determining compliance with the OBRA 1993 DSH limit; the OBRA 1993 DSH limit for each hospital will be determined in accordance with subparagraph D.2.b(2), above.

3. The federal DSH allotment will be applied with respect to the payment adjustments that are made for the subject payment adjustment year as described in subsections D.1 and D.2. For purposes of determining compliance with the federal DSH allotment, the costs incurred during the state fiscal year that are used to establish the cost-based DSH claims will be deemed to be payment adjustments for the period October 1 through June 30 of the applicable federal fiscal year.

E. Methodology for Determining Hospital Uncompensated Care Costs

Each eligible hospital's Medi-Cal 2552-96 cost report will be the basis for determining the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs. The determinations will be used for purposes of establishing and applying the OBRA 1993 limit described in Section F, below, and, with respect to cost-based DSH facilities, for purposes of establishing the cost based DSH claims that will be made by the State.

1. Interim Determination of Uncompensated Care Costs

a. Using the hospital's most recently filed Medi-Cal 2552-96 cost report and auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges), the cost report apportionment process as prescribed in the Worksheet D series will be applied to compute the hospital's interim uncompensated care costs. This data will be submitted to the State. The data must be from the period which corresponds to the most recently filed Medi-Cal cost report.

b. Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics, such as relative value units, in the cost report apportionment process) may also use alternative statistics as a substitute for charges in all of the apportionment processes described in this Section E. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

c. On the Medi-Cal 2552-96 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26. If the costs have been removed, the allowable interns and residents costs will be added back to each affected cost center prior to the

computation of cost-to-charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) for the Worksheet C computation of cost-to-charge ratios. Only those allowable interns and residents costs that are consistent with Medicare cost principles will be added back. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as Graduate Medical Education (GME) under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

d. For hospitals that remove inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), necessary adjustments will be made to the Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for inpatient dental services. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

e. All applicable Medicaid inpatient and outpatient hospital revenues, and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed inpatient and outpatient hospital cost above to arrive at the hospital's total interim uncompensated care costs. Payments, funding and subsidies made by a state or a unit of local government will not be offset (e.g., state-only, local-only or state-local health programs). The revenue and payment data will relate to services rendered during the period that corresponds to that of the Medi-Cal cost report upon which the inpatient and outpatient hospital cost determination is based.

f. The interim uncompensated care costs computed above will be trended to current year based on Market Basket update factor(s) or other approved hospital-related indices as approved by CMS. The interim uncompensated care costs may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1) Inpatient and outpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim uncompensated care costs are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the current year.

(2) Inpatient and outpatient hospital costs incurred and reflected in the filed Medi-Cal 2552-96 cost report from which the interim uncompensated care costs are developed, but which would not be

incurred or reflected on the Medi-Cal 2552-96 cost report for the current year.

Such costs must be properly documented by the hospital, and are subject to review by the State and CMS.

g. The interim uncompensated care costs determined under this subsection E.1 will not include any of the hospital's expenditures for which demonstration funding is or will be claimed for the provision of inpatient hospital and outpatient hospital services to uninsured patients for the subject payment adjustment year. Accordingly, the uncompensated care costs that are used to claim demonstration funding will be considered Medicaid revenue for purposes of subsection E.1, but the payment amounts actually received by the hospitals will not.

h. The State may apply an audit factor to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. The State will identify such percentage to CMS.

2. Interim Reconciliation of Uncompensated Care Costs

a. Each eligible hospital's interim uncompensated care costs will be reconciled based on its filed Medi-Cal 2552-96 cost report for the subject payment adjustment year.

b. The hospital's total uncompensated care costs shall be determined using the filed Medi-Cal 2552-96 cost report and applying the steps set forth in paragraphs E.1.a through E.1.e, and paragraphs E.1.g. and E.1.h, above.

3. Final Reconciliation of Uncompensated Care Costs

a. Each eligible hospital's interim uncompensated care costs (and any interim adjustments) will be reconciled based on its finalized Medi-Cal 2552-96 cost report for the subject payment adjustment year.

b. The hospital's total uncompensated care costs shall be determined using the finalized Medi-Cal 2552-96 cost report and applying the steps set forth in paragraphs E.1.a through E.1.e, and paragraph E.1.g., above.

F. Computation of OBRA 1993 Hospital-Specific DSH Limits

Federal financial participation is available only for DSH funding amounts claimed by the State that do not exceed the OBRA 1993 hospital-specific limits established by 42 U.S.C. §1396r-4(g).

1. With respect to each eligible hospital, the determination of the OBRA 1993 limit shall be as follows:

   a. The OBRA 1993 limit shall be based upon each hospital's uncompensated care costs that are determined in accordance with Section E for the applicable payment adjustment year. Except as provided in paragraph b., the hospital's OBRA 1993 limit shall be 100% of its uncompensated care costs.

   b. For those eligible hospitals that are high DSH facilities, the OBRA 1993 limit shall be 175% of the hospital's uncompensated care costs determined for the payment adjustment year. For the 2005-06 and 2006-07 payment adjustment years, a high DSH facility's expenditures for the provision of inpatient and outpatient hospital services to uninsured patients for which demonstration funding is claimed by the State will not be excluded from uncompensated care costs for purposes of determining the hospital's OBRA 1993 limit.

2. With respect to each hospital that is a non cost-based DSH facility, for each payment adjustment year the sum of the payments made to the hospital under subsection D.1 shall not exceed the OBRA 1993 limit determined for the hospital under subsection F.1, above.

3. With respect to each hospital that is a cost-based DSH facility, for each payment adjustment year the sum of the direct DSH payments made to the hospital under paragraph D.2.a, plus the amount of the hospital's uncompensated care costs for which the State made cost-based DSH claims from the federal DSH allotment, shall not exceed the OBRA 1993 limit determined for the hospital under subsection F.1, above.

Final List of DSH Eligible Hospitals for SFY 2005-06	OSHPD FACILITY ID
Designated Public Hospitals	**22 hospitals**
ALAMEDA COUNTY MEDICAL CENTER-HIGHLAND CAMPUS	10846
ARROWHEAD REGIONAL MEDICAL CENTER	364231
CONTRA COSTA REGIONAL MEDICAL CENTER	70924
KERN MEDICAL CENTER	150736
L.A. CO. HARBOR/UCLA MEDICAL CENTER	191227
L.A. CO. MARTIN LUTHER KING JR/DREW MED CTR	191230
L.A. CO. OLIVE VIEW MEDICAL CENTER	191231
L.A. CO. RANCHO LOS AMIGOS NATIONAL REHAB. CTR.	191306
L.A. CO. U.S.C. MEDICAL CENTER	191228
NATIVIDAD MEDICAL CENTER	274043
RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	334487
SAN FRANCISCO GENERAL HOSPITAL	380939
SAN JOAQUIN GENERAL HOSPITAL	391010
SAN MATEO COUNTY GENERAL HOSPITAL	410782
SANTA CLARA VALLEY MEDICAL CENTER	430883
TUOLUMNE GENERAL HOSPITAL	551061
UNIV OF CALIF DAVIS MEDICAL CENTER	341006
UNIV OF CALIF IRVINE MEDICAL CENTER	301279
UNIV OF CALIF LOS ANGELES MEDICAL CENTER/SANTA MONICA	190796
UNIV OF CALIF SAN DIEGO MEDICAL CENTER	370782
UNIV OF CALIF SAN FRANCISCO MEDICAL CENTER	381154
VENTURA COUNTY MEDICAL CENTER	560481
Non-Designated Public Hospital	**30 Hospitals**
ANTELOPE VALLEY HOSPITAL MEDICAL CENTER	190034
BEAR VALLEY COMMUNITY HOSPITAL	361110
COALINGA REGIONAL MEDICAL CENTER	100697
EASTERN PLUMAS HEALTH CARE	320859
EL CENTRO REGIONAL MEDICAL CENTER	130699
FRESNO COUNTY PSYCHIATRIC HEALTH FACILITY	104089
HI-DESERT MEDICAL CENTER	362041
INDIAN VALLEY DISTRICT HOSPITAL	320874
JEROLD PHELPS COMMUNITY HOSPITAL	121031
JOHN C. FREMONT HEALTHCARE DISTRICT	220733
KERN VALLEY HEALTHCARE DISTRICT	150737
KINGSBURG MEDICAL CENTER	100745
LOMPOC DISTRICT HOSPITAL	420491
MAYERS MEMORIAL HOSPITAL	450936
MODOC MEDICAL CENTER	250956
MORENO VALLEY COMMUNITY HOSPITAL	334048
MOUNTAINS COMMUNITY HOSPITAL	361266
OAK VALLEY DISTRICT HOSPITAL	500967
PIONEERS MEMORIAL HOSPITAL	130760
SAN LUIS OBISPO COUNTY P.H.F.	404046
SANTA BARBARA P.H.F.	424002
SEMPERVIRENS PSYCHIATRIC HEALTH FACILITY	124004
SHASTA COUNTY PSYCHIATRIC HEALTH FACILITY	451019
SIERRA KINGS DISTRICT HOSPITAL	100797
SIERRA VIEW DISTRICT HOSPITAL	540798
SOUTHERN INYO HOSPITAL	141338
SURPRISE VALLEY COMMUNITY HOSPITAL	250955
UCLA NEUROPSYCHIATRIC HOSPITAL	190930
TRINITY HOSPITAL	531059
TULARE DISTRICT HOSPITAL	540816

Final List of DSH Eligible Hospitals for SFY 2005-06	OSHPD FACILITY ID
Private Hospitals	**103 Hospitals**
ALHAMBRA HOSPITAL MEDICAL CENTER	190017
ANAHEIM GENERAL HOSPITAL	301097
AURORA CHARTER OAK	190163
BELLFLOWER MEDICAL CENTER	190066
BEVERLY HOSPITAL	190081
BHC ALHAMBRA HOSPITAL	190020
CALIFORNIA HOSPITAL MEDICAL CENTER OF L.A.	190125
CALIFORNIA SPECIALTY HOSPITAL	481015
CANYON RIDGE HOSPITAL	364050
CENTRAL VALLEY GENERAL HOSPITAL	160787
CHILDREN'S HOSP. & RESEARCH CTR. AT OAKLAND	10776
CHILDREN'S HOSPITAL - SAN DIEGO	370673
CHILDREN'S HOSPITAL CENTRAL CALIFORNIA	204019
CHILDRENS HOSPITAL OF LOS ANGELES	190170
CHILDREN'S HOSPITAL OF ORANGE COUNTY	300032
CHINO VALLEY MEDICAL CENTER	361144
CITRUS VALLEY MEDICAL CENTER-QV CAMPUS	190636
CITY OF ANGELS MEDICAL CENTER-DOWNTOWN CAMPUS	190661
CITY OF HOPE NATIONAL MEDICAL CENTER	190176
COASTAL COMMUNITIES HOSPITAL	301258
COLLEGE HOSPITAL	190184
COLLEGE HOSPITAL COSTA MESA	301155
COMMUNITY & MISSION HOSP. OF HUNTINGTON PARK-SLAUS	190197
COMMUNITY HOSPITAL OF SAN BERNARDINO	361323
COMMUNITY MEDICAL CENTER-FRESNO	100717
DANIEL FREEMAN MEMORIAL HOSPITAL	190230
DELANO REGIONAL MEDICAL CENTER	150706
DOCTOR'S HOSPITAL MEDICAL CENTER OF MONTCLAIR	361166
DOCTORS HOSPITAL OF WEST COVINA	190857
DOCTORS MEDICAL CENTER OF MODESTO	500852
EARL & LORAINE MILLER CHILDREN'S HOSPITAL	196168
EAST LOS ANGELES DOCTOR'S HOSPITAL	190256
EAST VALLEY HOSPITAL MEDICAL CENTER	190328
ELASTAR COMMUNITY HOSPITAL	190685
FOUNTAIN VALLEY REGIONAL HOSP. & MED. CTR.-EUCLID	301175
FREMONT HOSPITAL	14034
GARDEN GROVE HOSPITAL & MEDICAL CENTER	301283
GARFIELD MEDICAL CENTER	190315
GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER	190317
GEORGE L. MEE MEMORIAL HOSPITAL	270777
GOOD SAMARITAN HOSPITAL OF BAKERSFIELD	150775
GREATER EL MONTE COMMUNITY HOSPITAL	190352
HEALTHBRIDGE CHILDREN'S HOSPITAL-ORANGE	304159
HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD	190380
JOHN F. KENNEDY MEMORIAL HOSPITAL	331216
KEDREN COMMUNITY MENTAL HEALTH CENTER	190150
LINCOLN HOSPITAL MEDICAL CENTER	190468
LITTLE COMPANY OF MARY/SAN PEDRO HOSPITAL	190680
LOMA LINDA UNIVERSITY MEDICAL CENTER	361246
LONG BEACH MEMORIAL MEDICAL CENTER	190525

Final List of DSH Eligible Hospitals for SFY 2005-06	OSHPD FACILITY ID
LOS ANGELES COMMUNITY HOSPITAL	190198
LOS ANGELES METROPOLITAN MEDICAL CENTER	190854
MADERA COMMUNITY HOSPITAL	201281
MEMORIAL HOSPITAL OF GARDENA	190521
MERCY HOSPITAL OF MT. SHASTA	470871
MERCY MEDICAL CENTER - MERCED	240942
MERCY WESTSIDE HOSPITAL	150830
METHODIST HOSPITAL OF SACRAMENTO	340951
MISSION COMMUNITY HOSPITAL OF PANORAMA	190524
MODESTO REHABILITATION HOSPITAL	500954
MONTEREY PARK HOSPITAL	190547
NORTH BAY MEDICAL CENTER	481357
NORTHRIDGE HOSPITAL MEDICAL CENTER - SHERMAN WAY	190810
OJAI VALLEY COMMUNITY HOSPITAL	560501
OROVILLE HOSPITAL	40937
ORTHOPAEDIC HOSPITAL	190581
PACIFIC ALLIANCE MEDICAL CENTER	190307
PACIFIC HOSPITAL OF LONG BEACH	190587
PACIFICA HOSPITAL OF THE VALLEY	190696
PALO VERDE HOSPITAL	331288
PARADISE VALLEY HOSPITAL	370759
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	331293
POMONA VALLEY HOSPITAL MEDICAL CENTER	190630
PROVIDENCE HOLY CROSS MEDICAL CENTER	190385
QUEEN OF ANGELS/HOLLYWOOD PRESBYTERIAN MED. CTR.	190382
REDBUD COMMUNITY HOSPITAL	171049
REGIONAL MEDICAL OF SAN JOSE	430705
ROBERT F. KENNEDY MEDICAL CENTER	190366
SAN VICENTE HOSPITAL	190681
SANTA ANA HOSPITAL MEDICAL CENTER	301314
SCRIPPS MERCY HOSPITAL	370744
SELMA COMMUNITY HOSPITAL	100793
SHARP CORONADO HOSPITAL & HEALTHCARE CENTER	370689
SHARP MARY BIRCH HOSPITAL FOR WOMEN	370695
ST. DOMINIC'S HOSPITAL	394009
ST. FRANCIS MEDICAL CENTER	190754
ST. JOSEPH HOSPITAL OF EUREKA	121080
ST. LUKE'S HOSPITAL	380964
ST. MARY MEDICAL CENTER	190053
ST. ROSE HOSPITAL	10967
SUBURBAN MEDICAL CENTER	190599
SUTTER MEDICAL CENTER OF SANTA ROSA	490919
SUTTER SOLANO MEDICAL CENTER	481094
TELECARE SOLANO PSYCHIATRIC HEALTH FACILITY	484028
TUSTIN HOSPITAL MEDICAL CENTER	301357
UKIAH VALLEY MEDICAL CENTER - HOSPITAL DR.	231396
UNIVERSITY COMMUNITY MEDICAL CENTER	370787
VALLEY PRESBYTERIAN HOSPITAL	190812
VICTOR VALLEY COMMUNITY HOSPITAL	361370
WESTERN MEDICAL CENTER - ANAHEIM	301188
WESTERN MEDICAL CENTER OF SANTA ANA	301566
WHITE MEMORIAL MEDICAL CENTER	190878
WHITTIER HOSPITAL MEDICAL CENTER	190883
Total Number of Hospitals	**156**

*Highlighted Hospitals were not on the 0405 List.

7. The data utilized by the Department shall relate to the hospital under present and previous ownership. When there has been a change of ownership, a change in the location of the main hospital facility, or a material change in patient admission patterns during the twenty-four months immediately prior to the payment adjustment year, and the change has resulted in a diminution of access for Medi-Cal inpatients at the hospital as determined by the Department, the Department shall, to the extent permitted by federal law, utilize current data that are reflective of the diminution of access, even if the data are not annual data.

8. The system of payment adjustments described in the former version of Attachment 4.19A (effective July 1, 1990) will become inoperative as of the approval date of this Attachment.

9. The payment adjustments under SPA 91-15 are not in consideration for services rendered prior to the effective date approved by HCFA. Such payment adjustments are distributed in conjunction with claims paid on and after the effective date as a mechanism to allocate funds relating to periods of time on and after the effective date.

10. If any payment adjustment that has been paid, or that is otherwise payable, under this Attachment exceeds the hospital-specific limitations set forth in Section J. of this Attachment, the Department shall withhold or recoup the payment adjustment amount that exceeds the limitation. The nonfederal component of the amount withheld or recouped shall be redeposited in, or shall remain in, the fund, as applicable, until used for the purposes described in paragraph (2) of subdivision (j) of Section 14163 of the Welfare and Institutions Code.

11. The payment adjustments under this Attachment shall be limited as specified in other provisions of this Attachment.

E. Additional Description

1. Except as otherwise provided in this Attachment, the disproportionate share payments shall be distributed concurrent with claims paid on those dates on or after July 1, 1991, for which federal approval is effective and as follows:

   a. For the fiscal year July 1, 1991 through June 30, 1992, the State shall determine which hospitals meet the disproportionate share definition set out in Section A. subsection 2. for the 1991-92 payment adjustment year, and the aggregate per diem payment adjustment amount for each hosptial. As soon as determined, the Department shall issue a disproportionate share list showing the name of each hospital qualifying for payment adjustments, the hospital's Medi-Cal utilization rate and low-income utilization rate, the hosptial's low income number, and the amount of the per diem payment adjustment to be made for each hospital for the 1991-92 fiscal year.

   b. No later than the fifth day of each fiscal year thereafter, the Department shall determine, for the particular payment adjustment year, which hospitals meet the disproportionate share definition set out in Section A., subsection 2. and the aggregate per diem payment adjustment amount for each hospital. When determined, the Department shall issue a disproportionate share list showing the name and license number of each hospital qualifying for payment adjustments, the hospital's Medi-Cal utilization rate and low-income utilization rate, the hospital's low-income number, and the amount of the per diem payment adjustments to be made for each such hospital.

   c. The determinations regarding disproportionate share hospital status and the payments made in accordance with paragraphs a. and b. above shall be final determinations and payments. Nothing on a disproportionate share list, once issued by the Department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the State.

2. Notwithstanding any other provision of this Attachment, to the extent necessary or appropriate to implement and administer the amendments to Section 14105.98 of the Welfare and Institutions Code enacted during the 1994 calendar year, the Department may utilize an approach involving interim payments, with reconciliation to final payments within a reasonable time.

F. **Supplemental Lump-Sum Payment Adjustments - September 30, 1993**

1. For the 1993-94 payment adjustment year, each eligible hospital shall also be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being included on the disproportionate share list as of September 30, 1993. For purposes of federal medicaid rules, including Section 447.297(d) of Title 42 of the Code of Federal Regulations, the supplemental payment adjustments shall be applicable to the federal fiscal year that ends on September 30, 1993.

2. The availability of supplemental payment adjustments under this paragraph shall be determined as follows:

   a. The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1993 federal fiscal year. This final allotment is two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000), as specified at page 43186 of Volume 58 of the Federal Register.

   b. The total amount of all disproportionate share hospital per diem payment adjustment amounts under this Attachment, whether paid or payable, that are applicable to the 1993 federal fiscal year shall be determined. The applicability of the per diem payment adjustment amounts to the 1993 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

c. The figure determined under paragraph b. above shall be subtracted from the figure identified under paragraph a. above. If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this Attachment in accordance with subsection 3.

3. The amount of the supplemental lump-sum payment adjustment to each eligible hospital shall be computed as follows:

a. The projected total of all disproportionate share per diem payment adjustment amounts payable to each particular eligible hospital under this Attachment for the 1993-94 payment adjustment year shall be determined. For each hospital, this figure shall be identical to the figure used for the same hospital in the calculations regarding transfer amounts under subdivision (h) of section 14163 of the California Welfare and Institutions Code for the 1993-94 state fiscal year.

b. The projected totals for all eligible hospitals determined under paragraph a. shall be added together to determine an aggregate total of all projected per diem payment adjustments for the 1993-94 payment adjustment year. This figure shall be identical to the aggregate figure for all hospitals used in the calculations regarding transfer amounts under subdivision (h) of Section 14163 of the California Welfare and Institutions Code for the 1993-94 state fiscal year.

c. The figure determined for each eligible hospital under paragraph a. shall be divided by the aggregate figure determined under paragraph b., yielding a percentage figure for each hospital.

d. The percentage figure determined for each hospital under paragraph c. above shall be multiplied by the positive remainder calculated under paragraph c. of subsection 2.

e. The product as so determined for each eligible hospital under paragraph d. shall be the

supplemental lump-sum payment adjustment amount payable to the particular hospital.

f. The Department shall make partial payments of the supplemental lump-sum payment adjustments to eligible hospitals on or before January 1, 1994. The Department shall make final calculations regarding the supplemental lump-sum payments based on data available as of March 1, 1994, and shall distribute the final payments promptly thereafter.

G. Supplemental Lump-Sum Payment Adjustments - June 30, 1994

In addition to the lump-sum payment adjustments under Section F. of this Attachment, with respect to the 1993-94 payment adjustment year, the availability of additional supplemental lump-sum payment adjustments shall be determined in accordance with the following:

1. Each eligible hospital that remains in operation as of June 30, 1994, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being a disproportionate share hospital in operation as of that date.

2. The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1994 federal fiscal year. This final allotment is two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000), as specified at page 22676 of Volume 59 of the Federal Register.

3. The total amount of all per diem payment adjustment amounts under this Attachment, whether paid or payable, that are applicable to the period October 1, 1993 through June 30, 1994, shall be determined. The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

4. The figure determined under subsection 3. shall be subtracted from the figure identified under subsection 2. If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this Attachment in accordance with subsections 5. through 10.

5. The projected total of all other payment adjustment amounts payable to each hospital under this Attachment applicable to the 1993-94 payment adjustment year shall be determined for those hospitals that are in operation as of June 30, 1994. For each such hospital, this figure shall be identical to the sum of the figures used for the same hospital in the calculations regarding transfer

amounts under subdivision (h) of Section 14163 for the 1993-94 state fiscal year, not including the supplemental lump-sum payments described in this Section.

6. The projected totals for all hospitals that are in operation as of June 30, 1994, as determined under subsection 5., shall be added together to determine an aggregate total.

7. The figure determined for each hospital under subsection 5. shall be divided by the aggregate figure determined under subsection 6., yielding a percentage figure for each hospital.

8. The percentage figure determined for each hospital under subsection 7. shall be multiplied by the positive remainder calculated under subsection 4.

9. The product determined under subsection 8. for each hospital shall be the supplemental lump-sum payment adjustment amount payable to the particular hospital, which shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1994.

10. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before October 31, 1994.

H. Payment Adjustment Program for 1994-95 Payment Adjustment Year

1. With respect to the 1994-95 payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

   a. No per diem payment adjustment amounts shall be payable in connection with the period July 1 through September 30 of the 1994-95 payment adjustment year. The Medi-Cal days of acute inpatient hospital service paid by or on behalf of the Department that otherwise would have given rise to payment adjustment amounts with respect to this period of time shall not count toward the maximum

limit set forth in Section D., subsection 3. of this Attachment.

b. All Medi-Cal days of acute inpatient hospital service paid by or on behalf of the Department that give rise to payment adjustment amounts with respect to the period October 1, 1994, though June 30, 1995, shall be treated as involving 1.4 days. As a result, each per diem payment adjustment amount otherwise payable to the hospital in connection with such paid days shall be increased by 40 percent. The Medi-Cal days in question shall be treated as involving 1.4 days toward the maximum limit set forth in Section D., subsection 3. of this Attachment.

c. For the 1994-95 payment adjustment year, no eligible hospital shall receive total payment adjustments, including per diem payment adjustment amounts and any supplemental lump-sum payment adjustment amounts, in excess of the projected total payment adjustment amounts that were computed or recomputed, as applicable, for the hospital by the Department with respect to the 1994-95 payment adjustment year. For each hospital, this maximum figure shall not exceed the sum of the following two components:

(1) The final figure computed by the Department as the hospital's total per diem composite amount (including any applicable adjustments under Section D., subsection 5.), multiplied by 80 percent of the hospital's annualized Medi-Cal inpatient paid days; and

(2) The amount calculated by the Department as the hospital's pro rata share (based on the figures for all hospitals computed under subparagraph (1)) of the remainder determined by subtracting the sum of the figures computed for all hospitals under subparagraph (1) from the final maximum state disproportionate share hospital allotment for California under applicable federal rules for the 1995 federal fiscal year.

d. Any payment adjustment amount that otherwise would be payable to a hospital, but that is not payable as a result of the provisions of paragraph c., shall be withheld or recouped by the Department and distributed on a descending pro rata basis as part of the supplemental lump-sum distribution described in subsection 2. below to those hospitals that have not reached their maximum figure as described in paragraph c.

2. The availability of supplemental lump-sum payment adjustments shall be determined in accordance with the following:

a. Each eligible hospital that remains in operation as of June 30, 1995, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being a disproportionate share hospital in operation as of that date.

b. The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1995 federal fiscal year.

c. The total amount of all per diem payment adjustment amounts under this Attachment, whether paid or payable, that are applicable to the period October 1, 1994 through June 30, 1995, shall be determined. The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

d. The figure determined under paragraph c. shall be subtracted from the figure identified under paragraph b. If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this Attachment in accordance with paragraphs e. through j.

e. The projected total of all other payment adjustment amounts payable to each hospital under this Attachment applicable to the 1994-95 payment adjustment year shall be determined for those hospitals that are in operation as of June 30, 1995. For each such hospital, this figure shall be identical to the sum of the figures used for the same hospital in the calculations regarding transfer amounts under subdivision (h) of Section 14163 for the 1994-95 state fiscal year, not including the supplemental lump-sum payments described in this Section.

f. The projected totals for all hospitals that are in operation as of June 30, 1995, as determined under paragraph e., shall be added together to determine an aggregate total.

g. The figure determined for each hospital under paragraph e. shall be divided by the aggregate figure determined under paragraph f., yielding a percentage figure for each hospital.

h. The percentage figure determined for each hospital under paragraph g. shall be multiplied by the positive remainder calculated under paragraph d.

i. The product determined under paragraph h. for each hospital shall be the supplemental lump-sum payment adjustment amount payable to the particular hospital, which shall be payable because the facility is a disproportionate share hospital in operation as June 30, 1995, subject to the limitations in subsection 1., paragraphs c. and d.

j. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before October 31, 1995.

3. For purposes of complying with section 13621 of the Omnibus Budget Reconciliation Act of 1993, the hospital-specific limitation described in Section J. shall be applicable to amounts otherwise paid or payable with respect to the 1994-95 payment adjustment year.

I. Payment Adjustment Program for 1995-96 Payment Adjustment Year

1. With respect to the 1995-96 payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

a. The Department shall, in the manner used for prior years, compute the projected total payment adjustment amounts for all eligible hospitals, by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days.

b. The products of the calculations under paragraph a. for all eligible hospitals shall be added together. The sum of all these figures shall be the unadjusted projected total payment adjustment program for the 1995-96 payment adjustment year.

c. The Department shall estimate the state disproportionate share hospital allotment for California for the 1996 federal fiscal year under applicable federal rules. The estimate shall not exceed the allotment that was applicable for California for the 1995 federal fiscal year.

d. The estimate identified under paragraph c. shall be reduced by subtracting the total amount of the supplemental lump-sum payments paid or payable under

Section G and Section H of this Attachment. The result of this calculation shall be the unadjusted tentative size of the payment adjustment program for the 1995-96 payment adjustment year.

e. The total per diem composite amount computed for each eligible hospital under paragraph a. shall be modified as follows:

(1) A percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount determined under paragraph d by the unadjusted projected total payment adjustment program amount determined under paragraph b.

(2) The percentage figure derived under subparagraph (1) shall be applied to the total per diem composite amount for each eligible hospital, yielding an adjusted total per diem composite amount for each hospital for the 1995-96 payment adjustment year.

(3) The adjusted projected total payment adjustment amount for each eligible hospital shall be computed as follows:

(a) The adjusted total per diem composite amount determined under subparagraph (2) for each eligible hospital shall be multiplied by 80 percent of the hospital's annualized Medi-Cal inpatient paid days.

(b) The amount computed for each hospital under clause (a) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J, the Department has computed for the particular hospital.

(c) Where the amount computed under clause (a) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under clause (a) shall be used for purposes of clause (e).

(d) Where the amount computed under clause (a) for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under clause (a) shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount as so reduced shall be used for purposes of clause (e).

(e) The amount for each hospital, as determined under either clause (c) or clause (d), as applicable, shall be the adjusted projected total payment adjustment amount for the hospital for the 1995-96 payment adjustment year.

(4) The adjusted figures computed for all eligible hospitals under subparagraph (3) shall be added together, yielding the adjusted tentative size of the payment adjustment program for the 1995-96 payment adjustment year.

f. For all eligible hospitals, the adjusted total per diem composite amounts as determined under paragraph e, subparagraph (2) shall be the amounts payable with respect to the period of October 1 through June 30 of the 1995-96 payment adjustment year, subject to the provisions of paragraphs h and i.

g. No per diem payment adjustment amount shall be payable in connection with the period July 1 though September 30 of the 1995-96 payment adjustment year. The Medi-Cal days of acute inpatient hospital service paid by or on behalf of the Department that otherwise would have given rise to payment adjustment amounts with respect to this period of time shall not count toward the maximum limit set forth in Section D, subsection 3 of this Attachment.

h. All Medi-Cal days of acute inpatient hospital service paid by or on behalf of the Department that give rise to payment adjustment amounts with respect to the period October 1, 1995, though June 30, 1996 shall be treated as involving 1.4 days. As a result, each per diem payment adjustment amount otherwise payable to the hospital in connection with such paid days shall be increased by 40 percent. The Medi-Cal days in question shall be treated as involving 1.4 days toward the maximum limit set forth in Section D, subsection 3 of this Attachment.

i. For the 1995-96 payment adjustment year, no eligible hospital shall receive total payment adjustments, including per diem payment adjustment amounts, supplemental lump-sum payment adjustment amounts (as described in subsection 2.) and secondary supplemental payment adjustments (as described in subsection 3.) in excess of the hospital's OBRA 1993 payment limitation as computed by the Department pursuant to Section J. No hospital shall receive secondary supplemental payment adjustments to the extent such payment adjustments would be inconsistent with the provisions of subsection 3.

Any payment adjustment amount that otherwise would be payable to a hospital, but that is barred by the results of paragraph i. shall be withheld or recouped by the Department and thereafter distributed to other eligible hospitals, processed pursuant to Welfare and Institutions Code Section 14163, or otherwise processed in accordance with the provisions of this Attachment that relate to the payment adjustment program.

k. The final total amount of per diem payment adjustments paid by the Department for the 1995-96 payment adjustment year, plus the final total amount of supplemental lump-sum payment adjustments (as described in subsection 2.) and secondary supplemental payment adjustments (as described in subsection 3.) paid by the Department for the 1995-96 payment adjustment year, shall be the maximum size of the payment adjustment program for the 1995-96 payment adjustment year.

2. The availability of supplemental lump-sum payment adjustments shall be determined in accordance with the following:

a. Each eligible hospital that remains in operation as of June 30, 1996, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being a disproportionate share hospital in operation as of that date.

b. The adjusted projected total payment adjustment amount for each hospital, as determined above pursuant to subsection 1., paragraph e., subparagraph (3) shall be identified.

c. The total amount of all per diem payment adjustment amounts under this Attachment, whether paid of payable, that are applicable to the period October 1, 1995 through June 30, 1996, shall be determined for each hospital. The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal Medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations

d. The figure determined under paragraph c for each hospital shall be subtracted from the figure identified under paragraph b for each hospital. If the remainder is a positive figure for the particular hospital, the supplemental lump-sum payment adjustment for the hospital shall be the positive remainder amount, which, subject to subsection 1, paragraph i and paragraph j, shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1996.

e. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments under this subsection on or before September 30, 1996.

3. The availability of secondary supplemental payment adjustments, which shall relate only to the 1995-96 payment adjustment year, shall be determined in accordance with the following:

a. Except as provided in subparagraphs (1) and (2) below, each eligible hospital that remains in operation as of June 30, 1996, shall also be eligible to receive a secondary supplemental payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date.

(1) Eligible hospitals that, without regard to any secondary supplemental payment adjustment, have otherwise received or have earned payment adjustments relating to the 1995-96 payment adjustment year greater than or equal to 95% of the particular hospital's OBRA 1993 hospital-specific payment limitation for the 1995-96 payment adjustment year (as computed by the Department pursuant to Section J.) shall not be entitled to receive any secondary supplemental payment adjustments under this subsection.

(2) Eligible hospitals that, as of July 1, 1995, were part of a county-operated health system of three or more eligible hospitals licensed to the county shall be deemed to have reached the limitation described in subparagraph (1).

b. The maximum amount of secondary supplemental payment adjustments available pursuant to this subsection shall be calculated as follows:

(1) The total amount of all per diem payment adjustment amounts, whether paid or payable, for the 1995-96 payment adjustment year, as determined under paragraph c. of subsection 2., shall be identified.

(2) The total amount of all supplemental lump-sum payment adjustments, whether paid or payable, as determined under paragraph d. of subsection 2., shall be identified.

(3) The Department shall estimate the total amount of payment adjustments under this Attachment that it anticipates will be applicable to the period July 1, 1996, through September 30, 1996. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(4) The Department shall identify the amount of the final maximum state disproportionate share hospital allotment for California for the 1996 federal fiscal year under applicable federal rules. The amount identified shall not exceed two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000).

(5) The amounts identified or estimated under subparagraphs (1), (2) and (3) shall be added together, and the sum of these amounts shall be subtracted from the amount identified under subparagraph (4). The remainder determined from this calculation, or the amount of two hundred million dollars ($200,000,000), whichever is less, shall be the maximum amount available for secondary supplemental payment adjustments under this subsection.

c. The maximum amount available for secondary supplemental payment adjustments, as identified under subparagraph (5) of paragraph b., shall be distributed to eligible hospitals as follows:

(1) The total amount of all per diem payment adjustments and supplemental lump-sum payment adjustments relating to the 1995-96 payment adjustment year, whether paid or payable, shall be identified for each eligible hospital. However, notwithstanding any other provision of this Attachment, those hospitals referred to in subparagraphs (1) and (2) of paragraph a. shall not be included in this step, and shall not receive any secondary supplemental payment adjustments, as described therein.

(2) For purposes of secondary supplemental payment adjustments, eligible hospitals shall be grouped into various hospital types. No hospital may qualify for more than one of these groups. Notwithstanding clauses (i) through (v) below, the hospitals described in subparagraphs (1) and (2) of paragraph a. shall not be included in any of these groups. The following groups of hospitals shall be recognized:

(i) "State of California hospitals" (this group shall include all eligible hospitals that, as of July 1, 1995, were licensed to the State of California or to the University of California);

(ii) "County hospitals" (this group shall include all eligible hospitals that, as of July 1, 1995, were licensed to a county or a city and county);

(iii) "Other public hospitals" (this group shall include all eligible hospitals that, as of July 1, 1995, were licensed to a local hospital district, a local health authority, a city, or any other non-county political subdivision of the state);

(iv) "Children's hospitals" (this group shall include all eligible hospitals that, as of July 1, 1995, were included in the children's hospital group under paragraph b. of subsection 2. of Section C.);

(v) "Other non-public hospitals" (this group shall include all eligible hospitals that are not included in any group described in clauses (i) through (iv) above).

(3) The amount determined to be the maximum amount of secondary supplemental payment adjustments under subparagraph (5) of paragraph b. shall first be allocated among the groups of hospitals referred to in subparagraph (2), as follows:

(i) "State of California hospitals": 64.35% of the maximum amount;

(ii) "County hospitals": 18.095% of the maximum amount;

(iii) "Other public hospitals": 0.65% of the maximum amount;

(iv) "Children's hospitals": 6.755% of the maximum amount;

(v) "Other non-public hospitals": 10.15% of the maximum amount.

(4) The amount of funds allocated pursuant to subparagraph (3) to each of the particular groups of hospitals referred to in subparagraphs (2) and (3) shall then be distributed as secondary supplemental payment adjustments among the eligible hospitals within each particular group. The secondary supplemental distributions shall be made on a descending pro rata basis within each group. Each cycle of the descending pro rata distribution shall be considered to be a phase of the process. As described below, in each phase of the descending pro rata distribution, the pro rata share of the distribution to each hospital that remains eligible to receive additional distributions shall be computed based on the ratio of the total payment adjustments that the particular hospital has already earned under the payment adjustment program for the 1995-96 payment adjustment year, as compared to the total payment adjustments already earned by the other hospitals in the particular group that remain eligible to receive such additional distributions.

(i) For the first phase, the total amount of payment adjustments under this Attachment for the 1995-96 payment adjustment year (including all per diem payment adjustments and all supplemental lump-sum payment adjustments) that are determined by the Department as already being paid or payable to each hospital eligible for the distribution shall be determined.

(ii) The figures determined under clause (i) for each hospital in the particular group shall be added together to determine an aggregate total.

(iii) The figures determined for each hospital under clause (i) shall be divided by the aggregate figure determined under clause (ii), yielding a percentage figure for each hospital.

(iv) The percentage figure determined for each hospital under clause (iii) shall be applied to the maximum portion of the funds allocated to the particular group under subparagraph (3) that can be distributed in the particular phase until a hospital in the particular group reaches the limitation set forth in subparagraph (5).

(5) For each eligible hospital, no secondary supplemental payment adjustment shall be paid to the extent that such secondary supplemental payment adjustment would cause the total of all payment adjustments to the hospital under this Attachment relating to the 1995-96 payment adjustment year to exceed that amount which is the product of multiplying 95% times the particular hospital's OBRA 1993 payment limitation for the 1995-96 payment adjustment year (as computed by the Department in accordance with Section J.).

(6) Any secondary supplemental payment adjustment amount (or portion thereof) that otherwise would have been payable to a particular hospital under this paragraph c., but that is barred by the limitation described in subparagraph (5), shall be distributed by the Department through additional phases of the descending pro rata distribution process to those hospitals within the same group (as set forth in subparagraphs (2) and (3)) as the particular hospital. For each additional phase, the mathematical steps referred to in subparagraph (4) shall be repeated for those hospitals that have not reached the limitation set forth in subparagraph (5). The phases shall continue until the funds allocated to the particular group under subparagraph (3) have been fully exhausted. No such distribution in any phase, however, shall be in an amount that would cause any hospital to exceed the limitation set forth in subparagraph (5).

d. Data regarding all payment adjustments earned by eligible hospitals described in subparagraphs (1) and (2) of paragraph a. with respect to the 1995-96 payment adjustment year, whether paid of payable, shall be included in the computations under paragraph b., but excluded from the computations under paragraph c.

e. The Department shall make payments of the secondary supplemental payment adjustments to hospitals on or before November 30, 1996.

4. For purposes of complying with section 13621 of the Omnibus Budget Reconciliation Act of 1993, the hospital-specific limitation described in Section J shall be applicable to amounts otherwise paid or payable with respect to the 1995-96 payment adjustment year.

J. OBRA 1993 Hospital-Specific Limitations

1. General Background

   a. Section 1396r-4(g) of Title 42 of the United States Code, as added by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"), imposes hospital-specific limitations on the amount of federal financial participation available for payment adjustments for the 1994-95 payment adjustment year and subsequent payment adjustment years ("OBRA 1993 limits"). The OBRA 1993 limits are applied on an annual basis, based on the State fiscal year. As described in subsection 5 below, the limits apply to public hospitals for the 1994-95 payment adjustment year, and to all eligible hospitals for the 1995-96 and subsequent payment adjustment years.

   b. Under the OBRA 1993 limits, payment adjustments made to a hospital with respect to a State fiscal year may not exceed the costs incurred by the hospital of furnishing hospital services, net of Medi-Cal payments (other than disproportionate share hospital payment adjustments described at page 18 *et seq.* of this Attachment) and payments by uninsured patients, to individuals who either are eligible for the Medi-Cal program or have no health insurance (or other source of third party coverage) for services provided during the year. Payments made by a State or unit of local government to a hospital for services provided to indigent patients are not considered to be a source of third party payment.

2. General Approach To Calculations/Program Consistency

   a. Definitions

      For purposes of this Section J, the following definitions shall apply:

      (1) "Subject payment adjustment year" means the particular payment adjustment year to which the limitations described in this Section J are being applied.

(2) "Data determination date" means, with respect to the 1994-95 and 1995-96 payment adjustment years, the date of September 15, 1995. For the 1996-97 payment adjustment year and subsequent payment adjustment years, the date of June 15 immediately prior to the beginning of the subject payment adjustment year shall be the "data determination date" with respect to that subject payment adjustment year.

b. To facilitate implementation of the OBRA 1993 limits under the Medi-Cal program, the calculations of costs and revenues shall, except as otherwise provided in this Section J, be determined prior to the beginning of the subject payment adjustment year. For the most part, the data used in the calculations will be obtained through the data collection mechanisms and sources used in the determinations of hospital eligibility and payment adjustment levels under the payment adjustment program for the subject payment adjustment year.

c. In recognition of their unusual nature, three limited elements of Medi-Cal program costs and revenues will be computed based on more recent data than other costs and revenues. These three elements relate to the Medi-Cal Construction Renovation and Replacement Program under Welfare and Institutions Code Section 14085.5 ("CRRP"), the Medi-Cal Administrative Claiming program under Welfare and Institutions Code Section 14132.47 ("MAC") referred to as Medi-Cal Administrative Activities ("MAA"), and the Medi-Cal Targeted Case Management program under Welfare and Institutions Code Section 14132.44 ("TCM").

d. Except as otherwise provided in this Section J, the Department shall calculate the OBRA 1993 limit for each hospital prior to the beginning of the subject payment adjustment year, or as soon thereafter as possible. The calculations for the subject payment adjustment year shall be based only on that data available as of the data determination date, except for CRRP, MAA and TCM data described in the

preceding paragraph, which may include data collected through a survey completed after the data determination date and except for other data as described in this Section J.

e. With respect to the 1994-95 payment adjustment year, the methodology set forth in subsection 4 shall apply except as provided for in subsection 6.

f. Where a federal Medicaid demonstration project under Section 1315(a) of Title 42 of the United States Code is in effect, or may be in effect, during the subject payment adjustment year, the methodology set forth in subsection 4 shall apply, except as provided for in subsection 7.

3. Calculation Of OBRA 1993 Limit - General Methodology

a. With respect to each payment adjustment year referred to in subsection 5 below, the Department shall compute the OBRA 1993 limit for each eligible hospital, based on the data elements referred to below.

b. Except as otherwise provided in paragraph c, or in subsections 6 or 7, in determining expenses the Department shall use the data from the annual reports filed by hospitals with OSHPD that are used to structure the payment adjustment program for the subject payment adjustment year. All data from such reports shall be considered to be final for purposes of these calculations as of the February 1 immediately prior to the applicable data determination date for the subject payment adjustment year. For example, for the 1995-96 payment adjustment year, the Department shall use reports relating to the hospital's fiscal year that ended during calendar year 1993. The Department shall use a trend factor to project these expenses into the subject payment adjustment year, as described in subparagraph (1) of paragraph b of subsection 4 below. For the 1994-95 payment adjustment year, the Department shall implement the special rules set forth in subsection 6. Further, where federal demonstration projects are involved, the Department shall implement the special rules set forth in subsection 7.

c. With respect to MAA, TCM, and specified CRRP expenses, the Department shall conduct a survey of affected hospitals to compute such expenses for application of the OBRA 1993 limits relating to the subject payment adjustment year.

d. Except as otherwise provided in paragraph e, or in subsections 6 or 7, in calculating revenues the Department shall use data involving Medi-Cal payments made by the Department for hospital services during the calendar year ending six months prior to the beginning of the subject payment adjustment year. For the most part, these data shall be obtained from the data collection mechanisms and sources used to determine the annualized Medi-Cal inpatient paid days referred to in subsection 9 of Section B of this Attachment. For the 1994-95 payment adjustment year, the Department shall implement the special rules set forth in subsection 6. Further, where federal demonstration projects are involved, the Department shall implement the special rules set forth in subsection 7.

e. With respect to MAA, TCM, and specified CRRP revenues, the Department shall conduct a survey of affected hospitals to compute such revenues for application of the OBRA 1993 limits relating to the subject payment adjustment year. Surveys shall be conducted at such time that consistent and reliable data, as determined by the Department, is available statewide.

4. Calculation Of OBRA 1993 Limits - Formula To Be Used

The formula set forth below is for purposes of implementing the OBRA 1993 limits. The calculations involve various projections and estimates of hospital revenues and expenses.

a. The formula to be used by the Department for each eligible hospital shall be:

DSH_LMT = MCUN_EX - MCUN_RV

WHERE:

DSH_LMT=the OBRA 1993 hospital-specific limit

MCUN_EX=Medi-Cal/Uninsured Expenses

MCUN_RV=Medi-Cal/Uninsured Revenues

The specific elements yielding MCUN_EX and MCUN_RV are described below in paragraphs b and c, respectively.

b. "Medi-Cal/Uninsured Expenses" (MCUN_EX)

(1) "Projected Adjusted Hospital Operating Expenses" is computed from prior year OSHPD data that are projected ("trended") forward into the subject payment adjustment year. Except as provided in subsections 6 or 7, the Department shall use the data from the annual reports filed by hospitals with OSHPD that are used to determine eligibility for payments under the program (the "Hospital Disclosure Reports"). All data from such reports shall be considered to be final for purposes of these calculations as of the February 1 immediately prior to the applicable data determination date for the subject payment adjustment year. "Projected Adjusted Hospital Operating Expenses" is the "Total Operating Expenses" (TOT_OP) as reported on the applicable OSHPD report, minus "CRRP Costs" for the same period (CRRP) as determined by the applicable hospital-specific survey, multiplied by the trend factor (TREND).

The computation of the "Projected Adjusted Hospital Operating Expenses" (PR_ADJOP) is expressed as follows:

PR_ADJOP=(TOT_OP-CRRP)xTREND.

The applicable trend factor shall be derived from the Medicare hospital input price index ("Medicare hospital market basket"), developed

by the Health Care Financing Administration and forecasted by Data Resources, Inc./McGraw Hill. Except as provided in subsection 6, the trend factor shall equal the product of the Medicare hospital market basket percentage increases that were forecasted and published in the Federal Register for the three most recent federal fiscal years ("FFY") in conjunction with the annual "Medicare Program Changes to Hospital Inpatient Prospective Payment Systems and Rates" promulgated (or proposed, where final rules have not yet been promulgated) as of the applicable data determination date for the subject payment adjustment year. The earliest of the particular Medicare hospital market basket percentage increases used shall be multiplied by an adjustment factor to account for varying hospital OSHPD reporting periods. The applicable adjustment factor will depend on the particular month in which a hospital's OSHPD data reporting period ends, as follows:

OSHPD Reporting Period Ending	Adjustment Factor
Jan	1.417
Feb	1.333
Mar	1.250
Apr	1.167
May	1.083
Jun	1.000
Jul	.917
Aug	.833
Sep	.750
Oct	.667
Nov	.583
Dec	.500

For example, with respect to the 1995-96 payment adjustment year, the three applicable Medicare hospital market basket percentage increases are 4.3% (final federal figure for FFY 1994, 58 Fed.Reg. 46270), 3.6% (final federal figure for FFY 1995, 59 Fed.Reg. 45330), and 3.5% (final federal figure for FFY 1996, 60 Fed.Reg. 45778), as promulgated in the Federal Register on or before September 15, 1995. The applicable trend factor for the 1995-96 payment adjustment year is therefore computed as:

TREND = [1 + (.043 x 1.00*)] x 1.036 x 1.035.
*(Adjustment factor, for the earliest of the federal figures used (FFY 1994), for hospital with OSHPD data reporting period ending in June 1993.)

For a hospital with an OSHPD data reporting period ending in March 1993, the trend factor applicable for the 1995-96 payment adjustment year is computed as:

TREND = [1 + (.043 x 1.250*)] x 1.036 x 1.035.
*(Adjustment factor, for the earliest of the federal figures used (FFY 1994), for hospital with OSHPD data reporting period ending in March 1993.)

(2) "CRRP Costs" (CRRP_EX) derived from the applicable hospital-specific survey (which costs shall be limited to applicable depreciation, interest and, to the extent such costs are reflected in the debt service amounts recognized under Welfare and

Institutions Code Section 14085.5, the following other federally recognized capital-related costs as described in Title 42 of the Code of Federal Regulations, Section 413.130: taxes, costs of betterments and improvements, costs of minor equipment, insurance, debt issuance costs, debt discounts and debt redemption costs) are added to the "Projected Adjusted Hospital Operating Expenses," and "MAA Costs" (derived from the applicable hospital-specific survey) are subtracted, to arrive at the "Projected Total Hospital Expenses" for the subject payment adjustment year.

The computation of the "Projected Total Hospital Expenses" (PR_TOTEX) is expressed as follows:

PR_TOTEX = PR_ADJOP + CRRP_EX - MAA.

(3) A "Medi-Cal/Uninsured Patient Mix" ratio is applied to the "Projected Total Hospital Expenses." The "Medi-Cal/Uninsured Patient Mix" ratio is the ratio of all gross inpatient and outpatient charges (including charges associated with services provided under the Medi-Cal/Short-Doyle program, the San Mateo/Santa Barbara Health Initiative and other managed care programs) attributable to Medi-Cal patients, the County Indigent Program, and uninsured patients to total gross inpatient and outpatient charges. The necessary data elements are extracted from the applicable OSHPD report, the Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes, and the MEDS and OSHPD Confidential Discharge Data files.

The computation of the "Medi-Cal/Uninsured Patient Mix" ratio (MCUN_MIX) is as follows:

MCUN_MIX = (MCCRG + COINDCRG + UNINSCRG) ÷ (TOTIPCRG + TOTOPCRG).

WHERE:

MCCRG = Total Medi-Cal inpatient and outpatient charges (including charges associated with services provided under Medi-Cal managed care programs);

COINDCRG = Total County Indigent Program inpatient and outpatient charges;

UNINSCRG = Total charges attributable to uninsured patients;

TOTIPCRG = Total inpatient charges; and

TOTOPCRG = Total outpatient charges.

Projected "demonstration project expenses" (DEMO EX) are determined based on the terms and conditions of an approved federal Medicaid demonstration project, but only to the extent set forth in paragraph b of subsection 7. DEMO EX is added to the product of PR TOTEX and MCUN MIX to determine "Medi-Cal/Uninsured Expenses."

The computation of "Medi-Cal/Uninsured Expenses" (MCUN_EX) is therefore expressed as follows:

MCUN_EX = PR_TOTEX x MCUN_MIX + DEMO EX.

c. "Medi-Cal/Uninsured Revenues" (MCUN_RV) is comprised of the following components:

(1) "Medi-Cal Inpatient Revenues" (MIP_RV).

Except as otherwise provided in this Section J, "Medi-Cal Inpatient Revenues" shall be equal to the revenues for inpatient services, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the calendar year ending prior to the beginning of the subject

payment adjustment year. The revenue data shall be obtained from the data collection mechanisms and sources used by the Department in determining the hospital's annualized Medi-Cal inpatient paid days (as referred to in subsection 9 of Section B of this Attachment) as well as other applicable data maintained by the Department relating to Medi-Cal payments made during the same calendar year time period. These data sources are the Medi-Cal paid claims tapes, Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes and other managed care plan payment data. (This step does not include payments under Welfare and Institutions Code Section 14085.6, which are addressed in subparagraph (4) below. It also does not include certain demonstration project revenues, as described in subsection 7 below. For special rules regarding the 1994-95 payment adjustment year, see subsection 6 below.)

(2) "Medi-Cal Outpatient Revenues" (MOP_RV).

Except as otherwise provided in this Section J, "Medi-Cal Outpatient Revenues" shall be equal to Medi-Cal revenues for outpatient services, regardless of dates of services, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the calendar year ending prior to the beginning of the subject payment adjustment year. The revenue data shall be obtained from the data collection mechanisms and sources used by the Department in determining the hospital's annualized Medi-Cal inpatient paid days (as referred to in subsection 9 of Section B of this Attachment) as well as other applicable data maintained by the Department relating to Medi-Cal payments made during the same calendar year time period. These data sources are the Medi-Cal paid claims tapes, Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes, and other managed care plan

payment data. (This step does not include certain demonstration project revenues, as described in subsection 7 below. For special rules regarding the 1994-95 payment adjustment year, see subsection 6 below.)

(3) "CRRP Revenues" (CRRP_RV).

"CRRP Revenues" will be determined based on the results of the applicable hospital-specific survey.

(4) "Emergency Services/Supplemental Payments Revenues" (EMS_RV).

(a) Except as provided for in clause (d) or in subsection 7, the Department shall determine the hospital's revenue amount relating to the program under Welfare and Institutions Code Section 14085.6 ("S.B. 1255 program"), with respect to services to be rendered during the subject payment adjustment year, based on the best information available as of the data determination date, in the fashion described below.

(b) In determining the S.B. 1255 revenue amount to be included for the subject payment adjustment year, the Department shall use, in the following order of availability, the amount that:

(i) Is set forth in any contract between the hospital and the State as negotiated by the California Medical Assistance Commission ("CMAC") pursuant to Section 14085.6;

(ii) Has been agreed upon by the particular hospital and CMAC staff, but has not yet been formally approved by CMAC or by the hospital;

(iii) Represents the latest offer made by CMAC staff to the particular hospital; or,

(iv) The hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year, but only if (1) subclause (i), (ii), or (iii) do not apply, and (2) the hospital has communicated to CMAC an intent to participate in the S.B. 1255 program for the subject payment adjustment year. Should this clause (iv) apply for a hospital, the amount included by the Department shall not exceed the amount of S.B. 1255 program payments the hospital has requested from CMAC for the subject payment adjustment year.

(c) In the event that none of the data described in clause (b) is available as of the data determination date, the Department shall assume that the S.B. 1255 program revenue for the particular hospital for the subject payment adjustment year will be the amount the hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year. The Department, in cooperation with CMAC, shall notify hospitals of the existence and potential applicability of this provision at the time the S.B. 1255 program is initiated each year.

(d) With respect to the 1994-95 and 1995-96 payment adjustment years, the Department shall take into account, except as otherwise provided in subsection 7, the particular Medi-Cal contract amendment(s) for S.B. 1255 program payments effective for each period that have been entered into at the time that the computations pursuant to this Section J are made for each of the respective subject payment adjustment years.

(e) For purposes of clauses (b), (c), and (d) above, the Department shall use the contracted amount when the contracted "days of service" are equal to or less than 12 months. In the event that the "days of service" extend beyond 12 months, the Department shall reduce the total contract amount to reflect 12 months of revenue by dividing the total contract amount by the number of months represented in the contracted "days of service" and multiplying that number by 12.

(f) Except as provided in subclause (iv), for the 1996-97 payment adjustment year and subsequent payment adjustment years, if a hospital meets the conditions set forth in subclause (i), the Department shall take into account additional S.B. 1255 revenue amounts pursuant to subclauses (ii) and (iii).

(i) The hospital entered into a Medi-Cal contract amendment(s) since the last data determination date (September 15, 1995 and thereafter) that resulted in S.B. 1255 program payments to the hospital relating to services rendered in a fiscal year preceding the subject payment adjustment year, and such S.B. 1255 program payments were not included in the OBRA 1993 limit calculation for the year(s) during which such services were rendered.

(ii) The Department shall determine whether the inclusion of the additional S.B. 1255 program revenue described in subclause (i) would have resulted in a reduction in the hospital's disproportionate share payment amounts for the payment adjustment year for which the additional S.B. 1255 program payments were received.

(iii) To the extent that the additional S.B. 1255 revenue described in subclause (i) would have reduced the hospital's OBRA 1993 limit in an amount that would have resulted in the hospital surpassing its OBRA 1993 limit for a previous payment adjustment year, the amount of the additional S.B. 1255 revenue that would have caused the hospital to surpass its OBRA 1993 limit for any such prior year shall be added to the S.B. 1255 revenue amount for the subject payment adjustment year as determined under clauses (b)-(e).

(iv) Subclauses (i) through (iii) shall not apply to a hospital participating in a federal Medicaid demonstration project, if such demonstration project provides a repayment arrangement agreed to by the parties regarding disproportionate share payment adjustment amounts.

(5) "Targeted Case Management Revenues" (TCM_RV).

"Targeted Case Management Revenues" will be determined based on the results of the applicable hospital-specific survey.

(6) "Uninsured Cash Payments" (UNINS_RV).

Except as otherwise provided in this Section J, "Uninsured Cash Payment" will be derived from the applicable OSHPD report (as referred to in paragraph b of subsection 3). "Uninsured Cash Payments" shall be calculated as the sum of the inpatient and outpatient net revenues reported for "Other Payors" on page 12 of the OSHPD report. Consistent with section 1396r-4(g) of Title 42 of the United States Code, such sum shall not include payments made by the State, the University of California or a unit of local government to the hospital for services provided to indigent patients. The amount so determined from the applicable OSHPD report will be trended forward into the subject payment adjustment year (as referred to in subparagraph (1) of paragraph b of subsection 4).

7. Projected "demonstration project revenues" (DEMO RV) are determined based on the terms and conditions of an approved federal Medicaid demonstration project, but only to the extent set forth in paragraph b of subsection 7.

The computation of "Medi-Cal/Uninsured Revenues" (MCUN_RV) is therefore expressed as follows:

MCUN_RV = MIP_RV + MOP_RV + CRRP_RV + EMS_RV + TCM_RV + UNINS_RV + DEMO RV.

5. Application of Limit

a. For the 1994-95 payment adjustment year, the OBRA 1993 limits shall apply only to public hospitals. With respect to the 1994-95 payment adjustment year, the total disproportionate share payment adjustment amounts described at page 18 et seq. of this Attachment paid or payable to each eligible hospital that is owned or operated by the State (or by an instrumentality or a unit of government within the State) shall not exceed 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year; provided, however, that payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 200% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year.

b. For the 1995-96 and subsequent payment adjustment years, the OBRA 1993 limits shall apply to all eligible hospitals. With respect to any particular payment adjustment year, no eligible hospital shall receive total payment adjustment amounts under this Attachment in an amount that exceeds 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year, except as follows: (1) with respect to the 1997-98 and 1998-99 payment adjustment years, the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 175% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year; and (2) with respect to the 1999-2000 payment adjustment year and subsequent payment adjustment years, the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396-4(g)(2) of Title 42 of the United States Code) shall be limited to 100% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year, unless federal law sets forth or authorizes a different percentage figure or amount to be used for such hospital for such purposes for the subject payment adjustment year, in which case such different percentage figure or amount shall apply for such hospital for such payment adjustment year.

c. For the 1995-96 payment adjustment year, the OBRA 1993 limits shall be applied as set forth in subparagraph (3) of paragraph e of subsection 1 of Section I of this Attachment. For subsequent payment adjustment years, the OBRA 1993 limits shall be applied with respect to each year after performing computations under subsection 5 of Section D of this Attachment and as specified in other provisions of this Attachment. The OBRA 1993 limits shall be applied to the amounts computed for all affected hospitals prior to the computations of transfer amounts under Section 14163 of the Welfare and Institutions Code.

d. Where a payment adjustment amount that is otherwise paid or payable to an eligible hospital under this Attachment is; or would be, above the limits described in this Section J, the payment adjustment amount shall be subject to the provisions of subsection 9 of Section D of this Attachment.

6. Special Rules relating to 1994-95 Payment Adjustment Year.

With respect to the 1994-95 payment adjustment year, the OBRA 1993 limit shall be calculated for each eligible hospital in accordance with the methodology set forth in subsection 4 above, except as follows.

a. In determining expenses pursuant to paragraph b of subsection 4 (other than MAA and CRRP expenses), the Department shall use data from the annual OSHPD reports filed by hospitals for fiscal periods ending during the 1993 calendar year.

b. The applicable Medicare hospital market basket percentage increases, as referred to in subparagraph (1) of paragraph b of subsection 4 shall be 4.3% and 3.6% for FFY 1994 and FFY 1995, respectively (58 Fed.Reg. 46270; 59 Fed.Reg.45330). The Medicare hospital market basket percent increase for FFY 1994 shall be adjusted for varying hospital OSHPD reporting periods, as specified in subparagraph (1) of paragraph b of subsection 4.

c. The calculation of "Medi-Cal Inpatient Revenues," as referred to in subparagraph (1) of paragraph c of subsection 4, shall be based on data relating to revenues for inpatient services, regardless of dates of service, for which payment was made by of on behalf of the Department to a hospital, under present or previous ownership, during the 1994 calendar year.

d. The calculation of "Medi-Cal Outpatient Revenues," as referred to in subparagraph (2) of paragraph c of subsection 4, shall be based on data relating to revenues for outpatient services, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the 1994 calendar year.

e. "Uninsured Cash Payments," as referred to in subparagraph (6) of paragraph c of subsection 4, will be derived from the applicable annual OSHPD report referred to in paragraph a above. The amount so determined will be trended forward into the 1994-95 payment adjustment year based on the applicable Medicare hospital market basket percent increases set forth in paragraph b above.

7. Special Rules for Federal Medicaid Demonstration Projects.

a. This paragraph a shall apply where a federal demonstration project may occur, but the effective date of the project has not been approved by the federal government as of the data determination date for the subject payment adjustment year. This paragraph shall also apply where the federal government has approved the demonstration project, but the effective dates of the project do not include any time periods during the subject payment adjustment year. In such situations, any additional Medi-Cal and uninsured expenses and revenues that could potentially arise with respect to the subject payment adjustment year solely as a result of the hospital's participation in the demonstration project shall not be included in the computations set forth in subsection 4.

b. This paragraph b shall apply only where the federal government has approved a demonstration project, the federal approval has been issued prior to the data determination date for the subject payment adjustment year, and some or all of the federally approved effective dates of the project fall within the subject payment adjustment year. In such situations, to the extent that the Department determines (with concurrence of HCFA) that the terms and conditions of an approved federal Medicaid demonstration project constitute federally approved variations from the provisions of this Section J (including expenses, calculations, data elements, data collection and revenues federally recognized under the demonstration project for the computation of the OBRA 1993 limits hereunder), such terms and conditions of the approved demonstration project shall govern.

8. Department's Discretion

a. Notwithstanding any other provision of this Section J, but subject to paragraph b, below, the Department shall (with concurrence of HCFA) have the discretion to vary the mechanisms and sources, or formulas specified herein if the department finds that such variance is required to:

(1) Comply with federal law or regulations,

(2) Take into account the unavailability of particular data elements, or the impracticality of making a particular calculation, or

(3) Avoid inequitable or unintended results not consistent with OBRA 1993 or with the overall purpose and intent of this Section J.

b. A variance pursuant to paragraph a will be limited to making minor or insignificant adjustments to any formula, calculation, or methodology specified in this Section J, or to the specified sources of data to be used in any such formula, calculation, or methodology. These minor adjustments will be limited to instances when the format for reporting data used by the Department has been changed by the agency responsible for issuing the report, or when the information in an agency's report is incomplete and comparable information is available from the agency. Any minor adjustment made pursuant to this Section J will be made prior to the final calculation of OBRA '93 limits, and will not be made to effect a retroactive adjustment. A variance under this Section J will not be made to correct errors in data

submitted by a reporting hospital to the agency responsible for issuing the particular report, or to make any other correction, change, or adjustment in the data reported by a particular hospital. A variance under this Section J will not be made to alter the fundamental structure or general scheme of this Section J; where significant changes in the formulas, calculations, or methodologies specified in this Section J are necessary, the Department will submit a state plan amendment to the Health Care Financing Administration in the normal course.

9. Department Certification

The Department certifies that it is meeting the requirements of section 1923(g) of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of 1993) by applying the methodology set forth in this Section J. Further, the Department assures that it does not exceed the federal allotment for California set forth at section 1923(f) of the Act.

K. Supplemental Lump-Sum Payment Adjustments - June 30, 1997

1. For the 1996-97 payment adjustment year, each eligible hospital that remains in operation as of June 30, 1997, shall also be eligible to receive a supplemental lump-sum payment adjustment, that shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date.

2. The availability of supplemental payment adjustments under this paragraph shall be determined as follows:

   a. The projected total payment adjustment amount for each hospital, as determined by the department, including any reductions arising from payment limitations under this Attachment, shall be identified. For each hospital, this amount shall be identical to the amount used for the same hospital in the calculations regarding transfer amounts under subdivision (h) of Section 14163 of the California Welfare and Institutions Code for the 1996-97 state fiscal year.

   b. The total amount of all per diem payment adjustment amounts under this section, whether paid or payable, that are applicable to the period July 1, 1996, through June 30, 1997, shall be determined for each hospital. The applicability of the per diem payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

   c. The amount determined under paragraph b. for each hospital shall be subtracted from the amount identified under paragraph a. for each hospital. If the remainder is a positive figure for the particular hospital, the supplemental lump-sum adjustment for the hospital shall be the positive remainder amount, which shall be payable because the facility is a disproportionate share hospital in operation as of June 30, 1997.

   d. The Department shall make interim and final payments of the supplemental lump-sum payments under this paragraph on or before September 30, 1997.

3. For purposes of complying with section 13621 of the Omnibus Budget Reconciliation Act of 1993, the hospital-specific limitation described in Section J shall be applicable to amounts otherwise paid or payable with respect to the 1996-97 payment adjustment year.

L. Payment Adjustment Program for 1997-98 Payment Adjustment Year

With respect to the 1997-98 payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

1. Special Supplemental Payment Adjustments - September 30, 1997.

a. Each eligible hospital that meets the requirements of this subsection and that remains in operation as of September 30, 1997, also shall be eligible to receive a special supplemental payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date. For purposes of federal medicaid rules, including Section 447.297(d) of Title 42 of the Code of Federal Regulations, the special supplemental payment adjustments shall be applicable to the federal fiscal year that ends on September 30, 1997.

b. The availability of special supplemental payment adjustments under this subsection shall be determined as follows:

(1) The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1997 federal fiscal year.

(2) The total amount of all per diem payment adjustment amounts and supplemental payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the 1997 federal fiscal year, whether paid or payable, shall be determined. The applicability of per diem payment adjustment amounts and supplemental payment adjustments of all types to the 1997 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(3) The figure determined under subparagraph (2) shall be subtracted from the figure identified under subparagraph (1). If the remainder is a positive figure, special supplemental payment adjustments shall be made under this subsection in accordance with paragraphs c. through f. The positive remainder shall be the maximum amount of special supplemental payment adjustments under this subsection.

c. For purposes of these special supplemental payment adjustments, only hospitals that can be categorized into either of the two groups specified in subparagraphs (1) and (2) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that meet the definition of a public hospital based on the hospital's circumstances as of July 1, 1997.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that meet the definition of a nonpublic hospital based on the hospital's circumstances as of July 1, 1997.

d. The amount determined to be the maximum amount of special supplemental payment adjustments under subparagraph (3) of paragraph b. shall first be allocated between the two groups of hospitals referred to in paragraph c. as follows:

(1) "Public hospitals": 74.885 percent of the maximum amount.

(2) "Nonpublic hospitals": 25.115 percent of the maximum amount.

e. The amount of funds allocated pursuant to paragraph d. to each of the particular groups of hospitals referred to in paragraphs c. and d. shall then be distributed as special supplemental payment adjustments among the eligible hospitals within each of the two particular groups as follows:

(1) The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 1997-98 payment adjustment year, exclusive of any supplemental payments under this subsection or subsection 3. or subsection 4., by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days. For purposes of this clause, the determinations shall be without regard to the OBRA 1993 payment limitations.

(2) The amount computed under subparagraph (1) for each hospital described in paragraph c. shall be compared to the amount that is the product of multiplying 0.95 times the OBRA 1993 payment limitation that, in accordance with Section J. (including the modifications arising from the implementation of Section 4721(e) of the federal Balanced Budget Act of 1997), the department has computed for the particular hospital for the 1997-98 payment adjustment year.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the product computed for the hospital under subparagraph (2), the hospital shall not receive a special supplemental payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the product computed for the hospital under subparagraph (2), the amount computed under subparagraph (1) for the hospital shall be used for purposes of subparagraphs (5) through (8).

(5) The figures determined under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph d., to determine the hospital's pro rata share of the special supplemental payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1997, met the definition of a children's hospital, the pro rata share otherwise determined shall be multiplied by a factor of 1.09. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded.

(8) In no event shall a hospital receive special supplemental payment adjustment amounts in excess of the difference between the product computed for the hospital under subparagraph (1). Any special supplemental payment adjustment amount or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

f. The department shall make interim and final payments of the special supplemental payment adjustments to hospitals on or before February 28, 1998.

2. Non-Supplemental Payment adjustments – October 1, 1997, through June 30, 1998.

Payment adjustments with respect to the period October 1, 1997, through June 30, 1998 (exclusive of the supplemental lump-sum payment adjustments provided for under subsection 3. and the additional supplemental lump-sum payment adjustments provided for under subsection 4.) shall be structured as set forth below.

a. The initial maximum size of the payment adjustment program for the entire 1997-98 payment adjustment year shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payments under subsections 1., 3., or 4.

b. The department shall utilize the computations made pursuant to subparagraph (1) of paragraph e. of subsection 1. of the projected total payment adjustment amounts for all eligible hospitals for the entire 1997-98 payment adjustment year, exclusive of any supplemental payments under subsections 1., 3., or 4.

c. The computed amount referred to in paragraph b. for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J. (including the modifications arising from the implementation of Section 4721(e) of the federal Balanced Budget Act of 1997), the department has computed for the particular hospital.

d. Where the computed amount referred to in paragraph b. for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital , the amount computed under paragraph b. shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of paragraph f.

e. Where the computed amount referred to in paragraph b. for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in paragraph b. shall be used for purposes of paragraph f.

f. The amounts determined under paragraphs d. and e. for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the entire 1997-98 payment adjustment year, exclusive of any supplemental payments under subsections 1., 3., or 4.

g. The department shall increase or decrease the amount determined for each eligible hospital under paragraph d. or e., as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the entire 1997-98 payment adjustment year. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph a. by the aggregate sum determined under paragraph f. Except, however, the amount determined for a hospital under paragraphs d. or e. shall not be increased such that it would exceed the OBRA 1993 payment limitation for the hospital.

h. The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph g. shall be further adjusted as follows:

(1) Nonpublic/Converted Hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic/converted hospital, based on its circumstances as of July 1, 1997, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic/converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result in an amount, for each such hospital, equal to the amount used for the particular hospital under paragraph f. The amount so adjusted shall be used for purposes of clause (c).

(b) The total amount of all per diem payment adjustment amounts under this Attachment, whether paid or payable, applicable to the period July 1, 1997 through September 30, 1997, shall be determined for each hospital referred to in clause (a). The applicability of the per diem payment adjustment amounts to the period July 1, 1997 through September 30, 1997, shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(c) The amount determined for each hospital under clause (a) shall be reduced by the amount determined under clause (b) for the hospital. The resulting figure shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1997 through June 30, 1998, which shall be paid to the hospital in accordance with paragraph i.

(2) Nonpublic Hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic hospital, based on its circumstances as of July 1, 1997, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph g. for each nonpublic hospital described above shall be added together.

(ii) The amount identified in paragraph a. shall be divided by 2.38. The resulting figure shall then be reduced by the sum of the amounts determined for all nonpublic/converted hospitals under clauses (b) and (c) of subparagraph (1).

(iii) The amount computed under subclause (ii) shall be divided by 2, and the result thereof further reduced by the amount of thirty-seven million five hundred thousand dollars ($37,500,000).

(iv) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (iii) by the amount derived in subclause (i).

(b) The total amount of all per diem payment adjustment amounts under this Attachment, whether paid or payable, applicable to the period July 1, 1997 through September 30, 1997, shall be determined for each hospital referred to in clause (a). The applicability of the per diem payment adjustment amounts to the period July 1, 1997 through September 30, 1997, shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(c) The amount determined for each hospital under clause (a) shall be reduced by the amount determined under clause (b) for the hospital. The resulting figure shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1997 through June 30, 1998, which shall be paid to the hospital in accordance with paragraph i.

(3) Public Hospitals.

(a) For each eligible hospital that meets the definition of a public hospital, based on its circumstances as of July 1, 1997, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph g. for each public hospital described above shall be added together.

(ii) The amount identified in paragraph a. shall be reduced by the sum of the amounts determined for all nonpublic/converted hospitals under clauses (b) and (c) of subparagraph (1) and the sum of the amounts determined for all nonpublic hospitals under clauses (b) and (c) of subparagraph (2).

(iii) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (ii) by the amount derived in subclause (i).

(b) The total amount of all per diem payment adjustment amounts under this Attachment, whether paid or payable, applicable to the period July 1, 1997 through September 30, 1997, shall be determined for each hospital referred to in clause (a). The applicability of the per diem payment adjustment amounts to the period July 1, 1997 through September 30, 1997, shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(c) The amount determined for each hospital under clause (a) shall be reduced by the amount determined under clause (b) for the hospital. The resulting figure shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1997, through June 30, 1998, which shall be paid to the hospital in accordance with paragraph i.

i. The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1, 1997, through June 30, 1998, shall be distributed in 16 or fewer equal installments to be paid no later than the 10th and 25th day of each month during the period October 1, 1997, through May 25, 1998.

j. Notwithstanding any other provision of law, for the entire 1997-98 payment adjustment year, no eligible hospital shall receive total payment adjustments, including per diem payment adjustments relating to the period July 1, 1997, through September 30, 1997, payments under this subsection, and any supplemental payments under subsections 1., 3., or 4., in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to Section J. (including the modifications arising from the implementation of Section 4721(e) of the federal Balanced Budget Act of 1997). No hospital shall receive any special supplemental payment adjustments, supplemental lump-sum payment adjustments, or additional supplemental lump-sum payment adjustments to the extent the payments would be inconsistent with subsections 1., 3., or 4., respectively.

k. The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph h. for each eligible hospital for the period October 1, 1997, through June 30, 1998, plus the aggregate sum of the amounts determined for each eligible hospital under clause (b) of subparagraph (1) of paragraph h., clause (b) of subparagraph (2) of paragraph h., and clause (b) of subparagraph (3) of paragraph h., shall be the maximum size of the payment adjustment program for the entire 1997-98 payment adjustment year, exclusive of the special supplemental payment adjustments provided for under subsection 1., the supplemental lump-sum payment adjustments provided for under subsection 3., and the additional supplemental lump-sum payment adjustments provided for under subsection 4.

3. Supplemental Lump-Sum Payment Adjustments - June 30, 1998

a. Each eligible hospital that meets the requirements of this subsection and that remains in operation as of June 30, 1998, also shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1997, to June 30, 1998. inclusive.

b. The amount of supplemental lump-sum payment adjustments available to hospitals under this subsection shall be four hundred five million dollars ($405,000,000).

c. For purposes of these supplemental lump-sum payment adjustments, only hospitals that can be categorized into either of the two groups specified in subparagraphs (1) and (2) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that meet the definition of a public hospital based on the hospital's circumstances as of July 1, 1997.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that meet the definition of a nonpublic hospital based on the hospital's circumstances as of July 1, 1997.

d. The amount of supplemental lump-sum payment adjustments as referred to in paragraph b. shall first be allocated between the two groups of hospitals referred to in paragraph c. as follows:

(1) "Public hospitals": 72.17 percent of the amount.

(2) "Nonpublic hospitals": 27.83 percent of the amount.

e. The amount of funds allocated pursuant to paragraph d. to each of the particular groups of hospitals referred to in paragraphs c. and d. shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each of the two particular groups as follows:

(1) The department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection or subsection 4.) applicable to the 1997-98 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J. (including the modifications arising from the implementation of Section 4721(e) of the federal Balanced Budget Act of 1997), the department has computed for the particular hospital for the 1997-98 payment adjustment year.

(3) Where the amount identified under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount identified under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount identified under subparagraph (1) minus that amount paid or payable to the hospital under subsection 1. shall be used for purposes of subparagraphs (5) through (8).

(5) The figures determined under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph d., to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1997, met the definition of a children's hospital, the pro rata share otherwise determined shall be multiplied by a factor of 1.09. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded.

(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this subsection to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

f. The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before August 15, 1998.

g. Notwithstanding all other provisions of this Attachment, the payment adjustments, data, and related aspects of subsection 4. shall not be taken into account for any purpose under this subsection, subsection 1., or subsection 2.

4. Additional Supplemental Lump-Sum Payment Adjustments - June 30, 1998.

a. The provisions of this subsection shall apply for the 1997-98 payment adjustment year, and, for all purposes under the program, shall be implemented subsequent to the provisions of subsections 1., 2. and 3. Under this subsection, eligible hospitals that, as of October 1, 1997, were part of a county-operated health system of three or more eligible hospitals licensed to the county, and that are in operation as of June 30, 1998, shall be eligible to receive an additional lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1997, through June 30, 1998.

b. The maximum amount of additional supplemental lump-sum payment adjustments under this subsection shall be one hundred sixty-six million dollars.

c. The maximum amount of funds specified under paragraph b. shall be distributed as additional supplemental lump-sum payment adjustments among the hospitals eligible under this subsection as follows:

(1) The department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the 1997-98 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the department has computed for the particular hospital for the 1997-98 payment adjustment year.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive an additional supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (1) shall be used for purposes of subparagraphs (5) through (8).

(5) The figures determined under subparagraph (4) for each hospital eligible to receive additional supplemental lump-sum payment adjustments under this subsection shall be added together to determine an aggregate total.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5), yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum amount specified in paragraph b., to determine the hospital's pro rata share of the additional supplemental lump-sum payment adjustments.

(8) In no event shall a hospital receive additional supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any additional supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this subsection to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals eligible for distributions under this subsection that have not reached their OBRA 1993 payment limitation.

d. The department shall make interim and final payments of the additional supplemental lump-sum payment adjustments to hospitals on or before August 15, 1998.

M. Payment Adjustment Program for 1998-99 Payment Adjustment Year

With respect to the 1998-99 payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

1. Non-Supplemental Payment Adjustments - July 1, 1998 through June 30, 1999.

Payment adjustments with respect to the period July 1, 1998 through June 30, 1999 (exclusive of the supplemental lump-sum payment adjustments provided for under subsection 2.) shall be structured as set forth below.

a. The initial maximum size of the payment adjustment program for the 1998-99 payment adjustment year shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payment adjustments under subsection 2.

b. The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 1998-99 payment adjustment year, exclusive of any supplemental payment adjustments under subsection 2., by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days. For purposes of this paragraph, such determinations shall be without regard to the OBRA 1993 payment limitations. With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the projected total payment adjustment amount shall be reduced by an amount equal to the amount paid or payable to the hospital under subsection 4. of Section L.

c. The computed amount referred to in paragraph b. for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the department has computed for the particular hospital for the 1998-99 payment adjustment year.

d. Where the computed amount referred to in paragraph b. for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under paragraph b. shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of paragraph f. Except, however, with respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the amount as so reduced shall be increased by an amount equal to the amount paid or payable to the hospital under subsection 4. of Section L., and used for purposes of paragraph f.

e. Where the computed amount referred to in paragraph b. for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in paragraph b. shall be used for purposes of paragraph f. Except, however, with respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the computed amount shall be increased by an amount equal to the amount paid or payable to the hospital under subsection 4. of Section L., and used for purposes of paragraph f.

f. The amounts determined under paragraphs d. and e. for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the 1998-99 payment adjustment year, exclusive of any supplemental payment adjustments under subsection 2.

g. The department shall increase or decrease the amount determined for each eligible hospital under paragraph d. or e., as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the 1998-99 payment adjustment year. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph a. by the aggregate sum determined under paragraph f. Except, however, the amount determined for a hospital under paragraph d. or e., as applicable, shall not be increased such that it would exceed the OBRA 1993 payment limitation for the hospital, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amounts for all hospitals equals the amount set forth in paragraph a.

h. With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the amount determined under paragraph d. or e., as applicable, shall be reduced by an amount equal to the amount paid or payable to the hospital under subsection 4 of Section L., prior to applying the OBRA 1993 payment limitation under paragraph g. Notwithstanding the preceding sentence, all other computations under paragraph g., including the determination of the hospital's pro rata share of any reallocations, shall be made as though the reduction described in the preceding sentence had not occurred.

i. The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph g. shall be further adjusted as follows:

(1) Nonpublic/converted hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic/converted hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic/converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result for each such hospital in an amount equal to the amount used for the particular hospital under paragraph f.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998-99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph j.

(2) Converted Hospitals.

(a) For each eligible hospital that meets the definition of a converted hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result for each such hospital in an amount equal to: (i) 80 percent of the hospital's annualized Medi-Cal inpatient paid days; multiplied by (ii) the total per diem composite amount determined for the hospital, the calculation of such per diem composite amount being restricted by a maximum low-income number of 40 percent for the hospital, regardless if the hospital's low-income number would otherwise be higher. In no case shall the product of this calculation exceed the amount used for the particular hospital under paragraph f.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998-99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph j.

(3) Nonpublic Hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph g. for each nonpublic hospital described above shall be added together.

(ii) The amount identified in paragraph a. shall be divided by 2.347. The resulting figure shall then be reduced by the aggregate sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1) and the amounts determined for all converted hospitals under subparagraph (2).

(iii) The amount computed under subclause (ii) shall be divided by 2, and the result thereof further reduced by the amount of thirty-seven million five hundred thousand dollars ($37,500,000).

(iv) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (iii) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998-99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph j. Except, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (iii) of clause (a).

(4) Public Hospitals.

(a) For each eligible hospital that meets the definition of a public hospital as of July 1, 1998, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph g. for each public hospital described above shall be added together.

(ii) The amount identified in paragraph a. shall be reduced by the aggregate sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1), the amounts determined for all converted hospitals under subparagraph (2) and the amounts determined for all nonpublic hospitals under subparagraph (3).

(iii) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (ii) by the amount derived in subclause (i).

(b) The product determined for each hospital under clause (a) shall be further adjusted as follows:

(i) The product shall be reduced as necessary so as not to exceed the hospital's OBRA 1993 payment limitation.

(ii) With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the product shall, prior to the application of subclause (i), be reduced by an amount equal to the amount paid or payable to the hospital under subsection 4. of Section L.

(iii) Any amounts that would otherwise have been allocated to a hospital but for the hospital's OBRA 1993 payment limitation as applied under subclause (i) shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis. With respect to a public hospital described in subclause (ii), such hospital's pro rata share of any such reallocated amounts shall be based on the product derived for the hospital under clause (a).

(iv) The amount determined for each hospital pursuant to subclause (i) and subclause (ii), as applicable (including the reduction under subclause (ii)), plus any reallocations to the hospital under subclause (iii). shall be the final adjusted projected total payment adjustment amount for the hospital for the 1998-99 payment adjustment year, which shall be paid to the hospital in accordance with paragraph j.

j. The final adjusted projected total payment adjustment amount determined for each eligible hospital for the 1998-99 payment adjustment year shall be distributed as set forth below.

(1) With respect to the period July 1, 1998, through September 30, 1998, payment adjustment amounts shall be payable only to those eligible hospitals that, as of July 1, 1998, were not part of a county-operated health system of three or more eligible hospitals licensed to the county.

(a) The maximum amount of payment adjustments payable to eligible hospitals under this subparagraph for the period July 1, 1998, through September 30, 1998, shall be determined as follows:

(i) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1998 federal fiscal year. This maximum allotment is two billion one hundred seventeen million eight hundred ninety-nine thousand six hundred sixty-eight dollars ($2,117,899,668).

(ii) The total amount of all payment adjustments under this Attachment (exclusive of any payments under this subparagraph) applicable to the 1998 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 1998 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(iii) The figure determined under subclause (ii) shall be subtracted from the figure identified under subclause (i). The positive remainder shall be the maximum amount of payment adjustments payable with respect to the period July 1, 1998, through September 30, 1998, under this subparagraph.

(b) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a nonpublic/converted hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph i., multiplied by a fraction that is computed as follows:

(i) The maximum amount derived in subclause (iii) of clause (a) shall be increased by an amount equal to the total amount of payment adjustments paid or payable under subsection 4. of Section L.

(ii) The figure derived in subclause (i) shall be divided by one billion seven hundred fifty million dollars ($1,750,000,000).

(c) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a converted hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph i., multiplied by a fraction that is computed as follows:

(i) The maximum amount derived in subclause (iii) of clause (a) shall be increased by an amount equal to the total amount of payment adjustments paid or payable under subsection 4. of Section L.

(ii) The figure derived in subclause (i) shall be divided by one billion seven hundred fifty million dollars ($1,750,000,000).

(d) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a nonpublic hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph i., multiplied by a fraction that is computed as follows:

(i) The maximum amount derived in subclause (iii) of clause (a) shall be increased by an amount equal to the total amount of payment adjustments paid or payable under subsection 4. of Section L.

(ii) The figure derived in subclause (i) shall be divided by one billion seven hundred fifty million dollars ($1,750,000,000).

(e) With respect to an eligible hospital that, as of July 1, 1998, meets the definition of a public hospital, the maximum amount payable for the period July 1, 1998, through September 30, 1998, shall be equal to the product of the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph i., multiplied by a fraction that is computed as follows:

(i) The maximum amount derived in subclause (iii) of clause (a) shall be reduced by the aggregate sums of the amounts determined for all nonpublic/converted hospitals under clause (b), the amounts determined for all converted hospitals under clause (c) and the amounts determined for all nonpublic hospitals under clause (d).

(ii) The amounts computed under paragraph i. with respect to all public hospitals that are subject to this subparagraph (1) shall be added together, yielding an aggregate sum.

(iii) The figure derived in subclause (i) shall be divided by the aggregate sum derived in subclause (ii).

(f) The resulting product determined for each hospital pursuant to clauses (b) through (e), as applicable, shall be distributed to the hospital in 3 equal installments, each payable as of the last day of each month from July 1998 through September 1998. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month. To the extent that any hospital is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type (as such hospital types are described in clauses (b) through (e)) that remain in operation from July 1, 1998, through September 30, 1998, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of September 30, 1998.

(2) With respect to the period October 1, 1998, through June 30, 1999, payment adjustment amounts shall be payable to each eligible hospital in the amount equal to the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph i., less any payment adjustments paid or payable to the hospital (or payment adjustments that would have been payable but for the hospital's failure to remain in operation for a particular month) under subparagraph (1).

(a) The payment adjustments for the period shall be distributed in 8 equal amounts, each payable as of the last day of each month from October 1998 through May 1999. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month.

(b) To the extent that any hospital of either of the hospital types described in clause (d) or (e) of subparagraph (1) is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1, 1998, through June 30, 1999, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30, 1999.

(c) With respect to a public hospital that, as of July 1, 1998, is part of a county-operated health system of three or more eligible hospitals licensed to the county, the hospital's pro rata share of any reallocations under clause (b) shall be based on the final adjusted projected total payment adjustment amount determined for the hospital pursuant to paragraph i., as increased by an amount equal to the amount paid or payable to the hospital under subsection 4. of Section L.

k. No eligible hospital shall receive total payment adjustments for the 1998-99 payment adjustment year in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to Section J.

l. The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph i. for each eligible hospital shall be the maximum size of the payment adjustment program for the 1998-99 payment adjustment year, exclusive of the supplemental payment adjustments provided for under subsection 2.

2. Supplemental Lump-Sum Payment Adjustments - June 30, 1999.

a. For the 1998-99 payment adjustment year, eligible hospitals that meet the requirements of this subsection and that are in operation as of June 30, 1999, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1998, through June 30, 1999.

b. The availability of supplemental lump-sum payment adjustments under this subsection shall be determined as follows:

(1) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1999 federal fiscal year.

(2) The total amount of all payment adjustment amounts under this Attachment (exclusive of any payments under this subsection) applicable to the 1999 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 1999 federal fiscal year shall be determined in accordance with federal Medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(3) The figure determined under subparagraph (2) shall be subtracted from the figure identified under subparagraph (1). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subsection. The positive remainder shall be the maximum amount of supplemental lump-sum payment adjustments under this subsection.

c. For purposes of supplemental lump-sum payment adjustments under this subsection, only hospitals that can be categorized into either of the two groups specified in subparagraphs (1) and (2) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that, as of July 1, 1998, met the definition of a public hospital.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1, 1998, met the definition of a nonpublic hospital.

d. The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under subparagraph (3) of paragraph b. shall first be allocated between the two groups of hospitals referred to in paragraph c. as follows:

(1) "Public hospitals": 72.78% of the maximum amount.

(2) "Nonpublic hospitals": 27.22% of the maximum amount.

e. The amount of funds allocated pursuant to paragraph d. to each of the particular groups of hospitals referred to in paragraphs c. and d. shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(1) The department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the 1998-99 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that. in accordance with Section J., the department has computed for the particular hospital for the 1998-99 payment adjustment year.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (1) shall be used for purposes of subparagraphs (5) through (8). Except, however, with respect to a public hospital that, as of July 1, 1998, was part of a county-operated health system of three or more eligible hospitals licensed to the county, the amount computed under subparagraph (1), as increased by an amount equal to the amount paid or payable to the hospital pursuant to subsection 4. of Section L., shall be used for purposes of subparagraphs (5) through (7), while the amount computed under subparagraph (1) only shall be used for purposes of applying the OBRA 1993 payment limitation under subparagraph (8).

(5) The figures determined under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph d., to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1998, met the definition of a children's hospital, such pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).

(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

f. The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before August 15, 1999.

N. Payment Adjustment Program for 1999-2000 Payment Adjustment Year

With respect to the 1999-2000 payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

1. Non-Supplemental Payment Adjustments - July 1, 1999 - September 30, 1999.

   No payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 1999-2000 payment adjustment year.

2. Non-Supplemental Payment Adjustments - October 1, 1999 - June 30, 2000.

   Payment adjustments with respect to the period October 1, 1999, through June 30, 2000 (exclusive of the supplemental lump-sum payment adjustments provided for under subsection 3.), shall be structured as set forth below.

   a. The initial maximum size of the payment adjustment program for the period October 1, 1999, through June 30, 2000, shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payment adjustments under subsection 3.

   b. The department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 1999-2000 payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3., by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days. For purposes of this paragraph, such determinations shall be without regard to the OBRA 1993 payment limitations.

c. The computed amount referred to in paragraph b. for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the department has computed for the particular hospital for the 1999-2000 payment adjustment year.

d. Where the computed amount referred to in paragraph b. for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under paragraph b. shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of paragraph f.

e. Where the computed amount referred to in paragraph b. for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in paragraph b. shall be used for purposes of paragraph f.

f. The amounts determined under paragraphs d. and e. for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period October 1, 1999, through June 30, 2000, exclusive of any supplemental payment adjustments under subsection 3.

g. The department shall increase or decrease the amount determined for each eligible hospital under paragraph d. or e., as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1, 1999, through June 30, 2000. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph a. by the aggregate sum determined under paragraph f. Except, however, the amount determined for a hospital under paragraphs d. or e. shall not be increased such that it would exceed the OBRA 1993 payment limitation for the hospital, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amounts for all hospitals equals the amount set forth in paragraph a.

h. The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph g. shall be further adjusted as follows:

(1) Nonpublic/converted hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic/converted hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic/converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result in an amount for each such hospital equal to the amount used for the particular hospital under paragraph f.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph i.

(2) Converted Hospitals.

(a) For each eligible hospital that meets the definition of a converted hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall be that which is necessary to result for each such hospital in an amount equal to: (i) 80 percent of the hospital's annualized Medi-Cal inpatient paid days; multiplied by (ii) the total per diem composite amount determined for the hospital, the calculation of such per diem composite amount being restricted by a maximum low-income number of 40 percent for the hospital, regardless if the hospital's low income number would otherwise be higher. In no case shall the product of this calculation exceed the amount used for the particular hospital under paragraph f.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph i.

(3) Nonpublic Hospitals

(a) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph g. for each nonpublic hospital shall be added together.

(ii) The amount identified in paragraph a. shall be divided by 2.055. The resulting figure shall then be reduced by the aggregate sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1) and all converted hospitals under subparagraph (2).

(iii) The amount computed under subclause (ii) shall be divided by 2, and the result thereof further reduced by the amount of thirty seven million five hundred thousand dollars ($37,500,000).

(iv) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (iii) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph i. Except, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (iii) of clause (a).

(4) Public Hospitals.

(a) For each eligible hospital that meets the definition of a public hospital as of July 1, 1999, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph g. for each public hospital described above shall be added together.

(ii) The amount identified in paragraph a. shall be reduced by the aggregate sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1), the amounts determined for all converted hospitals under subparagraph (2) and the amounts determined for all nonpublic hospitals under subparagraph (3).

(iii) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (ii) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 1999, through June 30, 2000, which shall be paid to the hospital in accordance with paragraph i. Except, however, in no case shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (ii) of clause (a).

i. The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1, 1999, through June 30, 2000, shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each month from October 1999 through May 2000. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month. To the extent that any hospital of either of the hospital types described in subparagraph (3) or (4) of paragraph h. is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1, 1999, through June 30, 2000, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30, 2000.

j. Notwithstanding all other provisions of this subsection regarding the OBRA 1993 payment limitations, with respect to a hospital that meets the definition of a public hospital as of July 1, 1999, the provisions of paragraphs b. through i. shall initially be implemented for the period October 1, 1999, through December 31, 1999, without application of the OBRA 1993 payment limitations. As of January 1, 2000, the department shall recalculate all determinations under paragraphs b. through i. for the payment adjustment year, taking into account the hospital's OBRA 1993 payment limitation as determined pursuant to the provisions of Section J. that are in effect as of January 1, 2000, and adjust, as necessary, the monthly payment installments from January 2000 through May 2000 to take into account any modifications to the recalculated amounts payable for the period October 1999 through December 1999 as may arise from the application of this paragraph.

k. No eligible hospital shall receive total payment adjustments for the 1999-2000 payment adjustment year in excess of the hospital's OBRA 1993 payment limitation as computed by the department pursuant to Section J.

l. The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph h. for each eligible hospital for the period October 1, 1999, through June 30, 2000, shall be the maximum size of the payment adjustment program for the entire 1999-2000 payment adjustment year, exclusive of the supplemental payment adjustments provided for under subsection 3.

3. Supplemental Lump-Sum Payment Adjustments - June 30, 2000.

a. For the 1999-2000 payment adjustment year, eligible hospitals that meet the requirements of this subsection and that are in operation as of June 30, 2000, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 1999, through June 30, 2000.

b. The availability of supplemental lump-sum payment adjustments under this subsection shall be determined as follows:

(1) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules shall be identified for the 2000 federal fiscal year.

(2) The total amount of all payment adjustment amounts under this Attachment (exclusive of any payments under this subsection) applicable to the 2000 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 2000 federal fiscal year shall be determined in accordance with federal Medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(3) The figure determined under subparagraph (2) shall be subtracted from the figure identified under subparagraph (1). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subsection.

(4) The maximum amount of supplemental lump-sum payment adjustments under this subsection shall be the positive remainder derived in subparagraph (3).

c. For purposes of supplemental lump-sum payment adjustments under this subsection, only hospitals that can be categorized into either of the two groups specified in subparagraphs (1) and (2) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that, as of July 1, 1999, met the definition of a public hospital.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1, 1999, met the definition of a nonpublic hospital.

d. The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under paragraph b. shall first be allocated between the two groups of hospitals referred to in paragraph c. as follows:

(1) "Public hospitals": 71.64% of the maximum amount.

(2) "Nonpublic hospitals": 28.36% of the maximum amount.

e. The amount of funds allocated pursuant to paragraph d. to each of the particular groups of hospitals referred to in paragraphs c. and d. shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(1) The department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the 1999-2000 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal Medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the department has computed for the particular hospital for the 1999-2000 payment adjustment year. For all purposes under this subsection, calculations of the OBRA 1993 payment limitations for public hospitals shall not be performed prior to January 1, 2000, as referred to in paragraph j. of subsection 2.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (1) shall be used for purposes of subparagraphs (5) through (8).

(5) The figures determined under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph d., to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Except, however, in the case of a nonpublic hospital that, as of July 1, 1999, met the definition of a children's hospital, such pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this clause, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).

(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

f. The department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before August 15, 2000.

O. Payment Adjustment Program for 2000-01 Payment Adjustment Year.

With respect to the 2000-01 payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

1. Non-Supplemental Payment Adjustments - July 1, 2000 - September 30, 2000.

No payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 2000-01 payment adjustment year.

2. Non-Supplemental Payment Adjustments - October 1, 2000 - June 30, 2001.

Payment adjustments with respect to the period October 1, 2000, through June 30, 2001 (exclusive of the supplemental lump-sum payment adjustments provided for under subsection 3.), shall be structured as set forth below.

a. The initial maximum size of the payment adjustment program for the period October 1, 2000, through June 30, 2001, shall be set at one billion seven hundred fifty million dollars ($1,750,000,000), exclusive of any supplemental payment adjustments under subsection 3.

b. The Department shall compute the projected total payment adjustment amounts for all eligible hospitals for the 2000-01 payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3., by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days. For purposes of this paragraph, such determinations shall be made without regard to the OBRA 1993 payment limitations. Notwithstanding the foregoing, with respect to a hospital that, as of July 1, 2000, meets the definition of a converted hospital, the amount otherwise determined under this paragraph shall be reduced as necessary so as not to exceed the total amount of all payment adjustment amounts payable to the hospital under this Attachment for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

c. The computed amount referred to in paragraph b. for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the 2000-01 payment adjustment year.

d. Where the computed amount referred to in paragraph b. for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under paragraph b. shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of paragraph f.

e. Where the computed amount referred to in paragraph b. for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in paragraph b. shall be used for purposes of paragraph f.

f. The amounts determined under paragraphs d. and e. for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period October 1, 2000, through June 30, 2001, exclusive of any supplemental payment adjustments under subsection 3.

g. The Department shall increase or decrease the amount determined for each eligible hospital under paragraph d. or e., as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1, 2000, through June 30, 2001. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph a. by the aggregate sum determined under paragraph f. In no case, however, shall the amount determined for a hospital under paragraphs d. or e. be increased such that it would exceed the OBRA 1993 payment limitation for the hospital, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amounts for all hospitals equals the amount set forth in paragraph a.

h. The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph g. shall be further adjusted as follows:

(1) Nonpublic/converted hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic/converted hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic/converted hospital adjustment factor." The applicable adjustment factor shall be 0.81; except, however, where the hospital also meets the definition of a major teaching hospital as of July 1, 2000, the applicable adjustment factor shall be that which is necessary to result in an amount for the particular hospital equal to forty million dollars ($40,000,000).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000 through June 30, 2001, which shall be paid to the hospital in accordance with paragraph i. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(2) Converted Hospitals.

(a) For each eligible hospital that meets the definition of a converted hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall derived as follows:

(i) The maximum OBRA 1993 limit percentage that is applicable to the hospital for the 2000-01 payment adjustment year pursuant to subsection 5. of Section J. shall be subtracted from 175 percent (the maximum percentage that was applicable to the hospital as a public hospital during the 1999-2000 payment adjustment year).

(ii) The converted hospital adjustment factor shall be that figure derived in subclause (i), expressed as a fraction, subtracted from 1.00.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000, through June 30, 2001, which shall be paid to the hospital in accordance with paragraph i. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(3) Nonpublic Hospitals

(a) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amount determined under paragraph g. for each nonpublic hospital described above shall be added together.

(ii) The amount identified in paragraph a. shall be divided by 2.1527.

(iii) The resulting figure in clause (ii) shall be reduced by the following:

(I) the sum of the amounts determined for all nonpublic/converted hospitals under subparagraph (1); and

(II) the sum of that portion of the amount determined for any converted hospital under subparagraph (2) that is in excess of that amount equal to 31 percent of all payment adjustment amounts that were payable to the hospital for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(iv) The amount computed under subclause (iii) shall be divided by 2, and the result thereof further reduced by the amount of thirty-three million five hundred thousand dollars ($33,500,000).

(v) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (iv) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000, through June 30, 2001, which shall be paid to the hospital in accordance with paragraph i. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (iv) of clause (a).

(4) Public Hospitals.

(a) For each eligible hospital that meets the definition of a public hospital as of July 1, 2000, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph g. for each public hospital described above shall be added together.

(ii) The amount identified in paragraph a. shall be reduced by the sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1) and all converted hospitals under subparagraph (2), and the sum of the amounts determined for all nonpublic hospitals under subparagraph (3).

(iii) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (ii) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1, 2000, through June 30, 2001, which shall be paid to the hospital in accordance with paragraph i. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (ii) of clause (a).

i. The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1, 2000, through June 30, 2001, shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each month from October 2000 through May 2001. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month. To the extent that any hospital of either of the hospital types described in subparagraph (3) or (4) of paragraph h. is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1, 2000, through June 30, 2001, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30, 2001.

j. If, effective for the 2001 federal fiscal year, federal legislation is enacted that amends Section 1396r-4(f) of Title 42 of the United States Code to increase the amount for California for that fiscal year above the amount that would have otherwise been identified pursuant to that section as in existence on January 1, 2000, the Department shall implement the provisions of paragraphs a. through i. as modified below.

(1) The Department shall determine the maximum state disproportionate share hospital allotment for California for the 2001 federal fiscal year under the provisions of applicable federal Medicaid rules.

(2) The Department shall determine the maximum state disproportionate share hospital allotment for California for the 2001 federal fiscal year that would have resulted had Section 1396r-4(f) of Title 42 of the United States Code not been amended from the version of that section as in existence on January 1, 2000.

(3) The amount determined under subparagraph (2) shall be subtracted from the amount determined under subparagraph (1).

(4) For purposes of the calculations set forth in paragraph g. regarding each hospital's tentative adjusted projected total payment adjustment amount, the initial amount as set forth in paragraph a. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

(5) The difference derived in subparagraph (3) shall be divided by the amount determined in subparagraph (2). The resulting fraction shall be multiplied by 1.145, and the result thereof added to 1.00, yielding a factor for purposes of modifying the determination of the applicable nonpublic hospital adjustment factor pursuant to subparagraph (6).

(6) The resulting amount determined under subclause (ii) of clause (a) of subparagraph (3) of paragraph h. shall be multiplied by the factor derived in subparagraph (5) prior to applying the reductions pursuant to subclause (iii) of clause (a) of subparagraph (3) of paragraph h.

(7) For purposes of the calculations set forth in clause (a) of subparagraph (4) of paragraph h. regarding the determination of the applicable public hospital adjustment factor, the initial amount as set forth in paragraph a. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

k. No eligible hospital shall receive total payment adjustments for the 2000-01 payment adjustment year in excess of the hospital's OBRA 1993 payment limitation as computed by the Department pursuant to Section J.

l. The aggregate sum of the final adjusted projected total payment adjustment amounts computed under paragraph h. for each eligible hospital for the period October 1, 2000, through June 30, 2001, shall be the maximum size of the payment adjustment program for the entire 2000-01 payment adjustment year, exclusive of the supplemental payment adjustments provided for under subsection 3.

3. Supplemental Lump-Sum Payment Adjustments - June 30, 2001.

a. For the 2000-01 payment adjustment year, eligible hospitals that meet the requirements of this subsection and that are in operation as of June 30, 2001, shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1, 2000, through June 30, 2001.

b. The availability of supplemental lump-sum payment adjustments under this subsection shall be determined as follows:

(1) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules shall be identified for the 2001 federal fiscal year.

(2) The total amount of all payment adjustment amounts under this Attachment (exclusive of any payments under this subsection) applicable to the 2001 federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the 2001 federal fiscal year shall be determined in accordance with federal Medicaid rules.

(3) The figure determined under subparagraph (2) shall be subtracted from the figure identified under subparagraph (1). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subsection.

(4) The maximum amount of supplemental lump-sum payment adjustments under this subsection shall be the positive remainder derived in subparagraph (3).

c. For purposes of supplemental lump-sum payment adjustments under this subsection, only hospitals that can be categorized into either of the three groups specified in subparagraphs (1), (2) and (3) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the three groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that, as of July 1, 2000, met the definition of a public hospital.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1, 2000, met the definition of a nonpublic hospital.

(3) "Nonpublic/converted hospitals," which shall include all eligible hospitals that, as of July 1, 2000, met the definition of a nonpublic/converted hospital. Notwithstanding the foregoing, however, no hospital shall qualify to receive supplemental payment adjustments under this group if the final adjusted projected total payment adjustment amount payable to the hospital pursuant to subsection 2 of Section O (commencing with page 29vvv) is at least forty million dollars ($40,000,000).

d. Each eligible hospital that is within the nonpublic/converted hospitals group described in subparagraph (3) of paragraph c shall receive supplemental lump-sum payment adjustments in an amount equal to the amount of fifty-five million dollars ($55,000,000), multiplied by a fraction, the numerator of which is the final adjusted projected total payment adjustment amount payable to the hospital pursuant to subsection 2 of Section O (commencing with page 29vvv), and the denominator of which is the maximum state disproportionate share hospital allotment for California identified under subparagraph (1) of paragraph b of this subsection 3. Notwithstanding the foregoing, in no case shall any amount otherwise payable pursuant to this paragraph be paid in an amount that would cause any hospital to exceed the applicable OBRA 1993 payment limitation. Any amount that cannot be paid to a hospital as a result of the restriction in the preceding sentence shall revert for purposes of the allocations made pursuant to paragraph e.

e. The amount determined to be the maximum amount of supplemental lump-surn payment adjustments under paragraph b, less the amounts determined payable under paragraph d, shall be allocated among the public hospitals and nonpublic hospitals groups described in subparagraphs (1) and (2) of paragraph c as follows:

(1) With respect to that amount equal to thirty-six million, six hundred sixty-six thousand, six hundred sixty-seven dollars ($36,666,667) minus one-third of the total supplemental lump sum payment amounts determined payable pursuant to paragraph d, the allocation shall be 100.00% to nonpublic hospitals, and 0.00% to public hospitals.

(2) With respect to that amount which is equal to the maximum amount of supplemental lump-sum payment adjustments determined under paragraph b., minus the amount determined under subparagraph (1) and minus the amount determined payable under paragraph d, the allocation shall be 25.00% to nonpublic hospitals, and 75.00% to public hospitals.

f. The amount of funds allocated pursuant to paragraph e shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within the respective public hospitals group and nonpublic hospitals group as follows:

(1) The Department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the 2000-01 payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal Medicaid rules.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the 2000-01 payment adjustment year.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (1) shall be used for purposes of subparagraphs (5) through (8).

(5) The amounts identified under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph e, to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Notwithstanding the foregoing, however, in the case of a nonpublic hospital that, as of July 1, 2000, met the definition of a children's hospital, such pro rata share otherwise determined shall be multiplied by a factor of 1.69, yielding a modified pro rata share to be applied only with respect to the first one million dollars ($1,000,000) of the funds allocated to the nonpublic hospitals group pursuant to paragraph e, and, with respect to the remainder of the funds so allocated to such group, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share to be applied. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of

the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this subparagraph, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).

(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

g. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before June 30, 2001.

P. **Payment Adjustment Program for 2001-02 Payment Adjustment Year and Subsequent Payment Adjustment Years.**

With respect to the 2001-02 payment adjustment year and each subsequent payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

1. Non-Supplemental Payment Adjustments - July 1 - September 30.

No payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 2001-02 payment adjustment year and each subsequent payment adjustment year.

2. Non-Supplemental Payment Adjustments - October 1 - June 30.

Payment adjustments with respect to the period October 1 through June 30 of the 2001-02 payment adjustment year and each subsequent payment adjustment year (exclusive of the supplemental lump-sum payment adjustments provided for under subsection 3.), shall be structured as set forth below.

a. The Department shall determine the maximum state disproportionate share hospital allotment for California for the applicable federal fiscal year under the provisions of applicable federal Medicaid rules.

b. The initial maximum size of the payment adjustment program for the period October 1 through June 30 of each applicable payment adjustment year shall be set at one billion six hundred million dollars ($1,600,000,000), exclusive of any supplemental payment adjustments under subsection 3.

c. The Department shall compute the projected total payment adjustment amounts for all eligible hospitals for the applicable payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3., by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days. For purposes of this paragraph, such determinations shall be made without regard to the OBRA 1993 payment limitations. Notwithstanding the foregoing, with respect to a hospital that, as of July 1 of the applicable payment adjustment year, meets the definition of a converted hospital, the amount otherwise determined under this paragraph shall be reduced as necessary so as not to exceed the total amount of all payment adjustment amounts payable to the hospital under this Attachment for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

d. The computed amount referred to in paragraph c. for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the applicable payment adjustment year.

e. Where the computed amount referred to in paragraph c. for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under paragraph c. shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of paragraph g.

f. Where the computed amount referred to in paragraph c. for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in paragraph c. shall be used for purposes of paragraph g.

g. The amounts determined under paragraphs e. and f. for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period October 1 through June 30 of the applicable payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3.

h. The Department shall increase or decrease the amount determined for each eligible hospital under paragraph e. or f., as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1 through June 30 of the applicable payment adjustment year. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph b. by the aggregate sum determined under paragraph g. In no case, however, shall the amount determined for a hospital under paragraphs e. or f. be increased such that it would exceed the OBRA 1993 payment limitation for the hospital, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amounts for all hospitals equals the amount set forth in paragraph b.

i. The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph h. shall be further adjusted as follows:

(1) Nonpublic/converted hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic/converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic/converted hospital adjustment factor." The applicable adjustment factor shall be 0.835; except, however, where the hospital also meets the definition of a major teaching hospital as of July 1 of the applicable payment adjustment year, the applicable adjustment factor shall be the lesser of 1.00, or that which is necessary to result in an amount for the particular hospital equal to thirty-five million eight hundred thousand dollars ($35,800,000).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(2) Converted Hospitals.

(a) For each eligible hospital that meets the definition of a converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The maximum OBRA 1993 limit percentage that is applicable to the hospital for the applicable payment adjustment year pursuant to subsection 5. of Section J. shall be subtracted from 175 percent (the maximum percentage that was applicable to the hospital as a public hospital during the 1999-2000 payment adjustment year).

(ii) The converted hospital adjustment factor shall be that figure derived in subclause (i), expressed as a fraction, subtracted from 1.00.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(3) Nonpublic Hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amount determined under paragraph h. for each nonpublic hospital described above shall be added together.

(ii) The amount identified in paragraph b. shall be divided by 2.237.

(iii) The resulting figure in clause (ii) shall be increased by an amount equal to the product of the medical assistance increment multiplied by the maximum amount identified in paragraph a.

(iv) The amount derived under clause (iii) shall be reduced by the following:

(I) the sum of the amounts determined for all nonpublic/converted hospitals under subparagraph (1); and

(II) the sum of that portion of the amount determined for any converted hospital under subparagraph (2) that is in excess of that amount equal to 31 percent of all payment adjustment amounts that were payable to the hospital for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(v) The amount computed under subclause (iv) shall be divided by 2, and the result thereof further reduced by the amount of thirty-three million five hundred thousand dollars ($33,500,000).

(vi) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (v) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have

been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (v) of clause (a).

(4) Public Hospitals.

(a) For each eligible hospital that meets the definition of a public hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph h. for each public hospital described above shall be added together.

(ii) The amount identified in paragraph b. shall be reduced by the sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1) and all converted hospitals under subparagraph (2), and the sum of the amounts determined for all nonpublic hospitals under subparagraph (3).

(iii) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (ii) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have

been allocated to the particular hospital shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (ii) of clause (a).

j. If the Mental Health Limitation specified in subsection 6. of Section D. is applicable for the payment adjustment year, the amount computed under paragraph i. for each mental health facility shall be reduced on a pro-rata basis to the extent the aggregate payment for mental health facilities computed under paragraph i. exceeds the limitation in subsection 6. of Section D. the amount so reduced shall be used for purposes of paragraph k.

k. The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each month from October through May of the applicable payment adjustment year. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month. To the extent that any hospital of either of the hospital types described in subparagraph (3) or (4) of paragraph i. is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1 through June 30 of the applicable payment adjustment year, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30 of the applicable payment adjustment year.

l. If, with respect to the 2001-02 payment adjustment year or any subsequent payment adjustment year, the amount identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code exceeds the amount of eight hundred seventy-seven million dollars ($877,000,000), the Department shall implement the provisions of paragraphs a. through j. with respect to the applicable payment adjustment year as modified below.

(1) The Department shall determine the maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules.

(2) The Department shall calculate the maximum state disproportionate share hospital allotment for California, by substituting in the calculation the amount of eight hundred seventy-seven million dollars ($877,000,000), as though that amount was identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code.

(3) The amount determined under subparagraph (2) shall be subtracted from the amount determined under subparagraph (1).

(4) For purposes of the calculations set forth in paragraph h. regarding each hospital's tentative adjusted projected total payment adjustment amount, the initial amount as set forth in paragraph b. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

(5) The difference derived in subparagraph (3) shall be divided by the amount determined in subparagraph (2).

(6) For purposes of the determination made under clause (a) of subparagraph (1) of paragraph i. regarding nonpublic/converted hospitals that also meet the definition of a major teaching hospital, the amount of thirty-five million eight hundred thousand dollars ($35,800,000) as specified therein shall be multiplied by a number equal to the sum of the fraction derived in subparagraph (5) plus the number 1.00.

(7) The fraction derived in subparagraph (5) shall be multiplied by 1.226, and the result thereof added to 1.00, yielding a factor for purposes of modifying the determination of the applicable nonpublic hospital adjustment factor pursuant to subparagraphs (8) and (9).

(8) The amount derived under subclause (ii) of clause (a) of subparagraph (3) of paragraph i. shall be multiplied by the factor derived in subparagraph (7) prior to the application of the increase set forth in subclause (iii) of clause (a) of subparagraph (3) of paragraph i., as such increase is modified by subparagraph (9) below.

(9) The increase that is applied in subclause (iii) of clause (a) of subparagraph (3) of paragraph i. shall be equal to the product of the medical assistance increment multiplied by the maximum amount derived in subparagraph (2).

(10) For purposes of the calculations set forth in clause (a) of subparagraph (4) of paragraph i. regarding the determination of the applicable public hospital adjustment factor, the initial amount as set forth in paragraph b. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

m. No eligible hospital shall receive total payment adjustments for the applicable payment adjustment year in excess of the hospital's OBRA 1993 payment limitation as computed by the Department pursuant to Section J.

n. The aggregate sum of the final adjusted projected total payments adjustment amounts computed under paragraph i. ***and j.*** for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year shall be the maximum size of the payment adjustment program for the entire payment adjustment year, exclusive of the supplemental payment adjustments provided for under subsection 3.

3. Supplemental Lump-Sum Payment Adjustments - June 30.

a. For the 2001-02 payment adjustment year and each subsequent payment adjustment year, eligible hospitals that meet the requirements of this subsection and that are in operation as of June 30 of the applicable payment adjustment year shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1 through June 30 of the applicable payment adjustment year.

b. The availability of supplemental lump-sum payment adjustments under this subsection shall be determined as follows:

(1) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules shall be identified for the applicable federal fiscal year.

(2) The total amount of all payment adjustment amounts under this Attachment (exclusive of any payments under this subsection) applicable to the applicable federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the federal fiscal year shall be determined in accordance with federal Medicaid rules.

(3) The figure determined under subparagraph (2) shall be subtracted from the figure identified under subparagraph (1). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subsection.

(4) The maximum amount of supplemental lump-sum payment adjustments under this subsection shall be the positive remainder derived in subparagraph (3).

c. For purposes of supplemental lump-sum payment adjustments under this subsection, only hospitals that can be categorized into either of the two groups specified in subparagraphs (1) and (2) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a public hospital.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a nonpublic hospital.

d. The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under paragraph b. shall first be allocated between the two groups of hospitals referred to in paragraph c. as follows:

(1) "Public hospitals": 75.00% of that amount which is equal to the maximum amount identified in subparagraph (4) of paragraph b. of this subsection 3.

(2) "Nonpublic hospitals": That amount equal to the maximum amount identified in subparagraph (4) of paragraph b. of this subsection 3 less the amount allocated to public hospitals determined under subparagraph (1).

State: California

e. The amount of funds allocated pursuant to paragraph d. shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(1) The Department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal Medicaid rules.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the applicable payment adjustment year.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (1) shall be used for purposes of subparagraphs (5) through (8).

(5) The amounts identified under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph d., to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Notwithstanding the foregoing, however, in the case of a nonpublic hospital that, as of July 1 of the applicable payment adjustment year, met the definition of a children's hospital, such pro rata share otherwise determined shall be multiplied by a factor of 1.69, yielding a modified pro rata share to be applied only with respect to the first one million dollars ($1,000,000) of the funds allocated pursuant to subparagraph (2) of paragraph d., and, with respect to the remainder of the funds so allocated, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share to be applied. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this subparagraph, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).

(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

f. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before June 30 of the applicable payment adjustment year.

g. With respect to the 2001-02 payment adjustment year, supplemental lump-sum payment adjustments shall be determined and payable in conformance with the provisions of paragraph a. through f., except as set forth below.

(1) Each eligible hospital that, as of July 1, 2001, met the definition of a nonpublic/converted hospital, and that remains in operation as of June 30, 2002, shall be eligible to receive supplemental lump-sum adjustments in an amount equal to the amount of fifty-five million dollars ($55,000,000), multiplied by a fraction, the numerator of which is the total payment adjustment amount payable to the hospital pursuant to subsection 2 of Section P. (commencing with page 29ffff), and the denominator of which is the maximum state disproportionate share hospital allotment for California identified under subparagraph (1) of paragraph b. of this subsection 3.

Notwithstanding the foregoing, in no case shall any amount otherwise payable pursuant to this subparagraph (1) be paid in an amount that would cause any hospital to exceed the applicable OBRA 1993 payment limitation. Any amount that cannot be paid to a hospital as a result of the restriction in the preceding sentence shall revert for purposes of the allocations made pursuant to subparagraph (2).

(2) The allocation amounts specified in subparagraphs (1) and (2) of paragraph d. shall be modified as follows:

(a) With respect to that amount equal to thirty-six million, six hundred sixty-six thousand, six hundred sixty-seven dollars ($36,666,667) less one-third of the total supplemental lump-sum payment adjustments amounts payable to nonpublic/converted hospitals pursuant to subparagraph (1), the allocation shall be 0.00% to public hospitals, and 100% to nonpublic hospitals.

(b) With respect to that amount which is equal to the maximum amount of supplemental lump-sum payment adjustments identified in subparagraph (4) of paragraph b., minus the amounts payable to non-public/converted hospitals pursuant to subparagraph (1), and minus the amounts allocated pursuant to clause (a), the allocation shall be 75.00% to public hospitals, and 25.00% to nonpublic hospitals.

METHODS AND ASSUMPTIONS FOR DEFINING
DISPROPORTIONATE SHARE HOSPITALS

A. Final Determination

The annual determination of disproportionate share status as shown on the disproportionate share list will be final (no retroactive changes will be made based on actual year of service data).

The following describes the determination, data, and the processes to be used in determining a hospital's status as a disproportionate share provider and the applicable payment adjustments.

All calculations are to be rounded to the nearest tenth of a percent.

B. Medicaid Inpatient Utilization Rate

(1) Individual Hospital Calculation

A hospital's Medicaid inpatient utilization rate shall be the quotient (expressed as a percentage) which results from dividing the number of the hospital's acute care inpatient days attributable to patients who (for such days) were eligible for medical assistance under this State Plan during a defined 12-month period by the total number of the hospital's inpatient days during the same time period. In calculations involving Medicaid Inpatient Utilization Rates, this period is the most recent calendar year ending 18 months prior to the beginning of the payment adjustment year in question. For example, if disproportionality were being determined for the 1991-92 payment adjustment year, the defined period would be calendar year 1989.

To determine "Medicaid Days" the State shall total for each hospital the general acute care inpatient days, all nursery inpatient days, acute psychiatric inpatient days, transitional inpatient care days, and administrative days for the calendar year ending 18 months prior to the beginning of the payment adjustment year for which payment adjustments are required. These data are based on the Medi-Cal Month of Payment tapes created by the State's fiscal intermediary and

transmitted by the intermediary to the Department of Health Services. The acute psychiatric inpatient days provided to Medicaid eligible persons under the Short-Doyle/Medi-Cal program are taken from a separate file of the Medi-Cal Paid Claims System for the same calendar year. General acute care inpatient and acute psychiatric care inpatient days for Medicaid eligible persons paid by Health Insuring Organizations (HIO) are included in the calculations. When consistent and reliable data is available statewide as determined by the Department of Health Services, the Department may include general acute care inpatient and acute psychiatric care inpatient hospital days attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department to provide such services. Using the OSHPD statewide data base file for the calendar year ending 18 months prior to the beginning of the payment adjustment year for which payment adjustments are required, the number of Medicaid patient days for non-California Medicaid beneficiaries reported by each hospital is divided by the total number of Medicaid patient days reported by each hospital. The count of Medicaid patient days is based on discharge records which report that Medi-Cal (used synonymously with Title XIX) was the expected principal source of payment at the time of discharge. Acute care, psychiatric and rehabilitation care types of discharge records are included, while skilled nursing, intermediate care and non-acute alcohol/drug rehabilitation care discharge records are excluded from the calculation of the ratio. This ratio is then applied to each hospital's paid Medi-Cal days for the same period to estimate those Medicaid days which originate outside of the state. (It is noted that "Medicaid Days" does not include subacute care days and long term care days.)

To determine "Total Days" the State shall use data from the OSHPD statewide data base file for the calendar year ending 18 months prior to the beginning of the particular payment adjustment year. In calculating the actual number of "Total Days," the State shall add the general acute care inpatient days, all nursery inpatient days, acute psychiatric inpatient days, transitional inpatient care days, and a administrative days in the Annual Report and shall subtract the patient days

for chemical dependency recovery services in licensed general acute patient beds and in licensed acute psychiatric care beds in the Annual report.

The specific formulae used to derive this percentage are as follows:

MEDICAID_PERCENT = ((MEDICAID_DAYS/TOTAL_DAYS)*100)

WHERE:

MEDICAID_DAYS = Total_Paid_Medicaid_Days + Est._Out_of_State_Medicaid_Patient_Days

Total_Paid_Medicaid_Days = Medicaid_GAC_Days + Medicaid_APC_Days + Medicaid_Nursery_Days + Medicaid_Short_Doyle_Days + Medicaid_Transitional_Inpatient_Care_Days + Medicaid_Administrative_Days

Estimated_Out_of_State_Medicaid_Beneficiary_Patient_Days= (Total_Paid_Medicaid_Days * (Out_of_State_Medicaid_Beneficiary_Patient_Days /Total_Medicaid_Patient_Days))

Total_Medicaid_Patient_Days and Out_of_State_Medicaid_Beneficiary_Patient_Days are extracted directly from the OSHPD Discharge Data Set and are as reported by the hospital.

TOTAL_DAYS = Total_GAC_Days + Total_APC_Days + Total_Nursery_Days + Total_Transitional_Inpatient_Care_Days - Chem_Dependency_Days_in_GAC_Beds - Chem_Dependency_Days_in_APC_Beds

GAC = General Acute Care
APC = Acute Psychiatric Care

The following arithmetic symbols are used:

+	addition
- (dash)	subtraction
*	multiplication
/	division

In addition, the symbol _ (underscore) is used to connect words that are part of variable names.

(2) Calculation of Mean and Standard Deviation of Medicaid Utilization Rate

The mean and one standard deviation above the mean of the Medicaid utilization rate shall be calculated based on data for all hospitals receiving Medicaid payments in the State for the calendar year period ending 18 months prior to the beginning of the particular payment adjustment year. These statistics shall be weighted by the total patient days in each hospital.

C. Low-Income Utilization Rate

A hospital's low-income utilization rate for a defined period of time shall be the sum of two fractions (expressed as a percentage) which consist of the factors described below. In calculations involving Low-Income Utilization Rates, this defined period varies by hospital and is taken as the hospital's fiscal time period which ends during the calendar year which ends 18 months prior to the beginning of the particular payment adjustment year. For example, if disproportionality were being examined for the State's fiscal year 1991/92, the OSHPD Annual Financial Disclosure Report for the time period which ends in calendar year 1989 would be used.

LOW_INCOME = MEDICAID + CHARITY

(1) Fraction Number 1 (MEDICAID)

The first fraction involves the total revenues paid to a hospital for patient services - including cash subsidies from State and local governments. The numerator of this fraction is the total amount of dollar revenue paid to a hospital for the defined 12 month period for patient services (Inpatient and Outpatient) under the State Plan plus any cash subsidies for patient services received directly from State and local governments. The denominator of this fraction is the total amount of dollars paid to a hospital (including the amount of such cash subsidies) minus the disproportionate share payments made pursuant to page 18 et seq. of this Attachment 4.19A for the same defined period

for all patient services.

For the first fraction, the numerator shall consist of the following items from the applicable OSHPD Annual Financial Disclosure Report, OSHPD Annual Patient Discharge Data and data collected by the Department of Health Services: Medi-Cal Net Patient Revenue (Inpatient and Outpatient), minus the absolute value of Disproportionate Share Payments for Medi-Cal Patient Days (if any), plus County Indigent Program Net Patient Revenue (Inpatient and Outpatient), (if any) plus Managed Care Program Net Inpatient Medi-Cal Revenue (if any) plus the absolute value of U.C. Gross Clinical Teaching Support (if any). The denominator shall consist of the following items from the applicable OSHPD Annual Financial Disclosure Report: Total Net Patient Revenue for all patients minus the absolute value of Disproportionate Share Payments for Medi-Cal Patient Days.

MEDICAID = 100[(MCLPDPRV + CSHTOSUB) / TOTPDPRV].

Where:

MCLPDPRV = Medi-Cal Paid Patient Revenue
= MCNETPRV - |DISPSHRE| + MCPNIPRV.

MCNETPRV = Medi-Cal Net Patient Revenue.
DISPSHRE = Disproportionate Share Payments for Medi-Cal Patient Days.
MCPNIPRV = Managed Care Program Net Inpatient Medi-Cal Revenue.

CSHTOSUB = Total Cash Subsidies from State and Local Government
= |UCCLTCHS| + CIPNPREV.

UCCLTCHS = U.C. Gross Clinical Teaching Support.

CIPNPREV = County Indigent Program Net Patient Revenue.

TOTPDPRV = Total Paid Patient Revenue
= TOTNETPR - |DISPSHRE|.

TOTNETPR = Total Net Patient Revenue.
DISPSHRE = Disproportionate Share Payments for Medi-Cal Patient Days.

(2) Fraction Number 2 (CHARITY)

The second fraction involves the total charges of a hospital for inpatient hospital services. The numerator of this fraction is the total amount of the hospital's charges for inpatient hospital services attributable to charity care less the portion of any state and local government cash subsidies reasonably attributable to inpatient hospital services. The denominator of this fraction is the total amount the hospital charges for inpatient hospital services in the hospital for the defined period.

In this fraction, the numerator shall be calculated with items from the applicable OSHPD Annual Financial Disclosure Report as follows:

(a) Total Other Inpatient Charity is the sum of County Indigent Program Gross Inpatient Revenue (if any), minus County Indigent Program Gross Inpatient Charity (if any), plus Gross Inpatient Charity (if any), minus Hill Burton Gross Inpatient Charity (if any), plus U.C. Gross Inpatient Teaching Allowances (if any), plus the absolute value of U.C. Gross Inpatient Clinical Teaching Support (if any). Gross Inpatient Charity is the sum of Non-Medi-Cal Gross Inpatient Charity (if any), plus Medi-Cal

Gross Inpatient Charity (if any). Medi-Cal Gross Inpatient Charity is calculated by multiplying Medi-Cal Gross Patient Charity (if any) by the ratio of Medi-Cal Gross Inpatient Revenue to Medi-Cal Gross Patient Revenue. Hill Burton Gross Inpatient Charity is calculated by multiplying Hill Burton Gross Patient Charity by the ratio of Gross Inpatient Charity to Gross Patient Charity. This results in an estimate of the amount of charity attributable to inpatient services.

(b) The Inpatient Portion of Total Cash Subsidies from State and Local Government is the sum of County Indigent Program Net Inpatient Revenue (if any), plus the absolute value of U.C. Gross Inpatient Clinical Teaching Support (if any). This results in an estimate of the amount of subsidies paid to inpatient charity services.

(c) The result of step (b) is subtracted from the result of step (a).

The denominator shall consist of Gross Inpatient Revenue extracted from the applicable OSHPD Annual Financial Disclosure Report.

Charity charges attributable to a hospital's Hill-Burton obligation are excluded from the calculation of low-income.

The numerator and denominator are expressed in detail as formulae below:

CHARITY = 100[(CHRIPOTH - CSHIPSUB) / GRINPREV].

Where:

CHRIPOTH = Total Other Inpatient Charity
= CIPGIPRV - CIPGIPCH + GRINPCHR - PCTIPCHR[HBGRPCHR] + UCIPTCAL + |UCIPCLTS|.

CIPGIPRV = County Indigent Program Gross Inpatient Revenue.
CIPGIPCH = County Indigent Program Gross Inpatient Charity.
GRINPCHR = Gross Inpatient Charity
= NMCINPCR + MCINPCHR.

NMCINPCR = Non-Medi-Cal Gross Inpatient Charity.
MCINPCHR = Medi-Cal Gross Inpatient Charity
= PCTMCIPR[MCGRPCHR].

PCTMCIPR = Medi-Cal Gross Inpatient Revenue as a Percentage of Medi-Cal Gross Patient Revenue
= MCGRIPRV / MCGRPTRV.

MCGRIPRV = Medi-Cal Gross Inpatient Revenue.
MCGRPTRV = Medi-Cal Gross Patient Revenue.

MCGRPCHR = Medi-Cal Gross Patient Charity.

PCTIPCHR = Gross Inpatient Charity as a Percentage of Gross Patient Charity
= GRINPCHR / GRPATCHR.

GRINPCHR = Gross Inpatient Charity (defined above).
GRPATCHR = Gross Patient Charity.

HBGRPCHR = Hill Burton Gross Patient Charity.
UCIPTCAL = U.C. Gross Inpatient Teaching Allowances.
UCIPCLTS = U.C. Gross Inpatient Clinical Teaching Support.

CSHIPSUB = Inpatient Portion of Total Cash Subsidies from State And Local Government
= |UCIPCLTS| + CIPNIPRV.

UCIPCLTS = U.C. Gross Inpatient Clinical Teaching Support.
CIPNIPRV = County Indigent Program Net Inpatient Revenue.

GRINPREV = Gross Inpatient Revenue.

(3) Data Sources Used in Determining Various Factors

Except as provided below, the Annual Financial Disclosure Report of a hospital submitted to OSHPD, as clarified by the data collected by the Department in accordance with subdivision (f) of Section 14105.98 of the Welfare and Institutions Code, shall be the source to determine the amounts of the various elements in fractions 1 and 2. The Annual Financial Disclosure Report of an individual hospital to be used for a particular payment adjustment year for which payment adjustments are required shall be that Report which covers the hospital's reporting fiscal time period which ends during the calendar year which ends 18 months prior to the beginning of the particular payment adjustment year. When consistent and reliable data are available, Annual OSHPD Patient Discharge Data and data collected by the Department of Health Services will be used as the data sources to determine inpatient hospital revenue attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department.

State/Territory California

Citation | Condition or Requirement

REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL

ACUTE INPATIENT SERVICES

The policy of the State Agency is that reimbursement for Short-Doyle/Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMAs), negotiated rates, or actual cost if the provider does not contract on a negotiated rate basis. To provide mutually beneficial incentives for efficient fiscal management, providers contracting on a negotiated rate basis shall share equally with the Federal Government that portion of the Federal reimbursement that exceeds actual cost. In no case will payments exceed SMAs.

A. DEFINITIONS

"Published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, and other non-Title XIX payors. (42 CFR 447.271 and 405.503(a))

"Statewide maximum allowances" are upper limit rates, established for each type of service, for a unit of service. A unit of service is defined as a patient day for acute hospital inpatient services. Maximum allowances are established, and effective for, each state fiscal year.

"Negotiated rates" are fixed, prospective rates of reimbursement, subject to the limitations described in the first paragraph above.

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in HCFA Publication 15-1.

"Provider" means each legal entity providing Short-Doyle/Medi-Cal services.

"Legal entity" means each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency.

B. REIMBURSEMENT METHODOLOGY FOR NON-NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for non-**NEGOTIATED RATE PROVIDER** Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a **NOMINAL CHARGE PROVIDER** (as defined below).

2. The provider's allowable cost.

3. The SMAs established as defined in Section D. by the Department of Mental Health (DMH) and approved by the Department of Health Services (DHS).

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each hospital provider.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of actual cost or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for inpatient hospital services is made in accordance with Medicare rules at 42 CFR 413.13(f)(2)(iii).

C. **REIMBURSEMENT METHODOLOGY FOR NEGOTIATED RATE PROVIDERS**

REIMBURSEMENT LIMITS

The reimbursement methodology for **NEGOTIATED RATE PROVIDER** Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a **NOMINAL CHARGE PROVIDER** (as defined below),

2. The provider's negotiated rates, based on historic cost, approved by the State,

3. The SMAs established as defined in Section D. by the DMH and approved by the DHS.

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each hospital provider. If reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, 50 percent of the Federal Financial Participation (FFP) that exceeded actual costs will be returned to the Federal government.

NOMINAL CHARGE PROVIDER

Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of negotiated rates or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for inpatient hospital services is made in accordance with Medicare rules at 42 CFR 413.13(f)(2)(iii).

D. SMA METHODOLOGY

The SMAs are based on the statewide average cost of a hospital inpatient day as reported in year-end cost reports for the most recent year for which cost reports have been completed. County administrative and utilization review costs are isolated and not included in the direct treatment payment rates. After eliminating hospitals with rates in excess of one standard deviation from the mean, the top ten percent of providers with the highest rates are eliminated from the base data to afford cost containment and allow for an audit adjustment factor. The total remaining costs of hospital inpatient services are then divided by the total number of patient days to arrive at a statewide average rate. The adjusted average rates are inflated by a percentage equivalent to the medical component of the national Consumer Price Index for the period between the cost report year and the year in which the rates will be in effect.

The State Fiscal Year 1989-90 cost report data will be used to develop base rates. The rates from the base year will be adjusted for inflation annually by applying the medical component of the national Consumer Price Index. When the SMAs are re-based in no more than three years, the cost report data will be adjusted to reflect the lower of actual costs or the SMA's in effect for the base year.

State/Territory California

Citation | Condition or Requirement

REIMBURSEMENT FOR FEE-FOR-SERVICE MEDI-CAL

PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Notwithstanding any other provision of this Plan, the policy of the State Agency is that reimbursement for psychiatric inpatient hospital services to Fee-for-Service/Medi-Cal providers shall be the lower of the provider's customary charges or fixed per diem rates.

A. DEFINITIONS

"Mental Health Plan" (MHP) means an entity which enters into an agreement with the State to provide beneficiaries with psychiatric inpatient hospital services. A MHP may be a county, counties acting jointly, or another governmental or nongovernmental entity.

"Border community" means a town or city outside, but in close proximity to, the California border.

"Administrative day services" means services for a beneficiary residing in an acute psychiatric inpatient hospital when, due to a lack of residential placement options at non-acute treatment facilities, the beneficiary's stay at the acute psychiatric inpatient hospital must be continued beyond the beneficiary's need for acute care.

"Fee-for-Service/Medi-Cal provider means a provider who submits claims for Medi-Cal psychiatric inpatient hospital services through the State's fiscal intermediary.

"Hospital-based ancillary services" means services other than routine services that are received by a beneficiary admitted to a psychiatric inpatient hospital.

"Routine services" means bed, board, and all medical, nursing, and supportive services normally provided to an inpatient by an acute psychiatric inpatient hospital. Routine services do not include hospital-based ancillary services or physician or psychologist services that are separately billed.

"Allowable psychiatric accommodation code" means a reimbursable hospital billing code, based on room size and type of service, that may be used by Fee-for-Service/Medi-Cal providers to claim payment for psychiatric inpatient hospital services provided to beneficiaries.

B. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR CONTRACT, FEE-FOR-SERVICE/MEDI-CAL PROVIDERS.

1. Reimbursement for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal provider shall be based on a per diem rate established through negotiations between the provider and the Mental Health Plan (MHP) county in which the provider is located except when:

    a. The MHP from the county in which the provider is located delegates the rate negotiation responsibilities to an MHP in another county with the agreement of that MHP.

    b. The provider is located in a border community and an MHP wants to negotiate rates. The MHP shall request approval from the Department of Mental Health (DMH) to be designated as the negotiator.

    c. A provider is owned or operated by the same organizational entity as the MHP, in which case, the per diem rate must be approved by DMH.

2. The per diem rate shall include routine services and all hospital-based ancillary services.

3. Only one rate for each allowable psychiatric accommodation code for each Fee-for-Service/Medi-Cal provider may be established and shall be used by all MHPs. The negotiated rate shall not be subject to retrospective adjustment to cost.

4. Reimbursement for administrative day services shall be based on the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the cost of ancillary services equal to 25 percent of the prospective class median rate.

5. For both acute psychiatric inpatient hospital services and administrative day services, interim reimbursement to the provider shall be based on the per diem rate, net of third party liability and patient share of cost, but never to exceed the provider's customary charge.

6. The provider shall bill its customary charges.

7. At the end of each fiscal year, DMH shall compare, in aggregate, customary charges to per diem rate for each provider. Future claims shall be offset by the amount that the per diem rate exceeds the customary charges for that fiscal year.

8. The Medi-Cal payment constitutes payment in full.

9. These provisions will be in effect from January 1, 1995, until such time as the State's pending and related 1915(b) waiver is approved.

C. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR NON-CONTRACT, FEE-FOR-SERVICE/MEDI-CAL PROVIDERS

1. Reimbursement rates for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal provider with no contract with any MHP, shall be determined by DMH.

    a. The reimbursement rates in (1.) shall be calculated by DMH prior to the beginning of each fiscal year and shall not be modified for subsequent rate changes among contract providers or the addition of new contract providers.

    b. One rate per allowable psychiatric accommodation code per non-contract, Fee-for-Service/Medi-Cal provider per Rate Region listed in (9.) shall be established and shall be used by all MHPs.

    c. The rates shall not be subject to retrospective adjustment to cost.

2. The per diem rate includes routine services and all hospital-based ancillaries.

3. The per diem rate shall equal the weighted average per diem rates negotiated for all Fee-for-Service/Medi-Cal providers within the Rate Region where the non-contract provider is located and shall be based on the following information from each Fee-for-Service/Medi-Cal hospital with a contract in the Rate Region where the non-contract provider is located:

    a. The latest available fiscal year Medi-Cal paid claims data for Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days.

b. The negotiated per diem rates for the subsequent fiscal year.

4. Reimbursement for administrative day services shall be based on the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the cost of ancillary services equal to 25 percent of the prospective class median rate.

5. For both acute psychiatric inpatient services and administrative day services, interim reimbursement to the non-contract, Fee-for Service/Medi-Cal provider shall be based on the calculated per diem rate, net of third party liability and patient share of cost, but never to exceed the provider's customary charge.

6. The provider shall bill its customary charges.

7. At the end of each fiscal year, DMH shall compare, in aggregate, the customary charges to the per diem rate for each provider. Future claims shall be offset the amount that the per diem rate exceeds the customary charges for that fiscal year.

8. The Medi-Cal payment constitutes payment in full for acute psychiatric inpatient hospital services.

9. The Rate Regions are:

a. Superior - Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama and Trinity Counties and the border communities of Grants Pass, Klamath Falls, Lakeview, and Medford, Oregon.

b. Central Valley - Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo and Yuba Counties and the border communities of Carson City, Incline Village, Reno, and Sparks, Nevada.

c. Bay Area - Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano and Sonoma Counties.

d. Southern California - Imperial, Inyo, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara and Ventura Counties and the border communities of Las Vegas, and Yerington, Nevada, and Kingman and Yuma, Arizona.

e. Los Angeles County

10. These provisions shall take effect January 1, 1995.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED HOSPITALS FOR INPATIENT HOSPITAL SERVICES

Notwithstanding any other provision of this State Plan, reimbursement for the costs of inpatient hospital services described in this segment of Attachment 4.19-A that are provided to Medi-Cal beneficiaries by government-operated hospitals meeting the requirements below will be governed by this segment of Attachment 4.19-A.

A. Eligible Hospitals

1. Hospitals eligible for reimbursement under this segment of Attachment 4.19-A are government-operated hospitals specified in Appendix 1 to this Attachment 4.19-A, and any other government-operated hospitals receiving approval of the Centers for Medicare & Medicaid Services.

2. To be eligible for reimbursement under this segment of Attachment 4.19-A, government-operated hospitals specified pursuant to subsection 1 are required to maintain a Selective Provider Contracting Program (SPCP) contract with the California Department of Health Services (CDHS) in accordance with California Welfare and Institutions Code section 14081 et seq.

B. General Reimbursement Requirements

1. Except as provided in subparagraphs B.2 and B.3, below, payments to eligible hospitals for inpatient hospital services rendered to Medi-Cal beneficiaries, exclusive of psychiatric services and professional services, will be determined on a cost basis in accordance with this segment of Attachment 4.19-A.

2. Eligible hospitals may receive payments for specified inpatient hospital services that are paid independent of the cost-based payments specified in subparagraph B.1. Services to be paid pursuant to this subparagraph B.2 will be determined by the State. Such payments will be appropriately offset against the hospital's costs pursuant to subparagraph C.1.d, subparagraph D.3, and subparagraph E.4.

3. Eligible hospitals will receive supplemental payments for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code section 14085.5 and disproportionate share hospital payments

pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment.

4. The hospital's Medi-Cal 2552-96 cost report will be the basis for determining the reimbursable costs under this segment of Attachment 4.19-A.

   a. The term "finalized Medi-Cal 2552-96 cost report" refers to the cost report that is settled by the California Department of Health Services, Audits and Investigations (A&I) with the issuance of a Report On The Cost Report Review (Audit Report).

   b. The term "filed Medi-Cal 2552-96 cost report" refers to the cost report that is submitted by the hospital to A&I and is due five months after the end of the cost reporting period.

   c. Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics, such as relative value units, in the cost report apportionment process) may also use alternative statistics as a substitute for charges in the apportionment processes described in this segment of Attachment 4.19-A. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

5. Nothing in this segment of Attachment 4.19-A shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicaid program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

C. Interim Per Diem Rates

For each eligible hospital, an interim per diem rate will be computed on an annual basis using the following methodology:

1. Using the most recently filed Medi-Cal 2552-96 cost report, the cost apportionment process as prescribed in the Worksheet D series will be applied to arrive at the total Medicaid non-psychiatric inpatient hospital cost.

   a. On the Medi-Cal 2552-96 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26. If the costs have been removed, the allowable interns and residents costs will be added back to each affected cost center prior to the computation of cost-to-

charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) for the Worksheet C computation of cost-to-charge ratios. Only those allowable interns and residents costs that are consistent with Medicare cost principles will be added back. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as Graduate Medical Education (GME) under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

b. For hospitals that remove Medicaid inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), necessary adjustments will be made to the Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for the Medicaid inpatient dental services. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

c. The CDHS will perform those tests necessary to determine the reasonableness of the Medicaid program data (i.e., Medicaid days and Medicaid charges) from the reported Medi-Cal 2552-96 cost report's Worksheet D series. This will include reviewing the Medicaid program data generated from its MMIS/claims system for that period which corresponds to the most recently filed Medi-Cal 2552-96 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 CDHS 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 inpatient hospital cost computation should be used in the apportionment process.

d. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost before a per diem is computed in subsection 2. below. Supplemental payments under the contract for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code section 14085.5, and disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment, are not offset.

2. The Medicaid non-psychiatric inpatient hospital cost computed in subsection 1. above should be divided by the number of Medicaid non-psychiatric inpatient

hospital days as determined in subsection 1 above for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.

3. The Medicaid per day amount computed in subsection 2 above will be trended to current year based on Market Basket update factor(s) or other approved hospital-related indices. The Medicaid per day amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

   a. Inpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the current year to which the interim rate will apply.

   b. Inpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred and not reflected on the Medi-Cal 2552-96 cost report for the current year to which the interim rate will apply.

   Such costs must be properly documented by the hospital, and are subject to review. The result is the Medicaid non-psychiatric inpatient hospital cost per day amount to be used for interim Medicaid inpatient hospital payment rate purposes.

4. The CDHS may apply an audit factor to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. The CDHS will identify such percentage to CMS.

D. Interim Reconciliation

1. Each eligible hospital's interim Medicaid payments with respect to services rendered in a fiscal year will be reconciled to its filed Medi-Cal 2552-96 cost report for that same fiscal year.

2. The hospital's total Medicaid non-psychiatric inpatient hospital costs shall be determined using its filed Medi-Cal 2552-96 cost report for the applicable fiscal year and applying the steps set forth in paragraphs a – c of subsection 1 of Section C.

3. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, along with the interim Medicaid payments

received for services rendered in the fiscal year, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost. Supplemental payments under the contract for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code section 14085.5, and disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment, are not offset.

4. The CDHS may apply an audit factor to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made.

5. If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, appropriate adjustments will be made to offset or otherwise recover the overpayment.

E. Final Reconciliation

1. Each eligible hospital's interim payments and interim adjustments with respect to services rendered in a fiscal year subsequently will be reconciled to its Medi-Cal 2552-96 cost report for that same fiscal year as finalized by A&I for purposes of Medicaid reimbursement.

2. The hospital's total Medicaid non-psychiatric inpatient hospital costs shall be determined using its finalized Medi-Cal 2552-96 cost report and applying the steps set forth in paragraphs a – b of subsection 1 of Section C.

3. In computing the Medicaid non-psychiatric inpatient hospital cost from the finalized Medi-Cal 2552-96 cost report, the Medicaid program data (such as Medicaid days and charges) on the finalized cost report Worksheet D series will be updated as necessary using Medicaid program data generated from its MMIS/claims system for the respective cost reporting period. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

4. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, along with the interim Medicaid payments and interim adjustments received for services rendered in the fiscal year, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost. Supplemental payments under the contract for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code

section 14085.5, and disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment, are not offset.

5. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, appropriate adjustments will be made to offset or otherwise recover the overpayment.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

The government-operated hospitals listed below, and any other government-operated hospital that subsequently is approved by the Centers for Medicare & Medicaid Services, will receive federal reimbursement for inpatient hospital services provided to Medi-Cal beneficiaries using the cost-based reimbursement methodology specified on pages 46 through 50 of this Attachment:

(1) UC Davis Medical Center
(2) UC Irvine Medical Center
(3) UC San Diego Medical Center
(4) UC San Francisco Medical Center
(5) UC Los Angeles Medical Center, including Santa Monica/UCLA Medical Center
(6) L.A. County Harbor/UCLA Medical Center
(7) LA County Martin Luther King Jr. Charles R. Drew Medical Center
(8) LA County Olive View UCLA Medical Center
(9) LA County Rancho Los Amigos National Rehabilitation Center
(10) LA County University of Southern California Medical Center
(11) Alameda County Medical Center
(12) Arrowhead Regional Medical Center
(13) Contra Costa Regional Medical Center
(14) Kern Medical Center
(15 Natividad Medical Center
(16) Riverside County Regional Medical Center
(17) San Francisco General Hospital
(18) San Joaquin General Hospital
(19) San Mateo Medical Center
(20) Santa Clara Valley Medical Center
(21) Tuolumne General Hospital
(22) Ventura County Medical Center

"This Appendix 2 to Attachment 4.19-A comprises the "prior DSH methodology" in effect as of the 2004-05 payment adjustment year. The calculations set forth in this Appendix 2, including the strikeouts and interlineations in the document, are applicable solely for purposes of determining the payment adjustments for non cost-based DSH facilities and determining the proportionate share of payment adjustments for non-government operated hospitals pursuant to subsection D.1 and subsection A.3, respectively, of the DSH segment of Attachment 4.19-A (TN 05-022)."

State: California

INCREASE IN MEDICAID PAYMENT AMOUNTS FOR
CALIFORNIA DISPROPORTIONATE PROVIDERS

A. Disproportionate Share Hospitals

1. All hospitals in the State reimbursed under the State Plan provisions or the Selective Provider Contracting Program which meet the disproportionate share provider criteria specified in subsection 2 shall receive additional payment amounts (i.e., payment adjustments). The additional payment amounts shall be determined using the method described in Section C below, as modified by other provisions of this Attachment. ~~The disproportionate share payment amounts shall be distributed concurrent with certain claims that are processed on and after July 1, 1991, as described in this attachment. For the 1994-95 and 1995-96 payment adjustment years, the payments shall be made for three quarters of the state fiscal year by adjusting the payment adjustment amounts in accordance with Sections H. and I. of this Attachment~~. In addition, the Department shall pay to eligible hospitals any supplemental lump-sum payment adjustment amounts and any secondary supplemental payment adjustments that are payable and shall adjust payment amounts, in accordance with applicable provisions of this Attachment.

2. Hospitals shall be deemed disproportionate share hospitals if for a calendar year ending 18 months prior to the beginning of a particular State fiscal year:

   a. The hospital's Medicaid inpatient utilization rate as defined in Section 1396 r-4 (b)(2) of Title 42 of the United States Code, is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or

   b. The hospital's low income inpatient utilization rate as defined in Section 1396 r-4 (b)(3) of Title 42 of the United States Code, exceeds 25 percent;

   and in each case,

   c. The hospital has at least two obstetricians with staff privileges at the hospital who have agreed

to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the U.S. Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital (1) the inpatients of which are predominantly individuals under 18 years of age; or (2) which does not offer nonemergency obstetric procedures as of December 22, 1987; and

d. ~~For the 1994-95 payment adjustment year and subsequent payment adjustment years, the hospital's Medicaid inpatient utilization rate, as computed under paragraph a. above, is at least one percent~~.

B. Definitions

The following definitions apply for purposes of this Attachment:

1. "Department" means the State Department of Health Services.

2. "Disproportionate share list" means an annual list of disproportionate share hospitals that provide acute inpatient services issued by the Department for purposes of this Attachment.

3. "Fund" means the Medi-Cal Inpatient Payment Adjustment Fund.

4. "Eligible hospital" means a hospital included on a disproportionate share list, which is eligible to receive payment adjustments under this Attachment with respect to a particular state fiscal year.

State: California

Attachment 4.19-A
Page 19A

5. "Hospital" means a health facility that is licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code to provide acute inpatient hospital services, and includes all components of the facility.

6. "Payment adjustment" or "payment adjustment amount" means an amount paid under this Attachment for acute inpatient hospital services provided by a disproportionate share hospital.

7. "Payment adjustment year" means the particular state fiscal year with respect to which payments are to be made to eligible hospitals under this Attachment.

8. "Payment adjustment program" means the system of Medi-Cal payment adjustments for acute inpatient hospital services established by this Attachment.

State: California

9. "Annualized Medi-Cal inpatient paid days" means the total number of Medi-Cal acute inpatient hospital days, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the most recent calendar year ending prior to the beginning of a particular payment adjustment year, including all Medi-Cal acute inpatient-covered days of care for hospitals which are paid on a different basis than per diem payments.

10. "Low-income utilization rate" means a percentage rate determined by the Department in accordance with the requirements of Section 1396r-4(b) (3) of Title 42 of the United States Code, and included on a disproportionate share list.

11. "Low-income number" means a hospital's low-income utilization rate rounded down to the nearest whole number, and included on a disproportionate share list.

12. "1991 Peer Grouping Report" means the final report issued by the Department dated May 1991, entitled "Hospital Peer Grouping."

13. "Major teaching hospital" means a hospital that meets the definition of a university teaching hospital, major nonuniversity teaching hospital, or large teaching emphasis hospital as set forth on page 51 of the 1991 Peer Grouping Report.

14. "Children's hospital" means a hospital that meets the definition of a children's hospital-state defined, as set forth on page 53 of the 1991 Peer Grouping Report, or which is listed in subdivision (a), or subdivision (c) to (g), inclusive, of Section 16996, of the California Welfare and Institutions Code.

15. "Acute psychiatric hospital" means a hospital that meets the definition of an acute psychiatric hospital, a combination psychiatric/alcohol-drug rehabilitation hospital, or a psychiatric health facility, to the extent the facility is licensed to provide acute inpatient hospital service, as set forth on page 52 of the 1991 Peer Grouping Report.

TN #92-17
supersedes
TN #91-15

Approval Date: MAY 10 1993 Effective Date: ~~July 1, 1992~~ NOV 14 1992 CW 5-20-93

16. "Alcohol-drug rehabilitation hospital" means a hospital that meets the definition of an alcohol-drug rehabilitation hospital as set forth on page 52 of the 1991 Peer Grouping Report.

17. "Emergency Services Hospital" means a hospital that is a licensed provider of basic emergency services as described in Sections 70411 to 70419, inclusive, of Title 22 of the California Code of Regulations, or that is a licensed provider of comprehensive emergency medical services as described in Sections 70451 to 70459 inclusive, of Title 22 of the California Code of Regulations.

18. "OSHPD" means the Office of Statewide Health Planning and Development.

19. "OSHPD" statewide data base file" means the OSHPD statewide data base file from all of the following:

    (A) Hospital annual disclosure reports, filed with the Office of Statewide Health Planning and Development pursuant to Section 128735 (formerly Section 443.31) of the Health and Safety Code, for hospital fiscal years which ended during the calendar year ending 13 months prior to the applicable February 1.

    (B) Annual reports of hospitals, filed with the Office of Statewide Health Planning and Development pursuant to Section 127285 (formerly Section 439.2) of the Health and Safety Code, for the calendar year ending 13 months prior to the applicable February 1.

    (C) Hospital patient discharge data reports, filed with the Office of Statewide Health Planning and Development pursuant to subdivision (g) of Section 128735 (formerly Section 443.31) of the Health and Safety Code for the calendar year ending 13 months prior to the applicable February 1.

20. "Acute inpatient hospital day", for the purposes of this Attachment, will include days in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward

and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

21. "Total per diem composite amount" means, for each eligible hospital for a particular payment adjustment year, the total of the various per diem payment adjustment amounts to be paid to the hospital for each eligible day as calculated under applicable provisions of this Attachment.

22. "Supplemental lump-sum payment adjustment" means a lump-sum amount paid under this Attachment for acute inpatient hospital services provided by a disproportionate share hospital, but does not include secondary supplemental payment adjustments as described in subsection 26.

23. "Projected total payment adjustment amount" means, for each eligible hospital for a particular payment adjustment year, the amount calculated by the Department as the projected maximum total amount the hospital is expected to receive under the payment adjustment program for the particular payment adjustment year (including all per diem payment adjustment amounts and any applicable supplemental lump-sum payment adjustments, but not including secondary supplemental payment adjustments as described in subsection 26).

24. "To align the program with the federal allotment" means to modify the size of the payment adjustment program to be as close as reasonably feasible to, but not to exceed, the estimated or actual maximum state disproportionate share hospital allotment for the particular federal fiscal year for California under Section 1396r-4(f) of Title 42 of the United States Code.

25. "Descending pro rata basis" means an allocation methodology under which a pool of funds is distributed to hospitals on a pro rata basis until one of the recipient hospitals reaches its maximum payment limit, after which all remaining amounts in the pool are distributed on a pro rata basis to the recipient hospitals that have not reached their maximum payment limits, until another hospital reaches its maximum payment limit, and which process is repeated until the entire pool of funds has been distributed among the recipient hospitals.

State: California

26. ~~"Secondary supplemental payment adjustment" means a payment adjustment amount, whether paid or payable, to an eligible hospital as a second type of supplemental distribution earned as of June 30, 1996, with respect to the 1995-96 payment adjustment year~~.

27. "OBRA 1993 payment limitation" means the hospital-specific limitation on the total annual amount of payment adjustments to each eligible hospital under the payment adjustment program that can be made with federal financial participation under the provisions of Section 1396r-4(g) of Title 42 of the United States Code, as implemented pursuant to Section J. below.

28. "Transitional inpatient care" means the level of care needed by an individual: who has suffered an illness, injury, or exacerbation of a disease; whose medical condition has clinically stabilized so that daily physician services and the immediate availability of technically complex diagnostic and invasive procedures usually available only in the acute care hospital are not medically necessary; and whose physician assuming the responsibility of treatment management for the patient in transitional care has developed a definitive and time limited course of treatment.

29. "Public hospital" means a hospital that is licensed to a county, a city, a city and county, the State of California, the University of California, a local health care district, a local health authority, or any other political subdivision of the state.

30. "Nonpublic hospital" means a hospital that satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; does not meet the definition of a nonpublic/converted hospital as described in subsection 31; and does not meet the definition of a converted hospital as described in subsection 32.

31. "Nonpublic/converted hospital" means a hospital that satisfies all of the following, or, if two or more inpatient facilities are licensed by the Department under a consolidated license, a hospital as to which any component of the hospital satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; at any time during the 1994-95 payment adjustment year, was a public hospital as described in subsection 29 (whether or not the hospital or such component currently is located at the same site as it was located when it was a public hospital); and does not meet the definition of a converted hospital as described in subsection 32.

32. "Converted hospital" means a hospital that satisfies all of the following: the hospital does not meet the definition of a public hospital as described in subsection 29; and at any time during the 1999-2000 payment adjustment year, was an eligible hospital meeting the definition of a public hospital as described in subsection 29 (whether or not the hospital currently is located at the same site as it was located when it was a public hospital).

33. "Remained in operation" or "remains in operation" means that, except for closure or other cessation of services caused by natural disasters or other events beyond that hospital's reasonable control (including labor disputes), the hospital was licensed to provide hospital inpatient services, and continued to provide, or was available to provide, hospital inpatient services to Medi-Cal patients throughout the particular time period in question.

34. "Maximum state disproportionate share hospital allotment for California" means, with respect to the 1998 federal fiscal year and subsequent federal fiscal years, that amount specified for California under Section 1396r-4(f) of Title 42 of the United States Code for that fiscal year, divided by the federal medical assistance percentage applicable for federal financial participation purposes for Medi-Cal program expenditures with respect to that same federal fiscal year.

35. "Applicable federal fiscal year" means, with respect to the 2000-01 payment adjustment year and subsequent payment adjustment years, the federal fiscal year that commences on October 1 of the particular payment adjustment year.

36. "Medical assistance increment" means the federal medical assistance percentage applicable for federal financial participation purposes for Medi-Cal program expenditures, expressed as a percentage, less the number one-half, expressed as a percentage.

C. Determination of Payment Amounts

1. Except as otherwise provided in this Attachment, the additional payments will be distributed on a per diem basis. Each eligible hospital will receive a minimum specified payment adjustment which varies based on the type of hospital involved. Further, for some hospitals, a variable per diem amount, based on the hospital's low-income utilization rate, will also be paid.

2. Subject to the limitations in other Sections of this Attachment, the additional amount to be distributed to each hospital shall be determined as follows:

   a. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is a major teaching hospital, the hospital shall be paid the sum of all of the following amounts:

      (1) A minimum payment adjustment of three hundred dollars ($300).

      (2) The sum of the following amounts, minus three hundred dollars ($300).

         (A) A ninety dollar ($90) payment adjustment for each percentage point, from 25 percent to 29 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

         (B) A seventy dollar ($70) payment adjustment for each percentage point, from 30 percent to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A fifty dollar ($50) payment adjustment for each percentage point, from 35 percent to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A thirty dollar ($30) payment adjustment for each percentage point, from 45 percent to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A ten dollar ($10) payment adjustment for each percentage point, from 65 percent to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(3) If the sum calculated under subparagraph (2) is less than zero, it shall be disregarded for payment purposes.

b. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is a children's hospital, the hospital shall be paid the sum of four hundred fifty dollars ($450).

c. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital, on the first day of the payment adjustment year, is an acute psychiatric hospital, or an alcohol-drug rehabilitation hospital, the hospital shall be paid the sum of all of the following amounts:

(1) A minimum payment adjustment of fifty dollars ($50).

(2) The sum of the following amounts, minus fifty dollars ($50):

(A) A ten dollar ($10) payment adjustment for each percentage point, from 25 to 29 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(B) A seven dollar ($7) payment adjustment for each percentage point, from 30 to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A five dollar ($5) payment adjustment for each percentage point, from 35 to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A two dollar ($2) payment adjustment for each percentage point, from 45 to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A one dollar ($1) payment adjustment for each percentage point, from 65 to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(3) If the sum calculated under subparagraph (2) is less than zero, it shall be disregarded for payment purposes.

d. Concurrent with each Medi-Cal day of acute inpatient hospital service paid by or on behalf of the Department during a payment adjustment year, regardless of dates of service, to a hospital on the applicable disproportionate share list, where that hospital does not meet the criteria for receiving payments under paragraphs a., b., or c. above, the hospital shall be paid the sum of all of the following amounts:

State: California

(1) A minimum payment adjustment of one hundred dollars ($100).

(2) If the hospital is an emergency services hospital at the time the payment adjustment is paid, a two hundred dollar ($200) payment adjustment.

(3) The sum of the following amounts, minus one hundred dollars ($100), and minus an additional two hundred dollars ($200) if the hospital is an emergency services hospital at the time the payment adjustment is paid:

(A) A forty dollar ($40) payment adjustment for each percentage point, from 25 percent to 29 percent, inclusive, of the hospitals low-income number as shown on the disproportionate share list.

(B) A thirty-five dollar ($35) payment adjustment for each percentage point, from 30 percent to 34 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(C) A thirty dollar ($30) payment adjustment for each percentage point, from 35 percent to 44 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(D) A twenty dollar ($20) payment adjustment for each percentage point, from 45 percent to 64 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

(E) A fifteen dollar ($15) payment adjustment for each percentage point, from 65 percent to 80 percent, inclusive, of the hospital's low-income number as shown on the disproportionate share list.

TN #92-17
supersedes
TN #91-15

Approval Date: MAY 10 1993 Effective Date: ~~July 1, 1992~~ NOV 14 1992 CW 5-20-93

(4) If the sum calculated under subparagraph (3) is less than zero, it shall be disregarded for payment purposes.

3. When consistent and reliable data are available statewide as determined by the Department of Health Services, the Department may include those acute inpatient hospital days attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department to provide such services.

D. **Limitations**

1. To qualify for payment adjustment amounts under this Attachment, a hospital must have been included on the disproportionate share list for the particular payment adjustment year.

2. For any particular payment adjustment year, no hospital may qualify for payments under more than one category among those in Section C. above.

3. For each eligible hospital, there is a maximum limit on the number or Medi-Cal acute inpatient hospital days for which payment adjustment amounts may be paid for each payment adjustment year. The maximum limit shall be that number of days that equals 80 percent of the eligible hospital's annualized Medi-Cal inpatient paid days, as determined from all Medi-Cal paid claims records available through April 1 preceding the beginning of the payment adjustment year. When consistent and reliable data are available statewide as determined by the Department of Health Services, the Department may include those acute inpatient hospital days attributable to Medicaid beneficiaries enrolled under managed care organizations under contract with the Department to provide such services.

4. No payment adjustments under the payment adjustment program shall be payable in connection with claims paid prior to the effective data approved by the federal government for the payment adjustment program.

   No payment adjustments under any amendments to the payment adjustment program shall be payable in connection with claims paid prior to the effective date approved by the federal government for the amendments to the payment adjustment program.

5. Reductions in payment adjustment amounts shall apply when an insufficient amount of funds are available under the terms of the payment adjustment program. Any such reduction must be consistent with the following provisions.

The Department shall compute, prior to the beginning of each payment adjustment year, the projected size of the payment adjustment program for the particular payment adjustment year. To do so, the Department shall determine the projected total payment adjustment amount for each eligible hospital, and shall add these amounts together to determine the projected total size of the program. To the extent this projected total figure for the program exceeds the portion of the maximum state disproportionate share hospital allotment for California under federal law that the Department anticipates will be available for the period in question, the Department shall reduce the total per diem composite amounts of the various eligible hospitals in the fashion described below so that the allotment in question will not be exceeded.

a. All total per diem composite amounts for the entire payment adjustment year shall be reduced proportionately not to exceed two percent of each total per diem composite amount.

b. If the reductions authorized by paragraph a. are insufficient to align the program with the federal allotment for California, then the following shall apply:

(1) The adjusted total per diem composite amounts, as calculated under paragraph a., shall remain in effect for each eligible hospital whose low-income number is 30 percent or more.

(2) The adjusted total per diem composite amounts, as calculated under paragraph a., for all other eligible hospitals shall be further reduced proportionately to align the program with the federal allotment, but in no event to a level that is less than 65 percent of the total per diem composite amount that would have been payable to the eligible hospital had no reductions taken place.

c. If the steps set forth in paragraph b. are not adequate to align the program with the federal allotment, the adjusted total per diem composite amounts for all eligible hospitals for the entire payment adjustment year shall be further reduced proportionately to align the program with the federal allotment, but in no event to a level that would result in adjusted total per diem composite amounts that are less than 65 percent of the total per diem composite amounts that would have been payable had no reductions taken place.

d. At such time as all eligible hospitals have been reduced to the 65 percent level set forth in paragraph b. and paragraph c., the adjusted total per diem composite amounts for all eligible hospitals shall be further reduced proportionately as necessary to align the program with the federal allotment.

e. ~~This subsection 5 shall not apply to the 1995-96 payment adjustment year~~.

6. ***Mental Health Limitation.***

a. With respect to the 1997-98 payment adjustment year and each subsequent payment adjustment year, the aggregate payment adjustment amount for mental health facilities shall not exceed the lesser of $1,562,298 or 0.071% of the total disproportionate share hospital allotment for the particular payment adjustment year, as required under the provisions of Section 1396r-4(h) of Title 42 of the United States Code.

b. For purposes of this subsection, mental health facilities are institutions for mental disease, psychiatric acute care hospitals, and psychiatric health facilities. Mental health services provided by general acute care hospitals in psychiatric wards, wings, distinct parts, and units are not services provided by a "mental health facility."

c. For purposes of this subsection, mental health services includes acute inpatient and outpatient services provided in a psychiatric acute care hospital, psychiatric health facility, or, for patients under 21 years of age or over 64 years of age, in an institution for mental disease.

7. The data utilized by the Department shall relate to the hospital under present and previous ownership. When there has been a change of ownership, a change in the location of the main hospital facility, or a material change in patient admission patterns during the twenty-four months immediately prior to the payment adjustment year, and the change has resulted in a diminution of access for Medi-Cal inpatients at the hospital as determined by the Department, the Department shall, to the extent permitted by federal law, utilize current data that are reflective of the diminution of access, even if the data are not annual data.

8. ~~The system of payment adjustments described in the former version of Attachment 4.19A (effective July 1, 1990) will become inoperative as of the approval date of this Attachment.~~

9. ~~The payment adjustments under SPA 01-15 are not in consideration for services rendered prior to the effective date approved by HCFA. Such payment adjustments are distributed in conjunction with claims paid on and after the effective date as a mechanism to allocate funds relating to periods of time on and after the effective date~~.

10. If any payment adjustment that has been paid, or that is otherwise payable, under this Attachment exceeds the hospital-specific limitations set forth in Section J. of this Attachment, the Department shall withhold or recoup the payment adjustment amount that exceeds the limitation. The nonfederal component of the amount withheld or recouped shall be redeposited in, or shall remain in, the fund, as applicable, until used for the purposes described in paragraph (2) of subdivision (j) of Section 14163 of the Welfare and Institutions Code.

11. The payment adjustments under this Attachment shall be limited as specified in other provisions of this Attachment.

State: California

E. Additional Description

1. Except as otherwise provided in this Attachment, the disproportionate share payments shall be distributed concurrent with claims paid on those dates on or after July 1, 1991, for which federal approval is effective and as follows:

   a. ~~For the fiscal year July 1, 1991 through June 30, 1992, the State shall determine which hospitals meet the disproportionate share definition set out in Section A. subsection 2. for the 1991-92 payment adjustment year, and the aggregate per diem payment adjustment amount for each hosptial. As soon as determined, the Department shall issue a disproportionate share list showing the name of each hospital qualifying for payment adjustments, the hospital's Medi-Cal utilization rate and low-income utilization rate, the hosptial's low income number, and the amount of the per diem payment adjustment to be made for each hospital for the 1991-92 fiscal year~~.

   b. No later than the fifth day of each fiscal year ~~thereafter~~, the Department shall determine, for the particular payment adjustment year, which hospitals meet the disproportionate share definition set out in Section A., subsection 2. and the aggregate per diem payment adjustment amount for each hospital. When determined, the Department shall issue a disproportionate share list showing the name and license number of each hospital qualifying for payment adjustments, the hospital's Medi-Cal utilization rate and low-income utilization rate, the hospital's low-income number, and the amount of the per diem payment adjustments to be made for each such hospital.

   c. The determinations regarding disproportionate share hospital status and the payments made in accordance with paragraph~~s a. and~~ b. above shall be final determinations and payments. Nothing on a disproportionate share list, once issued by the Department, shall be modified for any reason other than mathematical or typographical errors or omissions on the part of the State.

State: California

2. Notwithstanding any other provision of this Attachment, to the extent necessary or appropriate to implement and administer the amendments to Section 14105.98 of the Welfare and Institutions Code enacted during the 1994 calendar year, the Department may utilize an approach involving interim payments, with reconciliation to final payments within a reasonable time.

~~F. Supplemental Lump Sum Payment Adjustments - September 30, 1993~~

~~1. For the 1993-94 payment adjustment year, each eligible hospital shall also be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the hospital being included on the disproportionate share list as of September 30, 1993. For purposes of federal medicaid rules, including Section 447.297(d) of Title 42 of the Code of Federal Regulations, the supplemental payment adjustments shall be applicable to the federal fiscal year that ends on September 30, 1993.~~

~~2. The availability of supplemental payment adjustments under this paragraph shall be determined as follows:~~

~~a. The final maximum state disproportionate share hospital allotment for California under the provisions of applicable federal medicaid rules shall be identified for the 1993 federal fiscal year. This final allotment is two billion one hundred ninety-one million four hundred fifty-one thousand dollars ($2,191,451,000), as specified at page 43186 of Volume 58 of the Federal Register.~~

~~b. The total amount of all disproportionate share hospital per diem payment adjustment amounts under this Attachment, whether paid or payable, that are applicable to the 1993 federal fiscal year shall be determined. The applicability of the per diem payment adjustment amounts to the 1993 federal fiscal year shall be determined in accordance with federal medicaid rules, including Sections 447.297(d)(3) and 447.298 of Title 42 of the Code of Federal Regulations.~~

State: California

J. OBRA 1993 Hospital-Specific Limitations

1. General Background

   a. Section 1396r-4(g) of Title 42 of the United States Code, as added by the Omnibus Budget Reconciliation Act of 1993 ("OBRA 1993"), imposes hospital-specific limitations on the amount of federal financial participation available for payment adjustments for the 1994-95 payment adjustment year and subsequent payment adjustment years ("OBRA 1993 limits"). The OBRA 1993 limits are applied on an annual basis, based on the State fiscal year. As described in subsection 5 below, the limits apply to public hospitals for the 1994-95 payment adjustment year, and to all eligible hospitals for the 1995-96 and subsequent payment adjustment years.

   b. Under the OBRA 1993 limits, payment adjustments made to a hospital with respect to a State fiscal year may not exceed the costs incurred by the hospital of furnishing hospital services, net of Medi-Cal payments (other than disproportionate share hospital payment adjustments described at page 18 *et seq.* of this Attachment) and payments by uninsured patients, to individuals who either are eligible for the Medi-Cal program or have no health insurance (or other source of third party coverage) for services provided during the year. Payments made by a State or unit of local government to a hospital for services provided to indigent patients are not considered to be a source of third party payment.

2. General Approach To Calculations/Program Consistency

   a. Definitions

      For purposes of this Section J, the following definitions shall apply:

      (1) "Subject payment adjustment year" means the particular payment adjustment year to which the limitations described in this Section J are being applied.

(2) "Data determination date" means, ~~with respect to the 1994-95 and 1995-96 payment adjustment years, the date of September 15, 1995~~. For the 1996-97 payment adjustment year and subsequent payment adjustment years, the date of June 15 immediately prior to the beginning of the subject payment adjustment year shall be the "data determination date" with respect to that subject payment adjustment year.

b. To facilitate implementation of the OBRA 1993 limits under the Medi-Cal program, the calculations of costs and revenues shall, except as otherwise provided in this Section J, be determined prior to the beginning of the subject payment adjustment year. For the most part, the data used in the calculations will be obtained through the data collection mechanisms and sources used in the determinations of hospital eligibility and payment adjustment levels under the payment adjustment program for the subject payment adjustment year.

c. In recognition of their unusual nature, three limited elements of Medi-Cal program costs and revenues will be computed based on more recent data than other costs and revenues. These three elements relate to the Medi-Cal Construction Renovation and Replacement Program under Welfare and Institutions Code Section 14085.5 ("CRRP"), the Medi-Cal Administrative Claiming program under Welfare and Institutions Code Section 14132.47 ("MAC") referred to as Medi-Cal Administrative Activities ("MAA"), and the Medi-Cal Targeted Case Management program under Welfare and Institutions Code Section 14132.44 ("TCM").

d. Except as otherwise provided in this Section J, the Department shall calculate the OBRA 1993 limit for each hospital prior to the beginning of the subject payment adjustment year, or as soon thereafter as possible. The calculations for the subject payment adjustment year shall be based only on that data available as of the data determination date, except for CRRP, MAA and TCM data described in the

preceding paragraph, which may include data collected through a survey completed after the data determination date and except for other data as described in this Section J.

e. ~~With respect to the 1994-95 payment adjustment year, the methodology set forth in subsection 4 shall apply except as provided for in subsection 6.~~

f. Where a federal Medicaid demonstration project under Section 1315(a) of Title 42 of the United States Code is in effect, or may be in effect, during the subject payment adjustment year, the methodology set forth in subsection 4 shall apply, except as provided for in subsection 7.

3. Calculation Of OBRA 1993 Limit - General Methodology

a. With respect to each payment adjustment year referred to in subsection 5 below, the Department shall compute the OBRA 1993 limit for each eligible hospital, based on the data elements referred to below.

b. Except as otherwise provided in paragraph c, ~~or in subsections 6 or 7~~, in determining expenses the Department shall use the data from the annual reports filed by hospitals with OSHPD that are used to structure the payment adjustment program for the subject payment adjustment year. All data from such reports shall be considered to be final for purposes of these calculations as of the February 1 immediately prior to the applicable data determination date for the subject payment adjustment year. For example, for the 1995-96 payment adjustment year, the Department shall use reports relating to the hospital's fiscal year that ended during calendar year 1993. The Department shall use a trend factor to project these expenses into the subject payment adjustment year, as described in subparagraph (1) of paragraph b of subsection 4 below. ~~For the 1994-95 payment adjustment year, the Department shall implement the special rules set forth in subsection 6. Further, where federal demonstration projects are involved, the Department shall implement the special rules set forth in subsection 7.~~

c. With respect to MAA, TCM, and specified CRRP expenses, the Department shall conduct a survey of affected hospitals to compute such expenses for application of the OBRA 1993 limits relating to the subject payment adjustment year.

d. Except as otherwise provided in paragraph e, ~~or in subsections [redacted] or 9~~, in calculating revenues the Department shall use data involving Medi-Cal payments made by the Department for hospital services during the calendar year ending six months prior to the beginning of the subject payment adjustment year. For the most part, these data shall be obtained from the data collection mechanisms and sources used to determine the annualized Medi-Cal inpatient paid days referred to in subsection 9 of Section B of this Attachment. ~~For the 1994-95 payment adjustment year, the Department shall implement the special rules set forth in subsection 6. Further, where federal demonstration projects are involved, the Department shall implement the special rules set forth in subsection 7.~~

e. With respect to MAA, TCM, and specified CRRP revenues, the Department shall conduct a survey of affected hospitals to compute such revenues for application of the OBRA 1993 limits relating to the subject payment adjustment year. Surveys shall be conducted at such time that consistent and reliable data, as determined by the Department, is available statewide.

4. Calculation Of OBRA 1993 Limits - Formula To Be Used

The formula set forth below is for purposes of implementing the OBRA 1993 limits. The calculations involve various projections and estimates of hospital revenues and expenses.

a. The formula to be used by the Department for each eligible hospital shall be:

DSH_LMT = MCUN_EX - MCUN_RV

WHERE:

DSH_LMT=the OBRA 1993 hospital-specific limit

MCUN_EX=Medi-Cal/Uninsured Expenses

MCUN_RV=Medi-Cal/Uninsured Revenues

The specific elements yielding MCUN_EX and MCUN_RV are described below in paragraphs b and c, respectively.

b. "Medi-Cal/Uninsured Expenses" (MCUN_EX)

(1) "Projected Adjusted Hospital Operating Expenses" is computed from prior year OSHPD data that are projected ("trended") forward into the subject payment adjustment year. ~~Except as provided in subsections 6 or 7,~~ the Department shall use the data from the annual reports filed by hospitals with OSHPD that are used to determine eligibility for payments under the program (the "Hospital Disclosure Reports"). All data from such reports shall be considered to be final for purposes of these calculations as of the February 1 immediately prior to the applicable data determination date for the subject payment adjustment year. "Projected Adjusted Hospital Operating Expenses" is the "Total Operating Expenses" (TOT_OP) as reported on the applicable OSHPD report, minus "CRRP Costs" for the same period (CRRP) as determined by the applicable hospital-specific survey, multiplied by the trend factor (TREND).

The computation of the "Projected Adjusted Hospital Operating Expenses" (PR_ADJOP) is expressed as follows:

PR_ADJOP=(TOT_OP-CRRP)xTREND.

The applicable trend factor shall be derived from the Medicare hospital input price index ("Medicare hospital market basket"), developed

by the Health Care Financing Administration and forecasted by Data Resources, Inc./McGraw Hill. ~~Except as provided in subsection 6~~, the trend factor shall equal the product of the Medicare hospital market basket percentage increases that were forecasted and published in the Federal Register for the three most recent federal fiscal years ("FFY") in conjunction with the annual "Medicare Program Changes to Hospital Inpatient Prospective Payment Systems and Rates" promulgated (or proposed, where final rules have not yet been promulgated) as of the applicable data determination date for the subject payment adjustment year. The earliest of the particular Medicare hospital market basket percentage increases used shall be multiplied by an adjustment factor to account for varying hospital OSHPD reporting periods. The applicable adjustment factor will depend on the particular month in which a hospital's OSHPD data reporting period ends, as follows:

OSHPD Reporting Period Ending	Adjustment Factor
Jan	1.417
Feb	1.333
Mar	1.250
Apr	1.167
May	1.083
Jun	1.000
Jul	.917
Aug	.833
Sep	.750
Oct	.667
Nov	.583
Dec	.500

For example, with respect to the 1995-96 payment adjustment year, the three applicable Medicare hospital market basket percentage increases are 4.3% (final federal figure for FFY 1994, 58 Fed.Reg. 46270), 3.6% (final federal figure for FFY 1995, 59 Fed.Reg. 45330), and 3.5% (final federal figure for FFY 1996, 60 Fed.Reg. 45778), as promulgated in the Federal Register on or before September 15, 1995. The applicable trend factor for the 1995-96 payment adjustment year is therefore computed as:

TREND = [1 + (.043 x 1.00*)] x 1.036 x 1.035.
*(Adjustment factor, for the earliest of the federal figures used (FFY 1994), for hospital with OSHPD data reporting period ending in June 1993.)

For a hospital with an OSHPD data reporting period ending in March 1993, the trend factor applicable for the 1995-96 payment adjustment year is computed as:

TREND = [1 + (.043 x 1.250*)] x 1.036 x 1.035.
*(Adjustment factor, for the earliest of the federal figures used (FFY 1994), for hospital with OSHPD data reporting period ending in March 1993.)

(2) "CRRP Costs" (CRRP_EX) derived from the applicable hospital-specific survey (which costs shall be limited to applicable depreciation, interest and, to the extent such costs are reflected in the debt service amounts recognized under Welfare and

Institutions Code Section 14085.5, the following other federally recognized capital-related costs as described in Title 42 of the Code of Federal Regulations, Section 413.130: taxes, costs of betterments and improvements, costs of minor equipment, insurance, debt issuance costs, debt discounts and debt redemption costs) are added to the "Projected Adjusted Hospital Operating Expenses," and "MAA Costs" (derived from the applicable hospital-specific survey) are subtracted, to arrive at the "Projected Total Hospital Expenses" for the subject payment adjustment year.

The computation of the "Projected Total Hospital Expenses" (PR_TOTEX) is expressed as follows:

PR_TOTEX = PR_ADJOP + CRRP_EX - MAA.

(3) A "Medi-Cal/Uninsured Patient Mix" ratio is applied to the "Projected Total Hospital Expenses." The "Medi-Cal/Uninsured Patient Mix" ratio is the ratio of all gross inpatient and outpatient charges (including charges associated with services provided under the Medi-Cal/Short-Doyle program, the San Mateo/Santa Barbara Health Initiative and other managed care programs) attributable to Medi-Cal patients, the County Indigent Program, and uninsured patients to total gross inpatient and outpatient charges. The necessary data elements are extracted from the applicable OSHPD report, the Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes, and the MEDS and OSHPD Confidential Discharge Data files.

The computation of the "Medi-Cal/Uninsured Patient Mix" ratio (MCUN_MIX) is as follows:

MCUN_MIX = (MCCRG + COINDCRG + UNINSCRG) ÷ (TOTIPCRG + TOTOPCRG).

WHERE:

MCCRG = Total Medi-Cal inpatient and outpatient charges (including charges associated with services provided under Medi-Cal managed care programs);

COINDCRG = Total County Indigent Program inpatient and outpatient charges;

UNINSCRG = Total charges attributable to uninsured patients;

TOTIPCRG = Total inpatient charges; and

TOTOPCRG = Total outpatient charges.

~~Projected "demonstration project expenses" (DEMO EX) are determined based on the terms and conditions of an approved federal Medicaid demonstration project, but only to the extent set forth in paragraph b of subsection 7. DEMO EX is added to the product of PR TOTEX and MCUN MIX to determine "Medi-Cal/Uninsured Expenses."~~

The computation of "Medi-Cal/Uninsured Expenses" (MCUN_EX) is therefore expressed as follows:

MCUN_EX = PR_TOTEX x MCUN_MIX + DEMO EX.

c. "Medi-Cal/Uninsured Revenues" (MCUN_RV) is comprised of the following components:

(1) "Medi-Cal Inpatient Revenues" (MIP_RV).

Except as otherwise provided in this Section J, "Medi-Cal Inpatient Revenues" shall be equal to the revenues for inpatient services, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the calendar year ending prior to the beginning of the subject

payment adjustment year. The revenue data shall be obtained from the data collection mechanisms and sources used by the Department in determining the hospital's annualized Medi-Cal inpatient paid days (as referred to in subsection 9 of Section B of this Attachment) as well as other applicable data maintained by the Department relating to Medi-Cal payments made during the same calendar year time period. These data sources are the Medi-Cal paid claims tapes, Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes and other managed care plan payment data. (This step does not include payments under Welfare and Institutions Code Section 14085.6, which are addressed in subparagraph (4) below. ~~It also does not include certain demonstration project revenues, as described in subsection 7 below. For special rules regarding the 1994-95 payment adjustment year, see subsection 6 below.)~~

(2) "Medi-Cal Outpatient Revenues" (MOP_RV).

Except as otherwise provided in this Section J, "Medi-Cal Outpatient Revenues" shall be equal to Medi-Cal revenues for outpatient services, regardless of dates of services, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the calendar year ending prior to the beginning of the subject payment adjustment year. The revenue data shall be obtained from the data collection mechanisms and sources used by the Department in determining the hospital's annualized Medi-Cal inpatient paid days (as referred to in subsection 9 of Section B of this Attachment) as well as other applicable data maintained by the Department relating to Medi-Cal payments made during the same calendar year time period. These data sources are the Medi-Cal paid claims tapes, Medi-Cal/Short-Doyle paid claims tapes, San Mateo/Santa Barbara Health Initiative paid claims tapes, and other managed care plan

payment data. ~~(This step does not include certain demonstration project revenues, as described in subsection 7 below. For special rules regarding the 1994-95 payment adjustment year, see subsection 6 below.)~~

(3) "CRRP Revenues" (CRRP_RV).

"CRRP Revenues" will be determined based on the results of the applicable hospital-specific survey.

(4) "Emergency Services/Supplemental Payments Revenues" (EMS_RV).

(a) ~~Except as provided for in clause (d) or in subsection 2~~, the Department shall determine the hospital's revenue amount relating to the program under Welfare and Institutions Code Section 14085.6 ("S.B. 1255 program"), with respect to services to be rendered during the subject payment adjustment year, based on the best information available as of the data determination date, in the fashion described below.

(b) In determining the S.B. 1255 revenue amount to be included for the subject payment adjustment year, the Department shall use, in the following order of availability, the amount that:

(i) Is set forth in any contract between the hospital and the State as negotiated by the California Medical Assistance Commission ("CMAC") pursuant to Section 14085.6;

(ii) Has been agreed upon by the particular hospital and CMAC staff, but has not yet been formally approved by CMAC or by the hospital;

(iii) Represents the latest offer made by CMAC staff to the particular hospital; or,

(iv) The hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year, but only if (1) subclause (i), (ii), or (iii) do not apply, and (2) the hospital has communicated to CMAC an intent to participate in the S.B. 1255 program for the subject payment adjustment year. Should this clause (iv) apply for a hospital, the amount included by the Department shall not exceed the amount of S.B. 1255 program payments the hospital has requested from CMAC for the subject payment adjustment year.

(c) In the event that none of the data described in clause (b) is available as of the data determination date, the Department shall assume that the S.B. 1255 program revenue for the particular hospital for the subject payment adjustment year will be the amount the hospital was granted with respect to the payment adjustment year immediately prior to the subject payment adjustment year. The Department, in cooperation with CMAC, shall notify hospitals of the existence and potential applicability of this provision at the time the S.B. 1255 program is initiated each year.

~~(d) With respect to the 1994-95 and 1995-96 payment adjustment years, the Department shall take into account, except as otherwise provided in subsection 7, the particular Medi-Cal contract amendment(s) for S.B. 1255 program payments effective for each period that have been entered into at the time that the computations pursuant to this Section J are made for each of the respective subject payment adjustment years.~~

(e) For purposes of clauses (b), (c), ~~and (d)~~ above, the Department shall use the contracted amount when the contracted "days of service" are equal to or less than 12 months. In the event that the "days of service" extend beyond 12 months, the Department shall reduce the total contract amount to reflect 12 months of revenue by dividing the total contract amount by the number of months represented in the contracted "days of service" and multiplying that number by 12.

(f) ~~Except as provided in subclause (iv)~~, for the 1996-97 payment adjustment year and subsequent payment adjustment years, if a hospital meets the conditions set forth in subclause (i), the Department shall take into account additional S.B. 1255 revenue amounts pursuant to subclauses (ii) and (iii).

(i) The hospital entered into a Medi-Cal contract amendment(s) since the last data determination date (September 15, 1995 and thereafter) that resulted in S.B. 1255 program payments to the hospital relating to services rendered in a fiscal year preceding the subject payment adjustment year, and such S.B. 1255 program payments were not included in the OBRA 1993 limit calculation for the year(s) during which such services were rendered.

(ii) The Department shall determine whether the inclusion of the additional S.B. 1255 program revenue described in subclause (i) would have resulted in a reduction in the hospital's disproportionate share payment amounts for the payment adjustment year for which the additional S.B. 1255 program payments were received.

(iii) To the extent that the additional S.B. 1255 revenue described in subclause (i) would have reduced the hospital's OBRA 1993 limit in an amount that would have resulted in the hospital surpassing its OBRA 1993 limit for a previous payment adjustment year, the amount of the additional S.B. 1255 revenue that would have caused the hospital to surpass its OBRA 1993 limit for any such prior year shall be added to the S.B. 1255 revenue amount for the subject payment adjustment year as determined under clauses (b)-(e).

~~(iv) Subclauses (i) through (iii) shall not apply to a hospital participating in a federal Medicaid demonstration project, if such demonstration project provides a repayment arrangement agreed to by the parties regarding disproportionate share payment adjustment amounts.~~

(5) "Targeted Case Management Revenues" (TCM_RV).

"Targeted Case Management Revenues" will be determined based on the results of the applicable hospital-specific survey.

(6) "Uninsured Cash Payments" (UNINS_RV).

Except as otherwise provided in this Section J, "Uninsured Cash Payment" will be derived from the applicable OSHPD report (as referred to in paragraph b of subsection 3). "Uninsured Cash Payments" shall be calculated as the sum of the inpatient and outpatient net revenues reported for "Other Payors" on page 12 of the OSHPD report. Consistent with section 1396r-4(g) of Title 42 of the United States Code, such sum shall not include payments made by the State, the University of California or a unit of local government to the hospital for services provided to indigent patients. The amount so determined from the applicable OSHPD report will be trended forward into the subject payment adjustment year (as referred to in subparagraph (1) of paragraph b of subsection 4).

7. ~~Projected "demonstration project revenues" (DEMO RV) are determined based on the terms and conditions of an approved federal Medicaid demonstration project, but only to the extent set forth in paragraph b of subsection 7.~~

The computation of "Medi-Cal/Uninsured Revenues" (MCUN_RV) is therefore expressed as follows:

MCUN_RV = MIP_RV + MOP_RV + CRRP_RV + EMS_RV + TCM_RV + UNINS_RV + ~~DEMO RV~~.

5. Application of Limit

~~a. For the 1994-95 payment adjustment year, the OBRA 1993 limits shall apply only to public hospitals. With respect to the 1994-95 payment adjustment year, the total disproportionate share payment adjustment amounts described at page 18 et seq. of this Attachment paid or payable to each eligible hospital that is owned or operated by the State (or by an instrumentality or a unit of government within the State) shall not exceed 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year; provided, however, that payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 200% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year.~~

b. For the 1995-96 and subsequent payment adjustment years, the OBRA 1993 limits shall apply to all eligible hospitals. With respect to any particular payment adjustment year, no eligible hospital shall receive total payment adjustment amounts under this Attachment in an amount that exceeds 100% of the hospital's OBRA 1993 limit as calculated pursuant to this Section J with respect to the subject payment adjustment year, except ~~as follows: (1) with respect to the 1997-98 and 1998-99 payment adjustment years,~~ the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 175% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year; ~~and (2) with respect to the 1999-2000 payment adjustment year and subsequent payment adjustment years, the payment adjustment amounts paid to those public hospitals that have "high disproportionate share" status (referred to in Section 1396r-4(g)(2) of Title 42 of the United States Code) shall be limited to 100% of the OBRA 1993 limit as calculated for the particular hospital pursuant to this Section J with respect to the subject payment adjustment year, unless federal law sets forth or authorizes a different percentage figure or amount to be used for such hospital for such purposes for the subject payment adjustment year, in which case such different percentage figure or amount shall apply for such hospital for such payment adjustment year.~~

c. ~~For the 1995-96 payment adjustment year, the~~ OBRA 1993 limits ~~shall be applied as set forth in subparagraph (3) of paragraph a of subsection 4 of Section I of this Attachment. For subsequent payment adjustment years, the~~ OBRA 1993 limits shall be applied with respect to each year after performing computations under subsection 5 of Section D of this Attachment and as specified in other provisions of this Attachment. The OBRA 1993 limits shall be applied to the amounts computed for all affected hospitals prior to the computations of transfer amounts under Section 14163 of the Welfare and Institutions Code.

d. Where a payment adjustment amount that is otherwise paid or payable to an eligible hospital under this Attachment is; or would be, above the limits described in this Section J, the payment adjustment amount shall be subject to the provisions of subsection ~~9~~ 10 of Section D of this Attachment.

~~6. Special Rules relating to 1994-95 Payment Adjustment Year.~~

~~With respect to the 1994-95 payment adjustment year, the OBRA 1993 limit shall be calculated for each eligible hospital in accordance with the methodology set forth in subsection 4 above, except as follows.~~

~~a. In determining expenses pursuant to paragraph b of subsection 4 (other than MAA and CRRP expenses), the Department shall use data from the annual OSHPD reports filed by hospitals for fiscal periods ending during the 1993 calendar year.~~

~~b. The applicable Medicare hospital market basket percentage increases, as referred to in subparagraph (1) of paragraph b of subsection 4 shall be 4.3% and 3.6% for FFY 1994 and FFY 1995, respectively (58 Fed.Reg. 46270; 59 Fed.Reg.45330). The Medicare hospital market basket percent increase for FFY 1994 shall be adjusted for varying hospital OSHPD reporting periods, as specified in subparagraph (1) of paragraph b of subsection 4.~~

State: California

c. The calculation of "Medi-Cal Inpatient Revenues," as referred to in subparagraph (1) of paragraph c of subsection 4, shall be based on data relating to revenues for inpatient services, regardless of dates of service, for which payment was made by of on behalf of the Department to a hospital, under present or previous ownership, during the 1994 calendar year.

d. The calculation of "Medi-Cal Outpatient Revenues," as referred to in subparagraph (2) of paragraph c of subsection 4, shall be based on data relating to revenues for outpatient services, regardless of dates of service, for which payment was made by or on behalf of the Department to a hospital, under present or previous ownership, during the 1994 calendar year.

e. "Uninsured Cash Payments," as referred to in subparagraph (6) of paragraph c of subsection 4, will be derived from the applicable annual OSHPD report referred to in paragraph a above. The amount so determined will be trended forward into the 1994-95 payment adjustment year based on the applicable Medicare hospital market basket percent increases set forth in paragraph b above.

7. Special Rules for Federal Medicaid Demonstration Projects.

a. This paragraph a shall apply where a federal demonstration project may occur, but the effective date of the project has not been approved by the federal government as of the data determination date for the subject payment adjustment year. This paragraph shall also apply where the federal government has approved the demonstration project, but the effective dates of the project do not include any time periods during the subject payment adjustment year. In such situations, any additional Medi-Cal and uninsured expenses and revenues that could potentially arise with respect to the subject payment adjustment year solely as a result of the hospital's participation in the demonstration project shall not be included in the computations set forth in subsection 4.

State: California

~~b. This paragraph b shall apply only where the federal government has approved a demonstration project, the federal approval has been issued prior to the data determination date for the subject payment adjustment year, and some or all of the federally approved effective dates of the project fall within the subject payment adjustment year. In such situations, to the extent that the Department determines (with concurrence of HCFA) that the terms and conditions of an approved federal Medicaid demonstration project constitute federally approved variations from the provisions of this Section J (including expenses, calculations, data elements, data collection and revenues federally recognized under the demonstration project for the computation of the OBRA 1993 limits hereunder), such terms and conditions of the approved demonstration project shall govern.~~

8. Department's Discretion

a. Notwithstanding any other provision of this Section J, but subject to paragraph b, below, the Department shall (with concurrence of HCFA) have the discretion to vary the mechanisms and sources, or formulas specified herein if the department finds that such variance is required to:

(1) Comply with federal law or regulations,

(2) Take into account the unavailability of particular data elements, or the impracticality of making a particular calculation, or

(3) Avoid inequitable or unintended results not consistent with OBRA 1993 or with the overall purpose and intent of this Section J.

b. A variance pursuant to paragraph a will be limited to making minor or insignificant adjustments to any formula, calculation, or methodology specified in this Section J, or to the specified sources of data to be used in any such formula, calculation, or methodology. These minor adjustments will be limited to instances when the format for reporting data used by the *Department has been changed by the agency responsible for issuing the* report, or when the information in an agency's report is incomplete and comparable information is available from the agency. Any minor adjustment made pursuant to this Section J will be made prior to the final calculation of OBRA '93 limits, and will not be made to effect a retroactive adjustment. A variance under this Section J will not be made to correct errors in data

submitted by a reporting hospital to the agency responsible for issuing the particular report, or to make any other correction, change, or adjustment in the data reported by a particular hospital. A variance under this Section J will not be made to alter the fundamental structure or general scheme of this Section J; where significant changes in the formulas, calculations, or methodologies specified in this Section J are necessary, the Department will submit a state plan amendment to the Health Care Financing Administration in the normal course.

9. Department Certification

The Department certifies that it is meeting the requirements of section 1923(g) of the Social Security Act (as added by the Omnibus Budget Reconciliation Act of 1993) by applying the methodology set forth in this Section J. Further, the Department assures that it does not exceed the federal allotment for California set forth at section 1923(f) of the Act.

~~the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this subparagraph, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).~~

~~(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.~~

~~g. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before June 30, 2001.~~

P. **Payment Adjustment Program for 2001-02 Payment Adjustment Year and Subsequent Payment Adjustment Years.**

With respect to the 2001-02 payment adjustment year and each subsequent payment adjustment year, the program shall proceed in conformance with the provisions of other applicable Sections of this Attachment, except as set forth below.

1. Non-Supplemental Payment Adjustments - July 1 - September 30.

   No payment adjustment amounts shall be payable in connection with the period of July 1 through September 30 of the 2001-02 payment adjustment year and each subsequent payment adjustment year.

2. Non-Supplemental Payment Adjustments - October 1 - June 30.

   Payment adjustments with respect to the period October 1 through June 30 of the 2001-02 payment adjustment year and each subsequent payment adjustment year (exclusive of the supplemental lump-sum payment adjustments provided for under subsection 3.), shall be structured as set forth below.

   a. The Department shall determine the maximum state disproportionate share hospital allotment for California for the applicable federal fiscal year under the provisions of applicable federal Medicaid rules.

b. The initial maximum size of the payment adjustment program for the period October 1 through June 30 of each applicable payment adjustment year shall be set at one billion six hundred million dollars ($1,600,000,000), exclusive of any supplemental payment adjustments under subsection 3.

c. The Department shall compute the projected total payment adjustment amounts for all eligible hospitals for the applicable payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3., by determining for each eligible hospital its total per diem composite amount and multiplying that figure by 80 percent of the hospital's annualized Medi-Cal inpatient paid days. For purposes of this paragraph, such determinations shall be made without regard to the OBRA 1993 payment limitations. Notwithstanding the foregoing, with respect to a hospital that, as of July 1 of the applicable payment adjustment year, meets the definition of a converted hospital, the amount otherwise determined under this paragraph shall be reduced as necessary so as not to exceed the total amount of all payment adjustment amounts payable to the hospital under this Attachment for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

d. The computed amount referred to in paragraph c. for each hospital shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the applicable payment adjustment year.

e. Where the computed amount referred to in paragraph c. for the particular hospital exceeds the OBRA 1993 payment limitation for the hospital, the amount computed under paragraph c. shall be reduced to an amount equal to the OBRA 1993 payment limitation for the particular hospital. The amount so reduced shall be used for purposes of paragraph g.

f. Where the computed amount referred to in paragraph c. for the particular hospital is equal to or less than the OBRA 1993 payment limitation for the hospital, the computed amount referred to in paragraph c. shall be used for purposes of paragraph g.

g. The amounts determined under paragraphs e. and f. for all eligible hospitals shall be added together, yielding an aggregate sum. The aggregate sum shall be the unadjusted projected total payment adjustment program for the period October 1 through June 30 of the applicable payment adjustment year, exclusive of any supplemental payment adjustments under subsection 3.

h. The Department shall increase or decrease the amount determined for each eligible hospital under paragraph e. or f., as applicable, by multiplying the amount by an identical percentage, yielding the hospital's tentative adjusted projected total payment adjustment amount for the period October 1 through June 30 of the applicable payment adjustment year. The identical percentage figure to be used for this purpose shall be that percentage that is derived by dividing the amount set forth in paragraph b. by the aggregate sum determined under paragraph g. In no case, however, shall the amount determined for a hospital under paragraphs e. or f. be increased such that it would exceed the OBRA 1993 payment limitation for the hospital, and, where such would otherwise occur, the remaining amount that would have been allocated to the particular hospital shall be reallocated to all other hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the tentative adjusted projected total payment adjustment amounts for all hospitals equals the amount set forth in paragraph b.

i. The tentative adjusted projected total payment adjustment amount computed for each eligible hospital under paragraph h. shall be further adjusted as follows:

(1) Nonpublic/converted hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic/converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic/converted hospital adjustment factor." The applicable adjustment factor shall be 0.835; except, however, where the hospital also meets the definition of a major teaching hospital as of July 1 of the applicable payment adjustment year, the applicable adjustment factor shall be the lesser of 1.00, or that which is necessary to result in an amount for the particular hospital equal to thirty-five million eight hundred thousand dollars ($35,800,000).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(2) Converted Hospitals.

(a) For each eligible hospital that meets the definition of a converted hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "converted hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The maximum OBRA 1993 limit percentage that is applicable to the hospital for the applicable payment adjustment year pursuant to subsection 5. of Section J. shall be subtracted from 175 percent (the maximum percentage that was applicable to the hospital as a public hospital during the 1999-2000 payment adjustment year).

(ii) The converted hospital adjustment factor shall be that figure derived in subclause (i), expressed as a fraction, subtracted from 1.00.

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation.

(3) Nonpublic Hospitals.

(a) For each eligible hospital that meets the definition of a nonpublic hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "nonpublic hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(I) The tentative adjusted projected total payment adjustment amount determined under paragraph h. for each nonpublic hospital described above shall be added together.

(ii) The amount identified in paragraph b. shall be divided by 2.237.

(iii) The resulting figure in clause (ii) shall be increased by an amount equal to the product of the medical assistance increment multiplied by the maximum amount identified in paragraph a.

(iv) The amount derived under clause (iii) shall be reduced by the following:

(I) the sum of the amounts determined for all nonpublic/converted hospitals under subparagraph (1); and

(II) the sum of that portion of the amount determined for any converted hospital under subparagraph (2) that is in excess of that amount equal to 31 percent of all payment adjustment amounts that were payable to the hospital for that payment adjustment year in which the hospital was last an eligible hospital meeting the definition of a public hospital.

(v) The amount computed under subclause (iv) shall be divided by 2, and the result thereof further reduced by the amount of thirty-three million five hundred thousand dollars ($33,500,000).

(vi) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (v) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph j. does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have

been allocated to the particular hospital shall be reallocated to all other nonpublic hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all nonpublic hospitals equals the amount derived in subclause (v) of clause (a).

(4) Public Hospitals.

(a) For each eligible hospital that meets the definition of a public hospital as of July 1 of the applicable payment adjustment year, the hospital's tentative adjusted projected total payment adjustment amount shall be multiplied by a "public hospital adjustment factor." The applicable adjustment factor shall be derived as follows:

(i) The tentative adjusted projected total payment adjustment amounts determined under paragraph h. for each public hospital described above shall be added together.

(ii) The amount identified in paragraph b. shall be reduced by the sums of the amounts determined for all nonpublic/converted hospitals under subparagraph (1) and all converted hospitals under subparagraph (2), and the sum of the amounts determined for all nonpublic hospitals under subparagraph (3).

(iii) The applicable adjustment factor shall be that ratio that results from dividing the amount derived in subclause (ii) by the amount derived in subclause (i).

(b) The resulting product shall be the final adjusted projected total payment adjustment amount for the hospital for the period October 1 through June 30 of the applicable payment adjustment year, which shall be paid to the hospital in accordance with paragraph ***k. to the extent paragraph*** j. ***does not apply***. In no case, however, shall the final adjusted projected total payment adjustment amount exceed the hospital's OBRA 1993 payment limitation, and, where such would otherwise occur, the remaining amount that would have

been allocated to the particular hospital shall be reallocated to all other public hospitals (that have not reached their OBRA 1993 payment limitation) on a descending pro rata basis so that the aggregate sum of the final adjusted projected total payment adjustment amounts for all public hospitals equals the amount derived in subclause (II) of clause (a).

j. If the Mental Health Limitation specified in subsection 6. of Section D. is applicable for the payment adjustment year, the amount computed under paragraph i. for each mental health facility shall be reduced on a pro-rata basis to the extent the aggregate payment for mental health facilities computed under paragraph i. exceeds the limitation in subsection 6. of Section D. the amount so reduced shall be used for purposes of paragraph k.

k. The final adjusted projected total payment adjustment amount determined for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year shall be distributed to the hospital in 8 equal installments, each payable as of the last day of each month from October through May of the applicable payment adjustment year. However, no hospital shall receive an installment for any month in which the hospital does not remain in operation for the entire month. To the extent that any hospital of either of the hospital types described in subparagraph (3) or (4) of paragraph i. is not entitled to receive an installment that otherwise would be payable but for the hospital's failure to remain in operation through the last day of a particular month, the amount that would have been paid to the hospital shall be redistributed among those hospitals of the same hospital type that remain in operation from October 1 through June 30 of the applicable payment adjustment year, to be distributed on a pro rata basis. The redistributed amounts shall be payable as of June 30 of the applicable payment adjustment year.

l. If, with respect to the 2001-02 payment adjustment year or any subsequent payment adjustment year, the amount identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code exceeds the amount of eight hundred seventy-seven million dollars ($877,000,000), the Department shall implement the provisions of paragraphs a. through j. with respect to the applicable payment adjustment year as modified below.

(1) The Department shall determine the maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules.

(2) The Department shall calculate the maximum state disproportionate share hospital allotment for California, by substituting in the calculation the amount of eight hundred seventy-seven million dollars ($877,000,000), as though that amount was identified for California for the applicable federal fiscal year pursuant to Section 1396r-4(f) of Title 42 of the United States Code.

(3) The amount determined under subparagraph (2) shall be subtracted from the amount determined under subparagraph (1)

(4) For purposes of the calculations set forth in paragraph h. regarding each hospital's tentative adjusted projected total payment adjustment amount, the initial amount as set forth in paragraph b. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

(5) The difference derived in subparagraph (3) shall be divided by the amount determined in subparagraph (2).

(6) For purposes of the determination made under clause (a) of subparagraph (1) of paragraph i. regarding nonpublic/converted hospitals that also meet the definition of a major teaching hospital, the amount of thirty-five million eight hundred thousand dollars ($35,800,000) as specified therein shall be multiplied by a number equal to the sum of the fraction derived in subparagraph (5) plus the number 1.00.

(7) The fraction derived in subparagraph (5) shall be multiplied by 1.226, and the result thereof added to 1.00, yielding a factor for purposes of modifying the determination of the applicable nonpublic hospital adjustment factor pursuant to subparagraphs (8) and (9).

(8) The amount derived under subclause (ii) of clause (a) of subparagraph (3) of paragraph i shall be multiplied by the factor derived in subparagraph (7) prior to the application of the increase set forth in subclause (iii) of clause (a) of subparagraph (3) of paragraph i., as such increase is modified by subparagraph (9) below

(9) The increase that is applied in subclause (iii) of clause (a) of subparagraph (3) of paragraph i. shall be equal to the product of the medical assistance increment multiplied by the maximum amount derived in subparagraph (2).

(10) For purposes of the calculations set forth in clause (a) of subparagraph (4) of paragraph i. regarding the determination of the applicable public hospital adjustment factor, the initial amount as set forth in paragraph b. shall, in each instance prior to its application in those calculations, be increased by the amount derived in subparagraph (3).

m. No eligible hospital shall receive total payment adjustments for the applicable payment adjustment year in excess of the hospital's OBRA 1993 payment limitation as computed by the Department pursuant to Section J.

n. The aggregate sum of the final adjusted projected total payments adjustment amounts computed under paragraph i. ***and*** *j.* for each eligible hospital for the period October 1 through June 30 of the applicable payment adjustment year shall be the maximum size of the payment adjustment program for the entire payment adjustment year, exclusive of the supplemental payment adjustments provided for under subsection 3.

3. Supplemental Lump-Sum Payment Adjustments - June 30.

a. For the 2001-02 payment adjustment year and each subsequent payment adjustment year, eligible hospitals that meet the requirements of this subsection and that are in operation as of June 30 of the applicable payment adjustment year shall be eligible to receive a supplemental lump-sum payment adjustment, which shall be payable as a result of the facility being a disproportionate share hospital in operation as of that date, but only if the hospital has remained in operation for the period October 1 through June 30 of the applicable payment adjustment year.

b. The availability of supplemental lump-sum payment adjustments under this subsection shall be determined as follows:

(1) The maximum state disproportionate share hospital allotment for California under the provisions of applicable federal Medicaid rules shall be identified for the applicable federal fiscal year

(2) The total amount of all payment adjustment amounts under this Attachment (exclusive of any payments under this subsection) applicable to the applicable federal fiscal year, whether paid or payable, shall be determined. The applicability of payment adjustment amounts to the federal fiscal year shall be determined in accordance with federal Medicaid rules.

(3) The figure determined under subparagraph (2) shall be subtracted from the figure identified under subparagraph (1). If the remainder is a positive figure, supplemental lump-sum payment adjustments shall be made under this subsection.

(4) The maximum amount of supplemental lump-sum payment adjustments under this subsection shall be the positive remainder derived in subparagraph (3).

c. For purposes of supplemental lump-sum payment adjustments under this subsection, only hospitals that can be categorized into either of the two groups specified in subparagraphs (1) and (2) below shall be eligible to receive the supplemental payment adjustments, and no hospital may qualify for more than one of the two groups. The following groups of hospitals shall be recognized:

(1) "Public hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a public hospital.

(2) "Nonpublic hospitals," which shall include all eligible hospitals that, as of July 1 of the applicable payment adjustment year, met the definition of a nonpublic hospital.

d. The amount determined to be the maximum amount of supplemental lump-sum payment adjustments under paragraph b. shall first be allocated between the two groups of hospitals referred to in paragraph c. as follows:

(1) "Public hospitals": 75.00% of that amount which is equal to the maximum amount identified in subparagraph (4) of paragraph b. of this subsection 3.

(2) "Nonpublic hospitals". That amount equal to the maximum amount identified in subparagraph (4) of paragraph b. of this subsection 3 less the amount allocated to public hospitals determined under subparagraph (1)

e. The amount of funds allocated pursuant to paragraph d. shall then be distributed as supplemental lump-sum payment adjustments among the eligible hospitals within each particular group as follows:

(1) The Department shall identify for each eligible hospital the total amount of payment adjustments under this Attachment (exclusive of any payments under this subsection) applicable to the payment adjustment year, whether paid or payable. The applicability of the payment adjustment amounts to this period of time shall be determined in accordance with federal Medicaid rules.

(2) The amount identified for each hospital under subparagraph (1) shall be compared to the OBRA 1993 payment limitation that, in accordance with Section J., the Department has computed for the particular hospital for the applicable payment adjustment year.

(3) Where the amount computed under subparagraph (1) for the particular hospital is equal to or exceeds the OBRA 1993 payment limitation for the hospital, the hospital shall not receive a supplemental lump-sum payment adjustment. Data regarding hospitals that have reached this limitation shall not be used for purposes of subparagraphs (5) through (8).

(4) Where the amount computed under subparagraph (1) for the particular hospital is less than the OBRA 1993 payment limitation for the hospital, the amount computed under subparagraph (1) shall be used for purposes of subparagraphs (5) through (8).

(5) The amounts identified under subparagraph (4) for each hospital in the particular group shall be added together to determine an aggregate total for each group.

(6) The figures determined for each hospital under subparagraph (4) shall be divided by the aggregate total determined under subparagraph (5) for the particular group, yielding a percentage figure for each hospital.

(7) The percentage figure determined for each hospital under subparagraph (6) shall be applied to the maximum portion of the funds allocated to the particular group under paragraph d., to determine the hospital's pro rata share of the supplemental lump-sum payment adjustments. Notwithstanding the foregoing, however, in the case of a nonpublic hospital that, as of July 1 of the applicable payment adjustment year, met the definition of a children's hospital, such pro rata share otherwise determined shall be multiplied by a factor of 1.69, yielding a modified pro rata share to be applied only with respect to the first one million dollars ($1,000,000) of the funds allocated pursuant to subparagraph (2) of paragraph d., and, with respect to the remainder of the funds so allocated, the pro rata share otherwise determined shall be multiplied by a factor of 1.09, yielding a modified pro rata share to be applied. The pro rata share for the other nonpublic hospitals shall be reduced accordingly, yielding a modified pro rata share, so that the maximum portion of the funds allocated to the nonpublic hospitals group will not be exceeded. The pro rata share or modified pro rata share, as applicable, for each hospital, as computed under this subparagraph, shall also be used for all purposes relating to descending pro rata distributions under subparagraph (8).

(8) In no event shall a hospital receive supplemental lump-sum payment adjustment amounts in excess of the difference between the OBRA 1993 payment limitation for the hospital and the amount computed for the hospital under subparagraph (1). Any supplemental lump-sum payment adjustment amount, or portion thereof, that otherwise would have been payable under this paragraph to a hospital, but that is barred by this limitation, shall be distributed on a descending pro rata basis to those hospitals within the same group.

f. The Department shall make interim and final payments of the supplemental lump-sum payment adjustments to hospitals on or before June 30 of the applicable payment adjustment year.

~~g. With respect to the 2001-02 payment adjustment year, supplemental lump-sum payment adjustments shall be determined and payable in conformance with the provisions of paragraph a. through f., except as set forth below.~~

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.

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).

TARGETED CASE MANAGEMENT SYSTEM

The methodology for computing the reimbursement rate for Targeted Case Management (TCM) services is set forth below:

1. Each regional center will utilize an average TCM unit of service rate. A TCM unit is a 15-minute increment of service.

2. The computation of the base rate (before adjusting for the California Consumer Price Index (CCPI)) is prospective and is established on the basis of historical costs. Each fiscal year, defined as the year ending June 30, the Department of Health Services (DHS) will establish a rate based upon information received from the Department of Developmental Services (DDS).

3. DDS will calculate a per unit rate for TCM services for each regional center based on twelve (12) months of regional center actual expenditure data and case management utilization factors from the fiscal year ended June 30th of the year prior to the year of calculation. All costs (direct costs, regional center administrative staff costs, operating expenses and other staff costs) used to develop the TCM rate for each individual Regional Center will be in accordance with OMB Circular A-122. Each regional center will submit expenditure information for each direct case management service classification on a Rate of Reimbursement, Schedule B, Summary of Applicable Regional Center Costs of the TCM Rate Study Package. At least once every three years, a one-month time survey will be used to determine the allowable time spent on case management services. Regional centers will receive instructions delineating allowable and non-allowable time. For example, assessments of a consumer's functioning levels, needs and progress are allowable case management services. Intake services prior to the determination that the client is developmentally disabled are not allowable case management services. The TCM rate will be calculated as described in step 4, below.

4. Utilizing the DDS consumer and DHS Medi-Cal databases, the percentage of Medi-Cal recipients will be determined based on the ratio of consumers on Medi-Cal to the total number of consumers receiving case management at the regional centers. Using this percentage DDS will:

    a. Multiply the percentage of Medi-Cal recipients by the case management costs for each direct service classification, using the expenditure information submitted pursuant to step 3, for the fiscal year ended June 30th of the year prior to the year of calculation.

    b. Multiply the case management costs per Medi-Cal recipient determined in step 4 a by the percentage of allowable case management time determined in step 3.

c. DDS will determine the appropriate allocation of regional center administrative staff costs, operating expenses and other staff costs to case management services by multiplying these costs by the percentage taken from an annual time survey of administrative staff for the year ended June 30th of the year prior to the year of calculation.

d. The regional center administrative staff costs, operating expenses and other staff costs derived in step 4 c, above, will then be multiplied by the percentage of Medi-Cal recipients, derived in step 4 a, above, to arrive at the regional center administrative staff costs, operating expenses and other staff costs applicable to Medi-Cal recipients.

e. Total allowable direct service costs, regional center administrative staff costs, operating expenses and other staff costs for Medi-Cal recipients, derived pursuant to steps a through d above, will be divided by the TCM units recorded during the year ended June 30th of the year prior to the year of calculation to arrive at a per unit rate for TCM services and regional center administrative costs.

5. Regional centers will submit data that reflects Medi-Cal allowable costs that are determined in accordance with cost reimbursement principles identified in 42 C.F.R. Part 413, and to the extent not governed by Part 413, in accordance with Generally Accepted Accounting Principles and OMB Circular No. A-122.

6. The new per unit rate will be effective July 1st of the fiscal year following the year of calculation, adjusted prospectively by the CCPI.

7. For the period of May 3, 2003, through June 30, 2005, DDS will submit for DHS' approval, a one-time, twenty-six (26) month transitional per unit rate for TCM services for each regional center based on the regional center's expenditures and data for the fiscal year ending June 30, 2001, and adjusted for the CCPI. DDS will submit revised invoices for the transition period reflecting previous claims, revised claims using the transitional rate, and the difference between the two rates.

8. Each year, DDS will submit to DHS the data and calculations that are developed, or were submitted, to respond to the requirements of steps 1 – 7, above.

MEDI-CAL CLAIMING PROCESS

1. TCM services will be documented by the case manager on a Medi-Cal eligible, client specific, activity log. (See page 5c of this supplement, which is an example of the documenting instrument to be employed by the regional centers.) The date of service, the case manager providing the service, the units of service (recorded in 15-minute increments of the service time), an explanation of the type of service, and the location of the service will be recorded on the activity logs. The total units of

service provided to each Medi-Cal recipient eligible for TCM services will then be tallied at the end of each month by the regional center and submitted to DDS. The regional center will retain a copy of the activity log for auditing purposes.

2. DDS will prepare a computer tape which contains the Medi-Cal eligible's name, gender, date of birth, Medi-Cal identification number, social security number, the provider number (regional center), the month service was provided, and total units of service provided during the month. This tape will be run against the Single State Agency's (DHS) master file of Medi-Cal eligibles. In California, this system is the Medi-Cal Eligibility Data System (MEDS).

3. DDS will certify to DHS, the single state agency, the extent of state funds expended as necessary for federal financial participation.

4. An invoice will be prepared by DHS and submitted to the Centers for Medicare & Medicaid Services for all regional center clients receiving TCM services who have been verified as Medi-Cal eligible (via computer match) for the month in which the service(s) was provided.

STATE OF CALIFORNIA -- DDS

CASE MANAGER CODE: 300 ATTACHMENT 1
CASE MANAGER NAME: WILLIAM PERRY

TARGETED CASE MANAGEMENT LOG
FOR THE MONTH OF JANUARY 1995

CLIENT NAME: JONES JOHN
CLIENT UCI: 4500201

CLIENT MEDI-CAL #:_____

DAY OF MONTH	ACTIVITY CODE	NUMBER OF UNITS	CLARIFICATION OF ACTIVITY CODE

TOTAL UNITS _____ SIGNATURE OF CASE MANAGER:_____

Reimbursement Methodology for Case Management Services as described in Supplements 1a, 1b, 1e and 1f to Attachment 3.1-A

1) Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter.

2) An encounter is defined as a face-to-face contact or a significant telephone contact in lieu of a face-to face contact when environmental considerations preclude a face-to-face encounter, for the purpose of rendering one or more TCM service components by a case manager.

3) A current year per encounter rate shall be established after evaluation of the total costs of providing case management services and the total number of encounters as reflected in the prior year cost report, defined by the department. The cost report shall accumulate allowable costs for the prior fiscal year, including both direct and indirect costs, as defined in OMB Circular A87.

   The per encounter rate is calculated by dividing the prior fiscal year costs of providing TCM services by the total number of encounters in that fiscal year. The per encounter rate is then multiplied by the projected number of encounters with Medicaid eligible persons to establish the total dollar amount that may be claimed in the current fiscal year.

   Total Medicaid reimbursement in the current year shall not exceed the product of:

   a. the projected number of Medicaid encounters for the current fiscal year; and
   b. the prior fiscal year costs of providing TCM services divided by the total number of encounters in that fiscal year.

   The costs associated with providing TCM services in the current fiscal year in excess of the total dollar amount for which reimbursement is made, are recognized in the cost report and become part of the calculation to determine the per encounter rate for the subsequent fiscal year.

4) Cost reports shall be due each year on or before November 1, for determination of the rate in the subsequent fiscal year. A certification statement, signed by a county-approved signator, shall accompany the cost report and attest to the validity and allowability of the cost data.

5) The department shall ensure "free care" and "third party liability" requirements are met.

6) The department shall conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

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

Reimbursement Methodology for Case Management Services as described in Supplement 1c to Attachment 3.1-A

1) Providers participating in Targeted Case Management (TCM) will be required to submit a annual survey identifying:

   a. labor costs of performing TCM services; and
   b. overhead costs related to performing TCM.

2) The unit of service shall be a 15 minute case manager time increment on an individual beneficiary basis and billed through Electronic Data Systems (EDS).

3) Payments for TCM services will be issued by EDS directly to the providers of these services. The Department will work with EDS on:

   a. establishing and implementing the reimbursement process; and
   b. determining the appropriate edits and audits to ensure program integrity.

4) The department shall ensure "free care" and "third party liability" requirements are met.

5) The department shall conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

6) Statewide hourly tiered rates will be established based on the annual survey submitted and will be grouped into low, medium, and high cost categories. Provider rates would be averaged for each of the 3 categories, providing the rate to be used by that grouping of providers.

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

Reimbursement Methodology for Case Management Services as described in Supplement 1d to Attachment 3.1-A

1) Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter.

2) An encounter is defined as a face-to-face encounter, or a significant telephone contact with or on behalf of the Medicaid eligible person, for the purpose of rendering one or more TCM service components by a case manager.

3) A current year per encounter rate shall be established after evaluation of the total costs of providing case management services and the total number of encounters as reflected in the prior year cost report, defined by the department. The cost report shall accumulate allowable costs for the prior fiscal year, including both direct and indirect costs, as defined in OMB Circular A87.

The per encounter rate is calculated by dividing the prior fiscal year costs of providing TCM services by the total number of encounters in that fiscal year. The per encounter rate is then multiplied by the projected number of encounters with Medicaid eligible persons to establish the total dollar amount that may be claimed in the current fiscal year.

Total Medicaid reimbursement in the current year shall not exceed the product of:

a. the projected number of Medicaid encounters for the current fiscal year; and
b. the prior fiscal year costs of providing TCM services divided by the total number of encounters in that fiscal year.

The costs associated with providing TCM services in the current fiscal year in excess of the total dollar amount for which reimbursement is made, are recognized in the cost report and become part of the calculation to determine the per encounter rate for the subsequent fiscal year.

4) Cost reports shall be due each year on or before November 1, for determination of the rate in the subsequent fiscal year. A certification statement, signed by a county-approved signator, shall accompany the cost report and attest to the validity and allowability of the cost data.

5) The department shall ensure "free care" and "third party liability" requirements are met.

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

6) The department shall conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A

Case management services will be provided by licensed and certified Public Health Nurses (PHN) who are experienced in providing case management services and who are employed by a jurisdiction's local health department.

Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter with Title XIX eligible infants, children, and young adults to age 21.

An encounter is defined as a face-to-face contact or a significant telephone contact with the Title XIX eligible individual or with the individual or legal guardian designated to act on behalf of the Title XIX eligible individual.

The reimbursement process is as follows:

1. The Department of Health Services, Childhood Lead Poisoning Prevention Branch (CLPPB) budget for fiscal year 1996-97, includes State General Funds for the provision of Medi-Cal Lead Poisoning Case Management Services to lead poisoned Med-Cal eligibles to age 21 by each jurisdiction's local health department.

2. For each jurisdiction's local health department, the CLPPB will calculate the estimated amount of per encounter costs based upon the statewide average cost of a Public Health Nurse (PHN) Medi-Cal Lead Poisoning Case Management encounter, the number of each jurisdiction's local health department's Medi-Cal eligibles to age 21 at risk for lead poisoning, and the number of each jurisdiction's local health department's lead poisoned Medi-Cal eligibles to age 21 currently receiving case management services.

3. The projected amount of State General Funds set aside for each jurisdiction's local health department will enable jurisdiction's local health departments to develop an annual Medi-Cal Lead Poisoning Case Management budget.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

Claims for federal financial participation reimbursement will be made retrospectively after Medi-Cal Lead Poisoning Case Management services have been provided and documented in each Medi-Cal eligible's chart and PHN personnel time is documented.

4. Each jurisdiction's local health department will conduct a regularly scheduled time study following federal OMB A-87 approved time study methodology. The time study will capture the PHN time spent providing case management services to both Medi-Cal and non-Medi-Cal eligibles in one or more components of case management services, such as assessment, plan development, referral, assistance in accessing services, follow-up crisis intervention planning, reevaluation, or on other activities that are directly related to the provision of case management services.

5. Each jurisdiction's local health department will establish a rate for case management services provided to Medi-Cal eligibles. The rate will be derived from the annual budget, which contains salary and benefits, and time studies that show time spent performing case management services, including travel. The total cost of providing case management services to Medi-Cal eligibles will be divided by the total number of Medi-Cal eligibles receiving case management services during the time-study period to arrive at a rate per Medi-Cal eligible.

6. Each jurisdiction's local health department will develop invoices for reimbursement of case management services provided to Medi-Cal eligibles. Invoices will be submitted quarterly to the Childhood Lead Poisoning Prevention Branch.

7. Each jurisdiction's local health department will maintain documentation in support of invoices submitted for case management services. The documentation will include:
   a. Date of service,
   b. name of Medi-Cal eligible,
   c. name of provider agency and person providing the case management service,
   d. nature, extent, or units of service,
   e. place of service, and
   f. completed time study for each case manager.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

Case Management

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

8. Fiscal monitoring will be conducted using an audit trail that includes a) the name, classification, duty statement, and amount of PHN time identified on the local health jurisdiction's budget submitted to and approved by the DHS/CLPPB; b) quarterly invoices submitted for reimbursement of PHN case management services; c) the time study identifying PHN time spent providing Medi-Cal Lead Poisoning Case Management services; and d) the PHN's field record documenting the recipient's Medi-Cal status, lab report documenting the Medi-Cal recipient's elevated blood lead level, the CLPPB Follow-up Form and PHN service plan that documents receipt of necessary follow-up activities.

9. The department shall ensure free care and third party liability requirements are met.

10. The department shall conduct an annual survey of insurance carriers to determine whether case management services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey result will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

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

CASE MANAGEMENT SERVICES

Reimbursement Methodology for Case Management Services as described in Supplement 1h to Attachment 3.1-A

1) Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter.

2) An encounter is defined as a face-to-face contact.

3) A current year per encounter rate shall be established after evaluation of the total costs of providing case management services and total number of encounters as reflected in the prior year cost report, defined by the department. The cost report shall accumulate allowable costs for the prior fiscal year, including both direct and indirect costs, as defined in OMB Circular A87.

   The per encounter rate is calculated by dividing the prior fiscal year costs of providing TCM services by the total number of encounters in that fiscal year. The per encounter rate is then multiplied by the projected number of encounters with Medicaid eligible persons to establish the total dollar amount that may be claimed in the current fiscal year.

   Total Medicaid reimbursement in the current year shall not exceed the product of:

   a. The projected number of Medicaid encounters for the current fiscal year; and
   b. The prior fiscal year costs of providing Targeted Case Management services divided by the total number of encounters in that fiscal year.

   The costs associated with providing Targeted Case Management services in the current fiscal year in excess of the total dollar amount for which reimbursement is made, are recognized in the cost report and become part of the calculation to determine the per encounter rate for the subsequent fiscal year.

4) Cost reports shall be due each year on or before November 1, for determination of the rate in the subsequent fiscal year. A certification statement, signed by a county-approved signatory, shall accompany the cost report and attest to the validity and allowability of the cost data.

5) The department shall ensure "free care" and "third party liability" requirements are met.

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

CASE MANAGEMENT SERVICES

Reimbursement Methodology for Case Management Services as described in Supplement 1h to Attachment 3.1-A (Continued)

6) The department shall conduct an annual survey of insurance carriers to determine whether Targeted Case Management services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

STATE PLAN AMENDMENT
PROSPECTIVE PAYMENT REIMBURSEMENT

A. General Applicability

1. Notwithstanding any other provision of this State Plan, reimbursement to all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for the types of services described in this Amendment will be made as set forth below. This Amendment will apply to Medi-Cal Services furnished to Medi-Cal beneficiaries for purposes of implementing Section 1902(bb) of the Social Security Act (the Act).

2. Under the California Section 1115 Medicaid Demonstration Project for Los Angeles No. 11 W-00076/9 (LA Waiver), specified FQHCs (or "FQHC look alike clinics") received 100 percent cost-based reimbursement under the Special Terms and Conditions of that waiver. Beginning July 1, 2005, FQHCs that received cost-based reimbursement under the LA Waiver will be paid under the methodology described under Section I.

3. Any facility that first qualified as an FQHC or RHC (as defined in Section B) prior to the close of its fiscal year ending in calendar year 2000 was reimbursed through the prospective payment methodology described under Section D, unless, within 30 days of written notification from DHS, the facility elected to be reimbursed under the alternative payment methodology described under Section E. If the alternative payment methodology described under Section E was selected by the facility, the initial selection of a payment methodology remained in effect through September 30, 2002.

4. Prior to October 1, 2002, each FQHC and RHC was required to choose a reimbursement method and to inform DHS of its election. The choice was whether its reimbursement rate calculation, which was to serve as the basis for all future Medicare Economic Index (MEI) increases and scope-of-service changes, would be either of the following:

   (1) The prospective payment reimbursement methodology described under Section D.

   (2) The alternative payment reimbursement methodology described under Section E.

For purposes of this segment of the State Plan, relating to prospective reimbursement for FQHCs and RHCs, the MEI is the annual percentage increase in costs as defined in Section 1842(i)(3) of the Act for primary care services, defined in Section 1842(i)(4) of the Act. The MEI is published each year in the Federal Register. The base rate selected for purposes of reimbursement under the methodology described under Section D or Section E is inclusive of the MEI increases that applied prior to October 1, 2002, as described under Section D and Section E. An FQHC or RHC that failed to notify DHS of its election of the alternative payment methodology within 30 days of written notification was assigned a reimbursement rate calculated using the prospective payment methodology described under Section D.

5. Provider-based entities are defined as the following:

(a) An FQHC that was provider-based as of July 1, 1998, or that had provider-based status pending on April 22, 1999, and has received Medi-Cal payments based on its provider-based status continuously since that date, was paid under either the prospective payment methodology (Section D) or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its FQHC provider-based status. The term "appropriately adjusted" means that an FQHC's provider-based rate includes the amount of the hospital's total costs allocable to the FQHC. These costs are in addition to those costs directly attributable to the operation of the FQHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If an FQHC receives "FQHC provider-based" designation under Medicare, pursuant to 42 CFR Part 413.65(n), from CMS, the FQHC may apply to DHS for Medi-Cal provider-based FQHC reimbursement status. Upon verification of such status, the FQHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its FQHC provider-based status.

(b) In accordance with 42 CFR Section 491.3, an RHC that received provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", will continue to be paid under either the prospective payment methodology (Section D), or the alternative payment methodology (Section E), as appropriately adjusted in accordance with its RHC provider-based status. The term "appropriately adjusted" in this context means that an RHC's provider-based rate includes the amount of the hospital's shared costs allocable to the RHC. These costs are in addition to those

costs directly attributable to the operation of the RHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If subsequent to the approval of this State Plan Amendment, an RHC receives provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", pursuant to 42 CFR Part 413.65, the RHC may apply to DHS for Medi-Cal provider-based RHC reimbursement status pursuant to 42 CFR Part 491.3. Upon verification of such status, the RHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its RHC provider-based status.

6. An FQHC or RHC may elect to have pharmacy services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. An FQHC or RHC that elects to have pharmacy services reimbursed on a fee-for-service basis will not have its reimbursement rate for those services converted to a fee-for-service basis until the FQHC or RHC completes a scope-of-service rate change request and the adjustment to the prospective payment system reimbursement rate has been completed. An FQHC or RHC that reverses its election under this provision will revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period adjusted for any increase or decrease associated with an applicable scope-of-service change as provided in Section K.

B. FQHCs and RHCs Eligible for Reimbursement Under This Amendment

FQHCs and RHCs eligible for prospective or alternative payment reimbursement are those defined as a "Federally Qualified Health Center" or "Rural Health Clinic" in Section 1905(l)(2)(B), and Section 1905(l)(1), respectively, of the Act.

C. Services Eligible for Reimbursement Under This Amendment

1. Services eligible for prospective or alternative payment reimbursement are covered benefits described in Section 1905(a)(2)(C) of the Act that are furnished by an FQHC and services described in Section 1905(a)(2)(B) of the Act that are furnished by an RHC. The services furnished will be reported to DHS annually, in a format prescribed by DHS.

2. A "visit" for purposes of reimbursing FQHC or RHC services includes any of the following:

   (a) A face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse

midwife, clinical psychologist, licensed clinical social worker, or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits under C.1. For purposes of this subparagraph 2(a), "physician" includes the following:

(i) A doctor of medicine or osteopathy licensed by the State to practice medicine and/or surgery and who is acting within the scope of his/her license.

(ii) A doctor of podiatry licensed by the State to practice podiatric medicine and who is acting within the scope of his/her license.

(iii) A doctor of optometry licensed by the State to practice optometry and who is acting within the scope of his/her license.

(iv) A chiropractor licensed by the State in the practice of chiropractic and who is acting within the scope of his/her license.

(v) A doctor of dental surgery (dentist) licensed by the State to practice dentistry and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

(b) Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner as defined in the California Code of Regulations, title 22, Section 51179.7.

(c) Adult Day Health Care (ADHC) services when all of the following requirements are met:

(i) ADHC services are provided pursuant to the requirements of California Code of Regulations, title 22, chapter 5, articles 1 through 5 (commencing with Section 54001, including Section 54113, which requires four or more hours of ADHC services per day be provided).

(ii) An FQHC or RHC providing the ADHC services has received approval from the federal Human Resources and Services Administration (HRSA) to provide ADHC services to the extent required by law.

(iii) The ADHC services are included in the State Plan.

3. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

(a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.

(b) The clinic patient has a face-to-face encounter with a dentist and then also has a face-to-face encounter with any one of the following providers: physician (as defined in subparagraphs C.2(a)(i)-(iv)), physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, comprehensive perinatal services practitioner or ADHC provider.

D. Prospective Payment Reimbursement

An FQHC or RHC that does not elect the alternative payment reimbursement methodology under Section E will receive reimbursement under the following prospective payment reimbursement methodology provisions:

1. On July 1, 2001, DHS implemented a prospective payment reimbursement methodology on a phased-in basis. Each FQHC or RHC receives payment in an amount calculated using the methodology described under paragraphs D.2 and D.4 effective the first day of the fiscal year on or after July 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section D became effective for a particular facility, each FQHC or RHC was paid in accordance with Section H.

2. (a) Beginning on January 1, 2001, the prospective payment reimbursement rate for an FQHC or RHC was equal to 100 percent of the average reported cost-based reimbursement rate per visit for fiscal years 1999 and 2000 for the FQHC or the RHC, as determined in accordance with cost reimbursement principles for allowable costs explained in 42 CFR Part 413, as well as, Generally Accepted Accounting Principles. For each FQHC or

RHC, the prospective payment reimbursement rate for the first fiscal year was calculated by adding the visit rate for fiscal years 1999 and 2000, and then dividing the total by two.

(b) If the cost per visit for the period(s) used to establish the prospective payment reimbursement rate in subparagraph D.2(a) was calculated using a visit definition that does not conform to Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certify to its authenticity within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC to determine whether a rate adjustment was necessary. This subparagraph D.2(b) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

3. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week, or mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when the facility is owned or operated by the same entity, as well as, licensed or enrolled as a Medi-Cal provider.

4. Effective October 1st of each year, for services furnished on and after that date, DHS will adjust the rates established under paragraph D.2 by the percentage increase in the MEI applicable to primary care services (as defined in Section 1842(i)(4) of the Act) as published in the Federal Register for that calendar year.

5. DHS will notify each FQHC and RHC of the effect of the annual MEI adjustment.

E. Alternative Payment Methodology Using the Reported Cost-Based Rate for the Fiscal Year Ending in Calendar Year 2000

An FQHC or RHC that elected the alternative payment methodology under this Section E receives reimbursement under the following provisions:

1. Each FQHC and RHC that elected to receive payment in an amount calculated using the alternative payment methodology described in this Section E, the rate was effective the first day of the fiscal year that began on or after January 1, 2001. For the period January 1, 2001, until the payment methodology described in this Section E became effective for the

particular facility, the FQHC or RHC was paid in accordance with Section H.

(a) Payments made to each FQHC or RHC in accordance with the alternative payment reimbursement methodology set forth in this Section E will be an amount(calculated on a per-visit basis) that is, equal to its reported cost-based rate (based on allowable costs) for the particular facility's fiscal year ending in calendar year 2000, increased by the percentage increase in the MEI. DHS determines all rates in accordance with cost reimbursement principles in 42 CFR Part 413, and with Generally Accepted Accounting Principles..

(b) (i) Each participating FQHC's or RHC's reported cost-based reimbursement rate (calculated on a per-visit basis) for the particular facility's fiscal year ending in calendar year 2000 serves as its prospective payment reimbursement rate under the alternative payment reimbursement methodology.

(ii) If the cost per visit for the period used to establish the alternative payment methodology rate in subparagraph E.1(b)(i) was calculated using a visit definition that does not conform with Section C, the FQHC or RHC must submit a revised visit count and supporting documentation that conforms with Section C. The FQHC or RHC must supply the revised visit count with supporting documentation and certification of accuracy within 90 days after the date written instructions are issued by DHS. DHS must review the revised visit count and supporting documentation supplied by the FQHC or RHC in determining if a rate adjustment was necessary. Subparagraph E.1(b)(ii) was applicable to either a FQHC or a RHC that established its PPS reimbursement rate for fiscal years 1999 and 2000 exclusively.

(c) As described in more detail below, the prospective payment reimbursement rate is increased by the percentage increase in the MEI applicable to primary care services, defined in Section 1842(i)(4) of the Act, for the particular calendar year as published in the Federal Register.

(d) Beginning July 1, 2001 and thereafter, the MEI increase is applicable to the period starting with the mid-point of each FQHC's or RHC's fiscal year through the mid-point of the rate periods (January 1, 2001 through June 30, 2001 and July 1, 2001 through September 30, 2002).

For example, if a FQHC or RHC had a June 30th fiscal year end, the period determining the first MEI increase was December 31, 1999 (the FQHC's or RHC's fiscal year mid-point) through April 1, 2001 (the midpoint for the rate period January 1, 2001 through June 30, 2001). The period determining the second MEI increase was April 1, 2001 through February 15, 2002 (the midpoint for the rate period July 1, 2001 through September 30, 2002). If a FQHC or a RHC has a December 31st fiscal year end, the period determining the first MEI increase was June 30, 2000 through April 1, 2001. As in the previous example, the period determining the second MEI increase was April 1, 2001 through February 15, 2002.

(e) In accordance with Section 1902(bb)(6)(B) of the Act, in order for an FQHC or RHC to receive the rate of payment under the alternative payment methodology, the rate must be no less than the rate calculated using the methodology described in Section D.

2. Services provided at intermittent service sites that are affiliated with an FQHC or RHC that operate less than 20 hours per week or in mobile facilities are reimbursed at the rate established for the affiliated FQHC or RHC. For purposes of this paragraph, a facility is affiliated with an FQHC or RHC when it is owned or operated by the same entity and is licensed or enrolled as a Medi-Cal provider.

3. Beginning October 1, 2002, and each October 1st thereafter, for services furnished on and after October 1, 2002, DHS will adjust the rates established under paragraph E.1, by the percentage increase in the MEI (as specified in subparagraph E.1(c), above).

F. Alternative Payment Methodology for an Existing FQHC or RHC that Relocates

1. An existing FQHC or RHC that relocates may elect to have its prospective payment reimbursement rate re-determined. DHS will establish a rate (calculated on a per-visit basis) that is equal to either of the following (as selected by the FQHC or RHC):

(a) The average of the rates established for three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph is subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal

year of the facility's operation at the newly relocated site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

2. A rate established for an existing FQHC or RHC under this Section F is effective for visits occurring at the new facility.

G. Payment Methodology for Extraordinary Circumstances

1. Supplemental payments, in proportion to the Medi-Cal services provided by the facility, may be established in accordance with this Amendment to reflect the net realized additional costs (as approved by DHS), not otherwise reimbursed by other sources, incurred as a result of extraordinary circumstances attributed to any of the following:

   (a) Acts of nature (e.g., flood, earthquake, lightning, or storms).

   (b) Acts of terrorism.

   (c) Acts of war.

   (d) Riots.

   (e) Changes in applicable requirements in the Health and Safety Code.

   (f) Changes in applicable licensing requirements.

   (g) Changes in state or federal laws or regulations applicable to FQHCs or RHCs.

2. The supplemental payment provided for in this Section G will apply only to the extent, and only for the period of time, that the additional costs for the event specified in paragraph G.1 are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation.

3. Where applicable, the supplemental payment provided in this Section G will be governed by cost reimbursement principles identified in 42 CFR

Part 413, and to the extent not governed by Part 413, by Generally Accepted Accounting Principles.

4. A request for supplemental payment will be accepted by DHS at any time in the prospective payment rate year. A request will be submitted for each affected year. A written request under this Section G must be made to DHS for its consideration and must include differences in costs and visits, if applicable, associated with operations before and after the event specified in paragraph G.1. Documentation in a manner and form specified by DHS showing the cost implications must be submitted. A supplemental payment will not be paid unless the cost impact will be material and significant (two hundred thousand dollars ($200,000) or 1.0 percent of an FQHC's or RHC's total costs, whichever is less).

5. DHS will decide whether a request for supplemental payment will be granted, and the amount of such payment. Amounts granted for supplemental payment requests will be paid as lump-sum amounts for those years and not as revised PPS rates. The FQHC or RHC must repay the unspent portion of the supplemental payment to DHS if it does not expend the full amount of the supplemental payment to meet costs associated with the catastrophic event.

6. The supplemental payment provided in this Section G is independent of a rate adjustment resulting from a scope-of-service change in accordance with Section K and will only be made for a qualifying event as described in this Section G. Costs eligible for a supplemental payment under this Section will be proportionate to the Medi-Cal services provided by the facility, determined utilizing a cost report format as specified by DHS, and will not include payment for any costs recovered as scope-of-service rate change(s) under Section K.

7. When determining eligibility for a supplemental payment, the FQHC or the RHC must show that its PPS rate is not sufficient to cover the costs associated with the extraordinary circumstance. If the PPS rate is sufficient to cover the costs associated with the events specified in paragraph G.1, or the PPS rate was adjusted to compensate the events specified in paragraph G.1, then no supplemental payment will be made.

H. Alternative Payment Methodology for Retroactive Reimbursement

1. For the period January 1, 2001, until the date that a particular FQHC or RHC begins to receive payment pursuant to the methodology set forth in Section D or Section E, such FQHC or RHC may elect to retroactively receive reimbursement under Section D or Section E, or to decline such reimbursement. An FQHC or RHC that fails to make an election within 30 days of written notification from DHS will receive retroactive payment

to January 1, 2001, under the prospective payment methodology described under Section D.

2. An FQHC or RHC that elected in writing to decline retroactive reimbursement under both Section D and Section E may continue to be paid under the cost-based reimbursement methodology as in effect prior to BIPA 2000 until payments under Section D or Section E take effect, subject to the requirements of Section 1902(bb)(6) of the Act, and to cost reconciliation when appropriate.

I. Alternative Payment Methodology for FQHCs Participating Under the LA Waiver

1. The LA Waiver expired on July 1, 2005. FQHCs participating in the LA Waiver that were established as an FQHC (as defined in Section B) prior to 1999 and elected to remain under cost-based reimbursement must convert to a prospective payment system reimbursement rate, effective July 1, 2005. FQHCs as described above must choose one of the following options for calculating their prospective payment system reimbursement rate:

   (a) Utilize the average of their "as reported" FY 1999 and FY 2000 cost reports, plus adjustments for the annual MEI increases described under paragraphs D.2-5.

   (b) Utilize only the "as reported" FY 2000 cost report, plus adjustments for annual MEI increases as described under subparagraph E.1(a)-(e) and paragraph E.3.

2. On October 1, 2005 and each October 1st thereafter, DHS will adjust the rate established under subparagraphs I.1(a) or (b) by the applicable percentage increase in the MEI, as specified in paragraph D.4 or paragraph E.3.

3. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 1999, but prior to the close of their FY 2000 will have their prospective payment system reimbursement rate calculated according to the methodology described in subparagraph I.1(b) above, and will have their prospective payment system reimbursement rate adjusted in accordance with paragraph I.2 above.

4. Clinics participating in the LA Waiver that attained FQHC designation (as defined in Section B) after FY 2000 will have their prospective payment system reimbursement rate calculated based on the first full fiscal year "as audited" cost report adjusted by the applicable MEI increase(s) to bring the prospective payment system reimbursement rate current to July 1,

2005, and will also have their prospective payment system reimbursement rate adjusted in accordance with paragraph I.2 above.

5. FQHCs that failed to elect an option by June 30, 2005, under either subparagraphs I.1(a) or (b) above, will be assigned the prospective payment system reimbursement rate described in Section I.1(a).

6. FQHCs participating in the LA Waiver that had applicable scope-of-service change(s) prior to July 1, 2005, must submit a scope-of-service change request describing the qualifying event. FQHCs must submit a scope-of-service change request no later than July 1, 2006.

J. Rate Setting for New Facilities

1. For the purpose of this Section J, a new facility is an FQHC or RHC (as defined in Section B) that meets all applicable licensing or enrollment requirements, and satisfies any of the following characteristics:

   (a) First qualifies as an FQHC or RHC after its fiscal year ending on or after calendar year 2000.

   (b) A new facility at a new location is added to an existing FQHC or RHC and is licensed or enrolled as a Medi-Cal provider.

2. DHS will require that the new facility identify at least three comparable FQHCs or RHCs providing similar services in the same or an adjacent geographic area with similar caseload. If no comparable FQHCs or RHCs are in operation in the same or an adjacent geographic area, the new facility will be required to identify at least three comparable FQHCs or RHCs in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics. If the facility is unable to identify three comparable FQHCs or RHCs, DHS will identify at least three comparable facilities with respect to relevant social, health care, and economic characteristics.

3. At a new facility's one time election, DHS will establish a rate (calculated on a per visit basis) that meets the requirements of Section 1902(bb)(4) of the Act and that is equal to one of the following:

   (a) The average of the rates established for the three comparable FQHCs or RHCs, as verified by DHS from information submitted as required under paragraph J.2. The prospective payment reimbursement rate established under this subparagraph will be subject to the annual MEI increases as described in paragraph D.4.

(b) Reimbursement at 100 percent of the projected allowable costs of the facility for furnishing services in the facility's first full fiscal year of the facility's operation at the new site. The projected allowable costs for the first fiscal year will be cost settled and the prospective payment reimbursement rate will be based on actual cost per visit. The prospective payment reimbursement rate, so established, will apply retrospectively to all services provided at the new site. After the facility's first fiscal year of operations at the new site, the prospective payment reimbursement rate established under this subparagraph, which is based on the projected allowable costs, will be subject to the annual MEI increases described in paragraph D.4.

4. If a new facility does not respond within 30 days of DHS' request for three comparable FQHCs or RHCs as described in subparagraph J.3(a) or the projected allowable costs as described in subparagraph J.3(b), DHS will suspend processing of the new facility's request for reimbursement as an FQHC or RHC, until the required information has been provided.

5. The effective date for the rate of a new facility under Section J is retroactive to the later of the date that the licensed FQHC or RHC was federally qualified as an FQHC or RHC, or the date a new FQHC or RHC at a new location was added to an existing FQHC or RHC as a licensed or enrolled Medi-Cal provider.

   (a) An FQHC or RHC may continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number. Until its FQHC or RHC provider number is received, a facility must not bill the Medi-Cal program using the FQHC or RHC provider number of another facility. The preceding sentence will not apply to intermittent service sites that are affiliated with an FQHC or RHC and that operate less than 20 hours per week or in mobile facilities.

   (b) DHS will reconcile the difference between the fee-for-service payments and the FQHC's or RHC's PPS rate following notification to the provider that its FQHC or RHC number has been activated.

6. In order to establish comparable FQHCs or RHCs providing similar services, DHS will require all FQHCs or RHCs to submit to DHS either of the following:

(a) Its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report.

(b) A similar report utilizing a format as specified by DHS applicable to the prior calendar year.

FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit a completed report in the format used in the prior calendar year. A new FQHC or RHC that has not previously submitted an annual utilization report will submit an annual utilization report or similar report as specified by DHS.

K. Scope-of-Service Rate Adjustments

An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope-of-services provided by the FQHC or RHC, subject to all of the following:

1. A change in costs, in and of itself, will not be considered a scope-of-service change unless all of the following apply:

   (a) The increase or decrease in cost is attributable to an increase or decrease in the scope of the services defined in paragraph C.1.

   (b) The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.

   (c) The change in the scope-of-services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

   (d) The net change in the FQHC's or RHC's per-visit rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs or RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold will be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. "Net change" means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

2. Rate changes based on a change in the scope-of-services provided by an FQHC or RHC will be evaluated in accordance with Medicare reasonable cost principles, as set forth in 42 CFR Part 413, or its successor. Subject

to the conditions set forth in subparagraphs (a) through (d), inclusive, of paragraph (1), a change in scope-of-service means any of the following:

(a) The addition of a new FQHC or RHC service (such as adding dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is not included in the existing prospective payment system reimbursement rate, or the deletion of an FQHC or RHC service (such as deleting dental services, another health professional service, or other Medi-Cal covered services that do not require a face-to-face visit with an FQHC or RHC provider, for example, laboratory, x-rays) that is included in the existing prospective payment system reimbursement rate.

(b) A change in service described in paragraph C.1 due to amended regulatory requirements or rules.

(c) A change in service described in paragraph C.1 resulting from either remodeling an FQHC or RHC, or relocating an FQHC or RHC if it has not elected to be treated as a newly qualified clinic under Section F.

(d) A change in types of services described in paragraph C.1 due to a change in applicable technology and medical practice utilized by the center or clinic.

(e) An increase in the intensity of a service described in paragraph C.1 attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(f) Changes in any of the services described in paragraph C.1, or in the provider mix of an FQHC or RHC or one of its sites.

(g) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in paragraph C.1, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(h) Costs incurred by an FQHC or RHC for indirect medical education adjustments and any direct graduate medical education payment necessary for providing teaching services to interns and residents

at the FQHC or RHC that are associated with a modification of the scope of any of the services described in paragraph C.1.

(i) A change in the scope of a project approved by HRSA where the change impacts a covered service described in paragraph C.1.

3. An FQHC or RHC may submit a request for scope-of-service changes once per fiscal year, within 150 days of the beginning of the FQHC's or RHC's fiscal year following the year in which the change occurred. Any approved increase or decrease in the provider's rate will be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

4. An FQHC or RHC must submit a scope-of-service rate change request within 150 days of the beginning of any FQHC's or RHC's fiscal year occurring after the effective date of this Section K, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope-of-services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If any FQHC or RHC discontinues providing onsite pharmacy or dental services, it must submit a scope-of-service rate change request within 150 days of the beginning of the fiscal year following the year in which the change occurred. As used in this paragraph, "significantly lower" means an average per-visit rate decrease in excess of 2.5 percent.

5. Notwithstanding paragraph K.4, if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change will be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph must be submitted within 150 days after the adoption and issuance of the written instructions by DHS.

6. The reimbursement rate for scope-of-service changes implemented within the FQHC's or RHC's fiscal year ending in calendar year 2004 and subsequent fiscal years will be calculated as follows:

(a) If DHS determines that documentation submitted by the FQHC or RHC accurately reflects the cost per-visit rate calculation for that particular year, DHS will subtract the current PPS per-visit rate from the newly calculated per-visit rate for that particular year. The "current PPS per-visit rate" means the PPS per-visit rate in effect on the last day of the reporting period during which the scope-of-service change occurred.

(b) The difference computed as in 6(a), between the newly calculated cost per-visit rate and the current PPS per-visit rate, is then multiplied by an 80 percent adjustment factor to arrive at an amount that is to be considered applicable to a scope-of-service adjustment for that year.

(c) That 80 percent adjustment amount is then added to the current PPS rate and the newly established rate becomes the newly adjusted PPS reimbursement rate, effective the first day following the fiscal year end that the FQHC or RHC submitted the documentation for the scope-of-service change. For example, a FQHC or RHC has a:

(i) Newly established per-visit rate of $115.00,

(ii) Current PPS per-visit rate of $95.00,

(iii) July 1, 2003, to June 30, 2004, fiscal year and a

(iv) Scope-of-service change date of February 15, 2004.

The newly established PPS rate is calculated and effective as follows:

(v) $20.00 is the difference between the newly established per-visit rate ($115.00) and the current PPS rate ($95.00),

(vi) $16.00 is the 80 percent adjustment amount ($20.00 X 80 percent),

(vii) $111.00 is the newly established PPS rate ($95.00 + $16.00),

(viii) July 1, 2004, is the date the $111.00 rate becomes effective.

(ix) The MEI will be applied to the PPS rate established in calendar year 2004 and subsequent fiscal years on the first day of October that is not within the particular FQHC's or RHC's fiscal year. For any FQHC or RHC that has a July 1, 2003, to June 30, 2004, fiscal year (as described in the example above), October 1, 2004, is the date of the MEI, which will be applied to the July 1, 2004, established PPS rate. For any FQHC or RHC that has a January 1, 2004 to December 31, 2004, fiscal year, October 1, 2005, is the

date the MEI will be applied to the January 1, 2005, established PPS rate.

(d) For scope-of-service changes implemented between the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001 and the last day of the FQHC's or RHC's fiscal year ending in calendar year 2003, the reimbursement rate will be calculated by taking the difference between the newly established per-visit rate and the initial PPS rate, then multiplying the difference by 80 percent for either two or three periods, depending on when the scope-of-service change occurred and when the cost report is filed. For example, an FQHC or RHC has a:

(i) Newly established per-visit rate of $120.00,

(ii) Initial PPS rate of $95.00,

(iii) July 1, 2002, to June 30, 2003, fiscal year, and

(iv) Scope-of-service change date of February 15, 2001.

Then the retroactive PPS rate for the fiscal years in question is calculated and becomes effective as follows:

(v) $25.00 is the difference between the newly established per-visit rate ($120.00) and the initial PPS rate ($95.00),

(vi) $20.00 is the 80 percent adjustment amount ($25.00 X 80%) for the July 1, 2002, to June 30, 2003, period, is added to the initial PPS rate for a PPS rate of $115.00 ($95.00 + $20.00), and is effective July 1, 2002, to September 30, 2003,

(vii) $16.00 is the 80 percent adjustment factor ($20.00 X 80%) for the July 1, 2001, to June 30, 2002, period, is added to the initial PPS rate for a PPS rate of $111.00 ($95.00 + $16.00), and is effective July 1, 2001, to June 30, 2002,

(viii) $12.80 is the 80 percent adjustment amount ($16.00 X 80%) for the January 1, 2001, to June 30, 2001, period, is added to the initial PPS rate for a PPS rate of $107.80 ($95.00 + $12.80), and is effective February 15, 2001, to June 30, 2001.

(ix) The MEI will be applied to the PPS rate established in calendar 2003 on the first day of October that is not within

the particular FQHC's or RHC's 2003 fiscal year. For any FQHC or RHC that has a July 1, 2002, to June 30, 2003, fiscal year (as described in the example above), October 1, 2003, is the date of the MEI, which will be applied to the July 1, 2002, to September 30, 2003, established PPS rate. For any FQHC or RHC that has a January 1, 2003, to December 31, 2003, fiscal year, October 1, 2004, is the date the MEI will be applied to the January 1, 2003, established PPS rate.

7. A written request under Section K must be made to DHS and include differences in costs and visits, if applicable, associated with scope-of-service change(s), utilizing a cost report format as specified by DHS. Costs must not be reported twice for duplicate reimbursement. Costs arising from extraordinary circumstances and for which the FQHC or RHC has either been reimbursed or for which supplemental reimbursement is pending under Section G will not be reimbursable as a scope-of-service rate change under either Sections F or K.

8. Rate adjustments for scope-of-service changes under this Section K for an FQHC's or RHC's fiscal year ending in 2004, were deemed to have been filed in a timely manner so long as they were filed within 90 days following the end of the 150 day timeframe applicable to retroactive scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year or the date the scope-of-service forms are received, whichever is later.

L. Administration of Managed Care Contracts

1. Where an FQHC or RHC furnishes services pursuant to a contract with a managed care entity (MCE) (as defined in Section 1932(a)(1)(B) of the Act), DHS will make supplemental payments to the extent required by Section 1902(bb)(5) of the Act.

2. Supplemental payments made pursuant to paragraph L.1. will be governed by the provisions of subparagraph (a) through (d), below.

   (a) FQHCs and RHCs that provide services under a contract with a MCE will receive, at least quarterly, state supplemental payments for such services that are an estimate of the difference between the payments the FQHC or RHC receives from MCEs and the payments the FQHC or RHC would have received under the methodology described in Section D, E, or J, and, if applicable, Section F.

(b) At the end of each FQHC's or RHC's fiscal year, the total amount of supplemental and MCE payments received by the FQHC or RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's or RHC's contract with MCEs would have yielded under the methodology described in Section D, E, or J, and, if applicable, Section G.

(c) If the amount calculated under the methodology described in Section D, E, or J, and, if applicable, Section G exceeds the total amount of supplemental and MCE payments, the FQHC or RHC will be paid the difference between the Section D, E, or J, and, if applicable, Section G amount calculated using the actual number of visits, and the total amount of supplemental and MCE payments received by the FQHC or RHC.

(d) If the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G is less than the total amount of supplemental and MCE payments, the FQHC or RHC will refund the difference between the amount calculated using the methodology described in Section D, E, or J, and, if applicable, Section G (based on actual visits) and the total amount of supplemental and MCE payments received by the FQHC or RHC.

3. Payments made to any FQHC or RHC for FQHC or RHC services under managed care contracts, as described in paragraphs 1 and 2 of this Section L, will exclude any financial incentive payments to the FQHC or RHC that are required by federal law to be excluded from the calculation described in paragraph L.2.

M. Payment for Services for Recipients with Medicare/Medi-Cal or Child Health and Disability Prevention (CHDP) Program Coverage

1. Where a recipient has coverage under the Medicare or the CHDP program, DHS will supplement the payment from those programs not to exceed the prospective payment reimbursement rates established under this Amendment.

2. Where an FQHC or RHC services are partially reimbursed by a third party such as CHDP, DHS will reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate. Such reimbursement may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

MAXIMUM STATEWIDE PAYMENT RATES -- FY 1997-98

Procedure Code	Procedure Description	Rate
A. PEDIATRIC PRACTITIONER SERVICES:		
99201	OFFICE VISIT, NEW, LEVEL 1	18.40
99202	OFFICE VISIT, NEW, LEVEL 2	27.60
99203	OFFICE VISIT, NEW, LEVEL 3	46.00
99204	OFFICE VISIT, NEW, LEVEL 4	55.38
99205	OFFICE VISIT, NEW, LEVEL 5, ADULT	64.40
99205	OFFICE VISIT, NEW, LEVEL 5, ADOLESCENT	50.50
99205	OFFICE VISIT, NEW, LEVEL 5, LATE CHILDHOOD	40.40
99205	OFFICE VISIT, NEW, LEVEL 5, EARLY CHILDHOOD	30.30
99205	OFFICE VISIT, NEW, LEVEL 5, INFANT	25.25
99211	OFFICE VISIT, EST., LEVEL 1	7.36
99212	OFFICE VISIT, EST., LEVEL 2	11.04
99213	OFFICE VISIT, EST., LEVEL 3	16.56
99214	OFFICE VISIT, EST., LEVEL 4	27.60
99215	OFFICE VISIT, EST., LEVEL 5, ADULT	46.00
99215	OFFICE VISIT, EST., LEVEL 5, ADOLESCENT	40.40
99215	OFFICE VISIT, EST., LEVEL 5, LATE CHILDHOOD	30.30
99215	OFFICE VISIT, EST., LEVEL 5, EARLY CHILDHOOD	25.25
99215	OFFICE VISIT, EST., LEVEL 5, INFANT	20.20
99241	OFFICE CONSULTATION, LEVEL 1	24.60
99242	OFFICE CONSULTATION, LEVEL 2	24.60
99243	OFFICE CONSULTATION, LEVEL 3	41.00
99244	OFFICE CONSULTATION, LEVEL 4	57.40
99245	OFFICE CONSULTATION, LEVEL 5	57.40
99271	CONFIRMATORY CONSULTATION, LEVEL 1	24.60
99272	CONFIRMATORY CONSULTATION, LEVEL 2	24.60
99273	CONFIRMATORY CONSULTATION, LEVEL 3	41.00
99274	CONFIRMATORY CONSULTATION, LEVEL 4	57.40
99275	CONFIRMATORY CONSULTATION, LEVEL 5	57.40
99341	HOME VISIT, NEW, LEVEL 1	33.12
99342	HOME VISIT, NEW, LEVEL 2	42.32
99343	HOME VISIT, NEW, LEVEL 3	53.36
99351	HOME VISIT, EST., LEVEL 1	17.48
99352	HOME VISIT, EST., LEVEL 2	28.52
99353	HOME VISIT, EST., LEVEL 3	34.96
99354	PROL PHYSICIAN SERV IN OFFICE/OTHER OUTP	33.92
99355	PROL PHYSICIAN SERV IN OFFICE/OTHER OUTP	15.76
99358	PROL EVAL AND MANAGEMENT SERV BEFORE AND	Non Benefit
99359	PROL EVAL AND MANAGEMENT SERV BEFORE AND	Non Benefit
99381	PREVENTIVE MED., NEW, INFANT	24.24
99382	PREVENTIVE MED., NEW, 1-4 YRS.	32.32
99383	PREVENTIVE MED., NEW, 5-11 YRS.	40.40
99384	PREVENTIVE MED., NEW, 12-17 YRS.	48.48
99391	PREVENTIVE MED., EST., INFANT	20.20
99392	PREVENTIVE MED., EST., 1-4 YRS.	24.24
99393	PREVENTIVE MED., EST., 5-11 YRS.	32.32
99394	PREVENTIVE MED., EST., 12-17 YRS.	40.40

MAXIMUM STATEWIDE PAYMENT RATES -- FY 1997-98

Procedure Code		Procedure Description	Rate
99401		COUNSELING, INDIVIDUAL, 15 MIN.	Non Benefit
99402		COUNSELING, INDIVIDUAL, 30 MIN.	Non Benefit
99403		COUNSELING, INDIVIDUAL, 45 MIN.	Non Benefit
99404		COUNSELING, INDIVIDUAL, 60MIN.	Non Benefit
99411		COUNSELING, GROUP 30 MIN.	Non Benefit
99412		COUNSELING, GROUP, 60 MIN.	Non Benefit
99420		HEALTH RISK APPRAISAL	Non Benefit
99429		UNLISTED PREVENTIVE MED.	By Report
99432		NEWBORN CARE, OUTSIDE HOSPITAL	55.20
X5332	(90700)	DTAP IMMUNIZATION	24.32
X5312	(90701)	DIPTHERIA/TETANUS TOXOID/PERTUSSIS-0.5ML	19.76
X5310	(90702)	DIPTHERIA/TETANUS TOXOID ADSORBED-0.5ML	9.43
X6954	(90703)	TETNUS TOXOID, ABSORBED - 0.5ML	9.43
X5324	(90704)	MUMPS VIRUS VACCINE LIVE SINGLE DOSE	24.15
X5300	(90705)	MEASLES(RUBEOLA VIRUS VACCINE-LIVE	19.79
X5322	(90706)	RUBELLA VIRUS VACCINE-LIVE SINGLE DOSE	23.00
X5320	(90707)	MEASLES/MUMPS/RUBELLA VIRUS VACCINE LIVE	36.77
X5318	(90708)	MEASLES(RUBEOLA)RUBELLA VIRUS VACCINE	29.00
X5302	(90709)	RUBELLA/MUMPS VIRUS VACCINE LIVE SGL DOS	30.52
90749	(90710)	MEASLES/MUMPS/RUBELLA VACCINE VARICELLA	By Report
90749	(90711)	DTP and INJECTABLE POLIO	By Report
X5326	(90712)	ORIMUNE DISPETTES - 0.5CC EA	18.98
X5328	(90712)	ORIMUNE - 2 DROP DOSE/VIAL	16.17
X6774	(90713)	POLIOMYELITIS VACCINE - 1CC AMP	27.44
X6990	(90714)	TYPHOID VACCINE-5 ML	9.43
X7106	(90716)	VARICELLA	47.44
X7024	(90717)	YELLOW FEVER VAC-YELLOW FEVER VAC CONNAU	9.19
X6100	(90719)	DIPTHERIA TOXOID ADSORBED(PED-5ML	9.43
X5321	(90720)	TETRAMUNE VACCINE 0.5CC DPT/HIB	33.63
90749	(90721)	DIPHTHERIA,TETANUS,and ACELLULAR PERTUSSIS (DTaP) AND HEMOPHILUS INFLUENZA B (HIB) VACCINE	By Report
X6218	(90724)	INFLUENZA VIRUS VACCINE(ADULT)0.5ML	11.61
X5938	(90725)	CHOLERA VACCINE-1.5ML	9.89
X5936	(90725)	CHOLERA VACCINE-20ML	8.49
90726	(90726)	RABIES IMMUNIZATION	By Report
X6770	(90727)	PLAGUE VACCINE-2 ML	12.99
X6768	(90727)	PLAGUE VACCINE-20 ML	8.69
X5730	(90728)	BCG VACCINE, PERCUTANEOUS	8.79
90749	(90730)	HEPATITIS A VACCINE	By Report
X6772	(90732)	PNEUMOCOCCAL VACCINE-0.5 ML	14.59
X6542	(90733)	MENINGOCOCCAL POLYSACCHARIDE-GROUP A 10	8.49
X6270	(90737)	HAEMOPHILUS INFLUENZAE VACCINE HIB TITER	22.00
X6268	(90737)	H. INFLUENZAE B VACCINE--0.SML	14.35
X6272	(90737)	H. INFL. VACCINE(PROHIBIT) 0.5 ML.	23.50
X6232	(90741)	IMMUNE SERUM GLOBULIN-HUMAN-2ML	10.26
X6230	(90741)	IMMUNE SERUM GLOBULIN-1ML	5.95

MAXIMUM STATEWIDE PAYMENT RATES -- FY 1997-98

Procedure Code		Procedure Description	Rate
		Specific Hyperimmune Serum Globulin:	
X6346	(90742)	MUMPS IMMUNE GLOBULIN(HUMAN-1.5ML	9.99
X6344	(90742)	MUMPS IMMUNE GLOBULIN(HUMAN-4.5ML	9.19
X6348	(90742)	PERTUSSIS IMMUNE GLOBULIN(HUMAN)1.25ML	20.19
X6280	(90742)	HEPATITIS B IMMUNE GLOBULIN(HUMAN)3ML	47.49
X6278	(90742)	HEPATITIS B IMMUNE GLOBULIN(HUMAN)4ML	47.49
X6276	(90742)	HEPATITIS B IMMUNE GLOBULIN(HUMAN)5ML	39.59
X5676	(90742)	TETANOS IMMUNE GLOBULIN(HUMAN)250 UNIT	8.53
X6098	(90742)	RHO(D)IMMUNE GLOBLIN(HUMAN)	50.24
X6350	(90742)	MICRO-GAM	33.04
X7088	(90744)	ENGERIX-B (PEDIATRIC) 10.0 MCG/0.5 ML.	30.95
X7092	(90744)	RECOMBIVAX HB (PEDIATRIC) 2.5 MCG/0.5 ML	25.50
X7098	(90744)	RECOMBIVAX HB (PEDIATRIC) 15.0 MCG/3.0 ML	39.83
X7090	(90745)	ENGERIX-B (ADULT TO 19 YEARS) 20.0 MCG/1.0 ML.	61.85
X7096	(90745)	RECOMBIVAX HB (ADULT) 10.0 MCG/1.0 ML	53.64
X7100	(90745)	RECOMBIVAX HB (ADULT) 30.0 MCG/3.0 ML	53.64
90749	(90749)	UNLISTED IMMUNIZATION, Including 90710, 90711, 90716, 90730	By Report

B. OBSTETRICAL PRACTITIONER SERVICES:

59000	AMNIOCENTESIS	50.67
59012	FETAL CORD PUNCTURE PRENATAL	132.25
59015	CHORION BIOPSY	Non Benefit
59020	FETAL CONTRACTION STRESS TEST	50.67
59025	FETAL NON-STRESS TEST	20.27
59030	FETAL SCALP BLOOD SAMPLE	50.67
59050	FETAL MONITOR DURING LABOR BY CONS PHYSI	81.07
59051	FETAL MONITORING DURING LABOR BY CONSULT	74.48
59100	REMOVE UTERUS LESION	709.38
59120	TREAT ECTOPIC PREGNANCY	709.38
59121	TREAT ECTOPIC PREGNANCY	709.38
59130	TREAT ECTOPIC PREGNANCY	By Report
59135	TREAT ECTOPIC PREGNANCY	841.12
59136	TREAT ECTOPIC PREGNANCY	841.12
59140	TREAT ECTOPIC PREGNANCY	By Report
59150	TREAT ECTOPIC PREGNANCY	385.09
59151	TREAT ECTOPIC PREGNANCY	385.09
59160	D&C AFTER DELIVERY	202.68
59200	INSERTION OF CERVICAL DILATOR	Non Benefit
59300	EPISIOTOMY OR VAGINAL REPAIR	101.34
59320	REVISION CERVIX	By Report
59325	REVISION CERVIX	By Report
59350	REPAIR OF UTERUS	699.25
59400	OBSTETRICAL CARE	961.20
59409	VAG DELIVERY ONLY (WITH OR W/OUT EPISIOT	480.60
59410	VAGINAL DELIVERY ONLY	Non Benefit
59412	ANTEPARTUM MANIPULATION	Non Benefit

MAXIMUM STATEWIDE PAYMENT RATES – FY 1997-98

Procedure Code	Procedure Description	Rate
59414	DELIVER PLACENTA	By Report
59425	ANTEPARTUM CARE ONLY	Non Benefit
59426	ANTEPARTUM CARE ONLY	Non Benefit
59430	CARE AFTER DELIVERY	Non Benefit
59510	CESAREAN DELIVERY	961.27
59514	CESAREAN DELIVERY ONLY	480.64
59515	CESAREAN DELIVERY	Non Benefit
59525	RML UTERUS AFTER CESAREAN	211.15
59812	TREATMENT OF MISCARRAIGE	148.92
59820	CARE OF MISCARRIAGE	148.92
59821	TREATMENT OF MISCARRIAGE	148.92
59830	TREAT UTERUS INFECTION	By Report
59840	ABORTION	158.10
59841	ABORTION	223.38
59850	ABORTION	206.76
59851	ABORTION	206.76
59852	ABORTION	521.22
59855	INDUCED ABORTION BY ONE/MORE VAG/SUPP	178.85
59856	INDUCED ABORTION BY ONE/MORE VAG/SUPP	258.11
59857	INDUCED ABORTION BY ONE/MORE VAG/SUPP	589.35
59870	EVACUATE MOLE UTERUS	304.02
59899	MATERNITY CARE PROCEDURE	By Report

MEDI-CAL PROGRAM
OBSTETRICAL PRACTITIONER PARTICIPATION

FIELD OFFICE DISTRICT	(1) AVAILABLE OBSTETRICAL PRACTITIONERS	(2) PARTICIPATING OBSTETRICAL PRACTITIONERS	(3) PERCENT PARTICIPATION
Oakland	614	385	62.70
Sacramento	902	723	80.16
San Francisco	645	457	70.85
Fresno	625	655	104.80
San Diego	805	593	73.66
San Bernardino	654	561	85.78
Los Angeles	2,534	2362	93.21
San Jose	629	356	56.60
Total	7,408	6,092	82.24

(1) Number of nonfederal office-based obstetricians, gynecologists, and family practitioners during calendar year 1996. SOURCE: American Medical Association (AMA), provided by special request.

(2) Fee-for-service obstetricians, gynecologists, and family practitioners paid during calendar year 1996, weighted for group practices. Previous analysis of "rendering providers" in group practice settings reflect an average of 2.52 physicians per family practice group, and 3.51 physicians per obstetrics/gynecology group.

(3) Percentages which exceed 100 indicate potential flaws in the database used for this table. Possible explanations include: a) a Medi-Cal physician could be double-counted if moving during the year from a private practice to a group practice; b) the statewide average number of physicians in group settings may be higher than the actual number for that county; or c) the AMA data may incompletely count office-based physicians.

Note: Data for the counties of Orange, San Mateo, Santa Barbara, Santa Cruz and Solano counties were excluded from this analysis because of the existence of county operated capitation programs and Geographic Managed Care arrangements.

MEDI-CAL PROGRAM
PEDIATRIC PRACTITIONER PARTICIPATION

FIELD OFFICE DISTRICT	(1) AVAILABLE PEDIATRIC PRACTITIONERS	(2) PARTICIPATING PEDIATRIC PRACTITIONERS	PERCENT PARTICIPATION
Oakland	737	472	64.04
Sacramento	930	678	72.90
San Francisco	727	482	66.30
Fresno	633	573	90.52
San Diego	852	738	86.62
San Bernardino	664	615	92.62
Los Angeles	2,666	2,281	85.56
San Jose	690	386	55.94
Total	7,899	6,225	78.81

(1) Number of nonfederal office-based pediatricians and family practitioners during calendar year 1996. SOURCE: American Medical Association (AMA), provided by special request.

(2) Fee-for-service pediatricians and family practitioners paid during calendar year 1996; weighted for group practices. Previous analysis of "rendering providers" in group practice settings reflect an average of 2.52 physicians per family practice group, and 4.58 physicians per pediatric group.

Note: Data for the counties of Orange, San Mateo, Santa Barbara, Santa Cruz and Solano counties were excluded from this analysis because of the existence of county operated capitation programs and Geographic Managed Care arrangements.

HMO PEDIATRIC AND OBSTETRICAL SERVICES

The Department's actuarial staff regularly prepares a comprehensive report which presents detailed information on how capitation rates for HMOs (Prepaid Health Plans) and other prepaid at-risk providers are established under the Medi-Cal Program. Due to its size, the report has not been included as a part of this State Plan Amendment; however, copies are available upon request.

The process of determining capitation rates is based on an actuarial analysis of "fee-for-service" (FFS) equivalent costs. This means that capitation rates are calculated to reflect the estimated per capita amount that would be paid under the FFS program for the same services covered by the Prepaid Health Plan (PHP) contract. These rate calculations also include adjustments to ensure actuarial equivalence and to account for administrative costs and program savings goals. Since FFS rates directly influence FFS program costs, which, in turn, directly influence PHP rates, FFS rates are clearly taken into account in establishing PHP rates.

Accordingly, the Department assures that its FFS payment rates for pediatric and obstetrical practitioner services are taken into account in developing the payment rates for HMOs (Prepaid Health Plans) with Section 1903(m) Medicaid contracts.

STATEWIDE AVERAGE PAYMENTS--1995-96

Procedure Code	Medi-Cal Code	Procedure Description	Average Payment
90701	X5312	DIPTHERIA/TETANUS TOXOID/PERTUSSIS-0.5ML	$13.99
90701	X5314	DIPTHERIA/TETANUS TOXOIDS/PERTUSSIS7.5ML	$15.57
90701	X5316	DIPTHERIA/TETANUS TOXOIDS/PERTUSSIS-7.5	$16.38
90707	X5320	MEASLES/MUMPS/RUBELLA VIRUS VACCINE LIVE	$25.30
90712	X5326	ORIMUNE DISPETTES - 0.5CC EA	$13.71
90712	X5328	ORIMUNE - 2 DROP DOSE/VIAL	$12.16
90737	X6268	H. INFLUENZAE B VACCINE--0.SML	$11.66
90737	X6270	HAEMOPHILUS INFLUENZAE VACCINE HIB TITER	$19.17
90737	X6272	H. INFL. VACCINE(PROHIBIT) 0.5 ML.	$17.82
90744-5	X7088	ENGERIX B 10 MCG/0.5 ML (EACH)	$24.93
90744-5	X7090	ENGERIX B 20 MCG/1.0 ML	$52.78
90744-5	X7092	RECOMBIVAX HB 2.5 MCG/0.5 ML (EACH)	$19.41
90744-5	X7094	RECOMBIVAX HB 5 MCG/0.5 ML (EACH)	$30.65
59400	59400	OBSTETRICAL CARE	$963.42
59409	59409	VAG DELIVERY ONLY (WITH OR W/OUT EPISIOT	$475.04
59410	59410	VAGINAL DELIVERY ONLY	$473.30
59412	59412	EXTERNAL CEPHALIC VERSION	Non-Benefit
59414	59414	DELIVER PLACENTA	$97.28
59425	59425	ANTEPARTUM CARE, ONLY	Non-Benefit
59426	59426	ANTEPARTUM CARE, ONLY	Non-Benefit
59430	59430	POSTPRTUM CARE, ONLY	Non-Benefit
59510	59510	CESARIAN DELIVERY	$958.62
59514	59514	CAESAREAN DELIVERY ONLY	$473.11
59515	59515	CESAREAN DELIVERY	$468.60
59525	59525	RML UTERUS AFTER CESAREAN	$788.90
99201	99201	OFFICE VISIT, NEW, LEVEL 1	$17.65
99202	99202	OFFICE VISIT, NEW, LEVEL 2	$25.89
99203	99203	OFFICE VISIT, NEW, LEVEL 3	$43.58
99204	99204	OFFICE VISIT, NEW, LEVEL 4	$53.79
99205	99205	OFFICE VISIT, NEW, LEVEL 5	$55.12
99211	99211	OFFICE VISIT, EST., LEVEL 1	$7.49
99212	99212	OFFICE VISIT, EST., LEVEL 2	$2.11
99213	99213	OFFICE VISIT, EST., LEVEL 3	$16.34
99214	99214	OFFICE VISIT, EST., LEVEL 4	$23.54
99215	99215	OFFICE VISIT, EST., LEVEL 5	$33.24
99381	99381	PREVENTIVE MED., NEW, INFANT	$23.95
99382	99382	PREVENTIVE MED., NEW, 1-4 YRS.	$31.84
99383	99383	PREVENTIVE MED., NEW, 5-11 YRS.	$40.00
99384	99384	PREVENTIVE MED., NEW, 12-17 YRS.	$47.90
99391	99391	PREVENTIVE MED., EST., INFANT	$20.07
99392	99392	PREVENTIVE MED., EST., 1-4 YRS.	$24.11
99393	99393	PREVENTIVE MED., EST., 5-11 YRS.	$32.11
99394	99394	PREVENTIVE MED., EST., 12-17 YRS.	$40.03

MEDI-CAL STATEWIDE AVERAGE PAYMENTS -- 1993-94

Procedure Code	Procedure Description	Average Payment
B. OBSTETRICAL PRACTITIONER SERVICES		
59400	Obstetrical care	959.68
59409	Vaginal delivery	Non Benefit*
59410	Vaginal delivery	475.94
59412	Antepartum manipulation	Non Benefit
59414	Deliver placenta	165.05
59425	Antepartum care only	Non Benefit
59426	Antepartum care only	Non Benefit
59430	Care after delivery	Non Benefit
59510	Obstetrical care	956.55
59514	Cesarean delivery	Non Benefit*
59515	Cesarean delivery	471.62
59525	Remove uterus after cesarean	204.55
Z1032	Initial pregnancy office visit	110.37
Z1032-ZL	Initial pregnancy office visit, if provided within 16 weeks of last menstrual period (Comprehensive Perinatal Service Providers only)	159.49
Z1034	Antepartum followup office visit	52.55
Z1036	Tenth and subsequent antepartum office visit (Comprehensive Perinatal Service providers only)	99.66
Z1038	Postpartum office visit	52.86

* New code in 1994 CPT, not covered during this payment period.

HMO PEDIATRIC AND OBSTETRICAL SERVICES

The Department's actuarial staff regularly prepares a comprehensive report which presents detailed information on how capitation rates for HMOs (Prepaid Health Plans) and other prepaid at-risk providers are established under the Medi-Cal program. Due to its size, the report has not been included as a part of this State Plan Amendment; however, copies are available upon request.

The process of determining capitation rates is based on an actuarial analysis of "fee-for-service" (FFS) equivalent costs. This means that capitation rates are calculated to reflect the estimated per capita amount that would be paid under the FFS program for the same services covered by the Prepaid Health Plan (PHP) contract. These rate calculations also include adjustments to ensure actuarial equivalence and to account for administrative costs and program savings goals. Since FFS rates directly influence FFS program costs, which, in turn, directly influence PHP rates, FFS rates are clearly taken into account in establishing PHP rates.

Accordingly, the Department assures that its FFS payment rates for pediatric and obstetrical practitioner services are taken into account in developing the payment rates for HMOs (Prepaid Health Plans) with Section 1903(m) Medicaid contracts.

MEDI-CAL STATEWIDE AVERAGE PAYMENTS -- FY 1992-93

Procedure Code		Procedure Description	Average Paid*
X6278	(90742)	Hepatitus B, 4 ml	29.38
X6276	(90742)	Hepatitus B, 5 ml	32.54
X5676	(90742)	Tetanus, 250 units	8.41
X6098	(90742)	RHO (D), full dose	41.23
X6350	(90742)	RHO (D), mini dose	16.59

B. OBSTETRICAL PRACTITIONER SERVICES:

Maternity Care and Delivery

	Incision	
59000	Amniocentesis	48.54
59012	Fetal cord puncture, prenatal	132.27
59015	Chorion biopsy	Non Benefit
59020	Fetal contract stress test	49.64
59025	Fetal non-stress test	20.24
59030	Fetal scalp blood sample	50.66
59050	Fetal monitor w/ report	80.67
59100	Remove uterus lesion	642.35
	Excision	
59120	Treat ectopic pregnancy	691.84
59121	Treat ectopic pregnancy	697.51
59130	Treat ectopic pregnancy	596.00
59135	Treat ectopic pregnancy	841.00
59136	Treat ectopic pregnancy	823.67
59140	Treat ectopic pregnancy	Not Paid
59150	Treat ectopic pregnancy	402.94
59151	Treat ectopic pregnancy	374.86
59160	D&C after delivery	196.43
	Introduction	
59200	Insert cervical dilator	Non Benefit
	Repair	
59300	Episiotomy or vaginal repair	87.50
59320	Revision of cervix	198.61
59325	Revision of cervix	332.50
59350	Repair of uterus	674.25
	Delivery, Antepartum and Postpartum Care	
59400	Obstetrical care	957.77

MEDI-CAL STATEWIDE AVERAGE PAYMENTS -- FY 1992-93

Procedure Code	Procedure Description	Average Paid*
59410	Obstetrical care	475.25
59412	Antepartum manipulation	Non Benefit
59414	Deliver placenta	70.34
59430	Care after delivery	Non Benefit
	Cesarean Delivery	
59510	Cesarean delivery	955.94
59515	Cesarean delivery	471.35
59525	Remove uteruus after cesarean	385.71
	Abortion	
59812	Treatment of miscarriage	142.92
59820	Care of miscarriage	126.71
59821	Treatment of miscarriage	143.64
59830	Treat uterus infection	144.95
59840	Abortion	155.16
59841	Abortion	221.14
59850	Abortion	190.07
59851	Abortion	193.83
59852	Abortion	506.33
	Additional Office Visit Procedures (Payable in addition to 59400-59525)	
Z1032	Initial pregnancy office visit	110.54
Z1032-ZL	Initial pregnancy office visit, if provided within 16 weeks of last menstrual period (Comprehensive Perinatal Service Providers only)	154.15
Z1036	Tenth and subsequent antepartum office visit (Comprehensive Perinatal Service providers only)	99.46

* Principal modifier

NOTE: Maximum payment rates for physician services under the Medi-Cal program are uniform throughout all areas of the State. Therefore, the average amounts reported above will vary only slightly, if at all, among different areas.

HMO PEDIATRIC AND OBSTETRICAL SERVICES

The Department's actuarial staff regularly prepares a comprehensive report which presents detailed information on how capitation rates for HMOs (Prepaid Health Plans) and other prepaid at-risk providers are established under the Medi-Cal program. Due to its size, the report has not been included as a part of this State Plan Amendment; however, copies are available upon request.

The process of determining capitation rates is based on an actuarial analysis of "fee-for-service" (FFS) equivalent costs." Capitation rates are calculated to reflect the estimated per capita amount that would be paid under the FFS program for the same services covered by the Prepaid Health Plan (PHP) contract. These rate calculations also include adjustments to ensure actuarial equivalence and to account for administrative costs and program savings goals. Since FFS rates directly influence FFS program costs, which, in turn, directly influence PHP rates, FFS rates are clearly taken into account in establishing PHP rates.

Accordingly, the Department assures that its FFS payment rates for pediatric and obstetrical practitioner services are taken into account in developing the payment rates for HMOs (Prepaid Health Plans) with Section 1903(m) Medicaid contracts.

Payment for Local Education Agency (LEA) Services is found in Supplement 8 in Attachment 4.19-B

Payment for Home Health Agency Services

The State developed fee schedule rates are the same for both public and private providers of home health agency services. The fee schedule and any annual or periodic adjustments to the fee schedule is published in California's Medi-Cal Inpatient/Outpatient Provider Manual at: www.medi-cal.ca.gov

State/Territory California

Citation | Condition or Requirement

REIMBURSEMENT FOR SHORT-DOYLE/MEDI-CAL

OUTPATIENT, REHABILITATIVE, CASE MANAGEMENT AND OTHER SERVICES

The policy of the State Agency is that reimbursement for Short-Doyle/Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMAs), negotiated rates, or actual cost if the provider does not contract on a negotiated rate basis. To provide mutually beneficial incentives for efficient fiscal management, providers contracting on a negotiated rate basis shall share equally with the Federal Government that portion of the Federal reimbursement that exceeds actual cost. In no case will payments exceed SMAs.

A. DEFINITIONS

"Published charges" are usual and customary charges prevalent in the public mental health sector that are used to bill the general public, insurers, and other non-Title XIX payors. (42 CFR 447.271 and 405.503(a))

"Statewide maximum allowances" are upper limit rates, established for each type of service, for a unit of service. Units of service are defined as patient days for residential programs, half-days or full-days for day services, blocks of four hours for crisis stabilization services, and minutes for all other program services.

"Negotiated rates" are fixed, prospective rates of reimbursement, subject to the limitations described in the first paragraph above.

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in HCFA Publication 15-1.

"Provider" means each legal entity providing Short-Doyle/Medi-Cal services.

"Legal entity" means each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency.

B. REIMBURSEMENT METHODOLOGY FOR NON-NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for non-NEGOTIATED RATE PROVIDER Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a NOMINAL CHARGE PROVIDER (as defined below).

2. The provider's allowable cost.

3. The SMAs established as defined in Section D. by the Department of Mental Health (DMH) and approved by the Department of Health Services (DHS).

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each legal entity providing services. For hospital providers, reimbursement is determined separately for inpatient and outpatient services. Reimbursement is based on comparisons of total, aggregated allowable costs after application of SMAs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of actual cost or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for outpatient, rehabilitative, case management, and other services is made in accordance with, and by extension from, Medicare inpatient rules at 42 CFR 413.13(f)(2)(iii). For

hospital providers, the determination is made separately for inpatient and outpatient services. The determination is based on comparisons of total, aggregated actual costs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

C. REIMBURSEMENT METHODOLOGY FOR NEGOTIATED RATE PROVIDERS

REIMBURSEMENT LIMITS

The reimbursement methodology for **NEGOTIATED RATE PROVIDER** Short-Doyle/Medi-Cal services, by legal entity, is based on the lowest of:

1. The provider's published charge to the general public, unless the provider is a **NOMINAL CHARGE PROVIDER** (as defined below),

2. The provider's negotiated rates, based on historic cost, approved by the State,

3. The SMAs established as defined in Section D. by the DMH and approved by the DHS.

The above reimbursement limits are applied at the time of settlement of the year-end cost report after determination of Nominal Charge status and are applied individually to each legal entity. The methodology is the same as in Section B except that the Negotiated Rates are construed to be actual costs. If reimbursement to a negotiated rate provider exceeds actual costs in the aggregate, 50 percent of the Federal Financial Participation (FFP) that exceeded actual costs will be returned to the Federal government.

NOMINAL CHARGE PROVIDER

Determination of Nominal Charge status is the first step in the cost report settlement process, before application of reimbursement limits. Pursuant to Medicare rules at 42 CFR 413.13, public providers and non-public providers with a significant portion of low-income patients are reimbursed the lower of negotiated rates or SMAs if total charges are 60 percent or less of the reasonable cost of services represented by the charges. The determination of nominal charges for outpatient, rehabilitative, case management, and other services is made in accordance with, and by extension from, Medicare inpatient rules at 42 CFR 413.13(f)(2)(iii).

For hospital providers, the determination is made separately for inpatient and outpatient services. The determination is based on comparisons of total, aggregated actual costs to total, aggregated published charges, by legal entity, computed separately for inpatient and outpatient services but without further distinction between different types of outpatient services.

D. SMA METHODOLOGY

The SMAs are based on the statewide average cost of each type of service as reported in year-end cost reports for the most recent year for which cost reports have been completed. County administrative and utilization review costs are isolated and not included in the direct treatment payment rates. After eliminating rates in excess of one standard deviation from the mean, the top ten percent of providers with the highest rates are eliminated from the base data to afford cost containment and allow for an audit adjustment factor. The total costs of each type of service are then divided by the total units of service to arrive at a statewide average rate. The adjusted average rates are inflated by a percentage equivalent to the Home Health Agency Market Basket Index for the period between the cost report year and the year in which the rates will be in effect.

The State Fiscal Year 1989-90 cost report data was used to develop base rates. The rates from the base year were adjusted for inflation annually by applying the Home Health Agency Market Basket Index. When the SMAs are re-based, the data will be adjusted to reflect the lower of actual costs or the SMA's in effect for the base year.

The SMAs for crisis stabilization, adult crisis residential treatment, and adult residential treatment are provisional because these are new services not included in the current database. The SMA for crisis stabilization is based on a cost survey of fourteen county programs that provide services for up to 24 hours in an emergency room setting. The SMAs for the two residential programs are based on a cost survey for approximately sixty facilities and include reimbursement only for treatment; room and board costs are excluded. No Federal funds will be used for IMD services. All three provisional rates will be reviewed and rebased for State Fiscal Year 1995-96 based on State Fiscal Year 1993-94 cost report data.

The SMA for psychiatric health facilities is also provisional and new for State Fiscal Year 1994-95. The SMA is based on a cost survey of six county programs which provide rehabilitative services in a non-IMD 24-hour environment. Room and board costs are excluded. The provisional SMA will be reviewed and rebased for State Fiscal Year 1996-97 based on State Fiscal Year 1994-95 cost report data.

E. ALLOWABLE SERVICES

Allowable outpatient, rehabilitative, case management, and other services and units of service are as follows:

Service	Unit of Service
Day Treatment Intensive	Half-day or Full-Day
Day Rehabilitative	Half-day or Full-Day
Mental Health Services	Single Minutes
Medication Support	Single Minutes
Crisis Intervention	Single Minutes
Crisis Stabilization	One-Hour Blocks
Case Management/Brokerage	Single Minutes
Adult Crisis Residential Treatment	Day (Excluding room and board)
Adult Residential Treatment	Day (Excluding room and board)
Psychiatric Health Facility	Day (Excluding room and board)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

REIMBURSEMENT FOR MEDI-CAL PERSONAL CARE SERVICES

A. REIMBURSEMENT PRINCIPLES

(1) It is the Department's policy, subject to the specific provisions set forth below and except as provided in paragraphs E and F, that reimbursement rates for Personal Care Services shall not be less than levels necessary to achieve adequate access to these services, but shall not exceed the lesser of specified limits, consistent with the requirements of Section 1902(a)(30)(A) of the Social Security Act.

(2) Paragraphs G and H, below, shall not apply to services provided in the manner specified in paragraphs E or F.

B. DEFINITIONS

(1) "Usual and Customary Charges" means the average or prevalent charge billed by the provider to the general public, insurers, or other non-Title XIX payors.

(2) "Schedule of Maximum Allowances" (SMA) means the maximum payment rates established for each unit of service. A unit of service is defined as a patient service hour or fraction or multiple thereof rendered to beneficiaries of Personal Care Services.

(3) "Medicare Maximum Allowances" are the reimbursement rates that are/would be made to providers of Personal Care Services by the federal Medicare Program.

(4) "Personal Care Services" are those services defined in Section 51183, Title 22, Division 3, California Code of Regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

(5) "In-Home Supportive Services" means the program defined in Section 12300 et seq. of the Welfare and Institutions Code.

(6) "Public authority" and "nonprofit consortium" mean the entities defined in Section 12301.6 of the California Welfare and Institutions Code.

(7) "Individual provider" means that individual described in Section 51181, title 22, Division 3, California Code of Regulations, who provides services under the Personal Care Services Program. (See Cal. Code Regs., tit. 22, § 51204(a).)

(8) "Personal care services provided under contract" means those services provided by a contractor under a contract with the county, but does not include a contract entered into pursuant to California Welfare and Institutions Code section 12302.7.

C. ADMINISTRATIVE PROCESS

Personal Care Services program reimbursement rates shall be subject to the general provisions of the section of this Attachment 4.19-B that is entitled, "Reimbursement Limits for Professional Services", commencing at page 1 hereof.

D. FUNDING

(1) To the extent that the Department finds that sufficient access to services is available, any rate increases granted under this program shall be no greater than the funds appropriated by the Legislature for such purpose, except as provided in paragraph D(2), below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

(2) If the funds appropriated by the Legislature do not include an increase for reimbursement rates for providers of personal care services sufficient to cover the increases recommended by the Department pursuant to the provisions of this section of the State plan, a county may use county-only funds to meet federal financial participation requirements, subject to specific provisions of this section of the State plan and subject to the Department's determination that the requirements of federal law have been complied with, including but not limited to the requirements of 42 Code of Federal Regulations, section 433.51.

E. REIMBURSEMENT RATE LIMITATIONS FOR PERSONAL CARE SERVICES PROVIDED UNDER CONTRACT

(1) A county may contract with a city, county, or city and county agency, a local health district, a voluntary nonprofit agency, a proprietary agency, or an individual for the purpose of providing personal care services.

The cost of the service will not exceed by more than 10 percent the allowable cost of the service as determined by the State Department of Health Services, in consultation with the State Department of Social Services.

The rate of reimbursement shall be negotiated consistent with applicable regulations promulgated by the State Department of Social Services or the State Department of Health Services. For any contract extended beyond the first contract term, the rate shall reflect, but is not limited to, the following financial considerations:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

(a) Actual expenditures by the contractor as documented during the first contract term and approved by the state.

(b) Changes in federal, state, or county program requirements.

(c) Federal and state minimum wage and contractual step merit increases.

(d) Statutory taxes.

(e) Insurance costs.

(f) Reasonable costs which have been approved by the county department of social services, as long as those costs do not increase unreimbursed county expenditures or lead to a reduction in client services, and those costs can be funded within the maximum allowable rates set by the State Department of Social Services for in-home supportive services contracts and the county's state allocation for in-home supportive services.

(g) Other reasonable costs over which the contracting parties have no control.

Applicable regulations promulgated by the State Department of Social Services and the State Department of Health Services will also establish standards governing acceptable contract provisions, the methods used to advertise, procure, select and award the contracts, and the procedures used to amend, renew, or extend an

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

existing contract with the same contractor including, in addition to rate changes, any other change in other terms of the contract.

(2) In addition, all contracts are subject to the following:

(a) Prior to initiating a contract or contracts, the county will publicize its intention to solicit bids to enter into the contracts.

(b) When the county has selected one or more contract proposals for tentative acceptance or intends to renew an existing contract, the county board of supervisors will conduct a hearing on the proposed contract, contracts, or renewal, which will be at a regularly scheduled meeting of the board of supervisors, and open to the public.

(c) Public findings based on the public hearing will be made available to interested parties.

(d) No contract will take effect until 30 calendar days have elapsed from the time of the public hearing required under this section.

(e) The county board of supervisors may award one or more contracts based upon the fiscal responsibility of the service providers and the experience of the service providers in providing services. The county board of supervisors may evaluate the bid proposal, the experience of the provider, the program plan, and the proposed contract rate, to determine if a bidder has demonstrated the ability to reasonably provide and sustain uninterrupted,

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

continuous services to recipients as required under the county's invitation for bid, prior to making a contract award. Nothing however, precludes a requirement that contracts under this section be awarded on a competitive bid basis.

3) The reimbursement rates shall not exceed the State's maximum authorized hourly In-Home Supportive Services program rates for the contract mode of service.

4) Reimbursement rates established through a contract between a county and a contract provider in compliance with this paragraph E constitute rates recommended by the Department for purposes of paragraph D(2), above.

F. RATE METHODOLOGY FOR SERVICES PROVIDED BY A PUBLIC AUTHORITY OR BY A NONPROFIT CONSORTIUM

(1) A county board of supervisors may, at its option, elect to do either of the following:

(a) Contract with a nonprofit consortium to provide for the delivery of personal care services.

(b) Establish a public authority to provide for the delivery of personal care services.

(2) Any nonprofit consortium contracting with a county pursuant to this section or any public authority will provide for the functions specified in California Welfare and Institutions Code section 12301.6, subdivision (d), including, but not limited to, performing functions related to the delivery of personal care services, and ensuring that the requirements of the personal care

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

option pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are met.

(3) Within the meaning of Chapter 10 (commencing with Section 3500) of Division 4 of Title 1 of the California Government Code relating to collective bargaining by employee organizations that include employees of a public agency, any public authority created pursuant to this section is deemed to be the employer of persons referred to recipients to provide personal care services and is also deemed to be the Medi-Cal provider of record.

(4) Any nonprofit consortium contracting with a county pursuant to this section is deemed to be the employer of personal care services personnel referred to recipients for the purposes of collective bargaining over wages, hours, and other terms and conditions of employment and is deemed to be the Medi-Cal provider of record.

(5) To the extent permitted by federal law, personal care option funds, obtained pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code, along with matching funds using the state and county sharing ratio established in California law or any other funds that are obtained pursuant to Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code, may be used to establish and operate an entity authorized by this section.

(6) The county, in exercising its option to establish a public authority, shall not be subject to competitive bidding requirements. However, contracts entered into by either the county, a public authority, or a nonprofit

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

consortium pursuant to this section shall be subject to competitive bidding as otherwise required by law.

(7) Recipients shall retain the right to select, terminate, and direct the work of any person providing personal care services to them.

(8) The Department will not reimburse a public authority or consortium for personal care services at more than 200 percent of California's hourly minimum wage (on a per unit of service basis).

(9) Payment rates established by a public authority or a nonprofit consortium in compliance with this paragraph F constitute rates recommended by the Department for purposes of paragraph D(2), above.

G. SCHEDULE OF MAXIMUM ALLOWANCE (SMA) RECOMMENDED RATES

(1) Based upon the SMA rate analysis performed pursuant to paragraph H, the Department will recommend SMA rates (as referenced in paragraph D(2), above) for reimbursement of individual providers of personal care services which may be statewide, or vary by county or other geographic area.

(2) Statewide, county, or other geographic area individual provider SMA recommended rates adopted pursuant to paragraph H, will not exceed prevailing wages including statutorily mandated employer contributions for benefit costs (i.e., Social Security, etc.) for like services on a statewide average or applicable geographic area average basis, respectively. If county or other geographic area rates are adopted, no such geographic rate shall exceed 115 percent of the statewide average of prevailing wages

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

in each county, as determined by the Employment Development Department (including employer benefit contributions) for like work.

(3) Any wages negotiated or paid by any public or private employer for Personal Care Services that are found by the Department to be substantially in excess of prevailing wages for job skills, ability, education or experience similar to those in the personal care industry shall be deemed excessive and not recognized in determining the SMA rates.

(4) The individual provider SMA recommended rates shall not exceed 150 percent of California's hourly minimum wage.

(5) The SMA rates shall not exceed Medicare maximum allowances for similar services, and shall conform to all applicable state and federal laws and regulations governing provider reimbursement rates.

H. SMA RATE METHODOLOGY FOR INDIVIDUAL PROVIDERS

(1) The SMA recommended rates for individual providers will be determined based on an analysis of appropriate economic factors, on a geographic or statewide basis within the State of California. The primary objectives of the analysis will be (a) identification of rates sufficient to ensure adequate access to Personal Care Services, and (b) that the rates are consistent with efficiency, economy and quality of care.

(2) Analysis of economic factors may include evaluation of wages for services comparable to Personal Care Services, on a geographic basis. Available county and/or state data may be analyzed to first determine if and where

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

logical geographic groupings occur. This may include cities, counties, and/or regions, depending upon the analysis results.

(3) Analysis of available claims data, combined with eligibility information, will provide the basis for an access study. This may be conducted over a period of time, depending on data availability, quality and consistency. Other available data from the paid claims system or other sources may be analyzed, as appropriate.

(4) The SMA recommended rates will be calculated, based on the results of the analysis of economic and other relevant factors, on a statewide, county, or other geographic area basis. Calculations may include a form of averaging, or identifying the mean of specific geographically comparable wages, or other factors. Other analyses may be undertaken to evaluate program effectiveness and adequacy of access. Such analyses may include, but not necessarily be limited to:

- o Geographic area analysis of expenditures per Medi-Cal recipient.
- o Geographic area analysis of average and total hours per Medi-Cal recipient.
- o Comparison of utilization to eligibility factors.

(5) Prior to commencing the rate study pursuant to this section, the department will make public a notification of its intent to commence the rate study. Counties may submit to the Department data regarding the county's individual economic conditions, prevailing wages for like services, access information, or any other information that the county finds relevant to the rate study.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

(6) SMA rates will be reviewed periodically, to ensure that access is not impaired. These reviews may include an analysis of inflation indicators, regional or statewide wage studies, or other appropriate data. Any county or group of counties may at any time request a periodic rate review, irrespective of any regularly scheduled periodic review, if the county or group of counties believe that conditions which bear on the results of the rate study have changed subsequent to the previous periodic review. The Department will consider such requests, and, based on the information presented in the request, may undertake a periodic rate review.

I. PAYMENTS AND UNITS OF SERVICE

Reimbursements for services shall be made only to the provider authorized by the Department to provide Personal Care Services to beneficiaries. The rates shall be based upon a time-based unit of service.

J. PUBLIC HEARING

(1) The evidentiary database used to develop the rates will be made publicly available and a public hearing convened pursuant to paragraph (b) at page 1 of this Attachment 4.19-B. Interested parties, including beneficiaries, counties, public authorities, nonprofit consortia, unions representing providers of personal care services, and the general public will have the opportunity at the public hearing to request adjustment of rates and may present any relevant testimony, including, but not limited to, any of the matters specified in Welfare and Institutions Code Section 14132.95, subdivision (j)(2).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

(2) Rates adopted in the California Code of Regulations will reflect the total rate, inclusive of any county participation in the state share pursuant to paragraph D(2), above.

State/Territory: California

Citation | Condition or Requirement

REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES

The policy of the State Agency is that reimbursement for Drug Medi-Cal (DMC) services shall be limited to the lowest of the county or contract provider's published or customary charge to the general public for providing the same or similar services, the provider's allowable costs of rendering these services, or the Statewide Maximum Allowances (SMA). For Narcotic Treatment Programs, reimbursement is limited to the lower of the provider's published or customary charge to the general public for the same or similar services, or the uniform statewide monthly reimbursement rate established in Section D below, as defined by the State Department of Alcohol and Drug Programs (ADP) and approved by the Department of Health Services (DHS). In no case shall payments exceed SMA.

A. DEFINITIONS

"Published charges" are usual and customary charges prevalent in the alcohol and drug treatment services sector that are used to bill the general public, insurers, and other non-Title XIX payers. (42 CFR 447.271 and 405.503(a)).

"Statewide maximum allowances" (SMA) are upper limit rates, established for each type of service, for a unit of service.

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in HCFA Publication 15-1.

"Provider of Services" means any private or public agency that provides direct substance abuse treatment services and is certified by the State as meeting applicable standards for participation in the DMC Program, as defined in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics.

"Unit of service" (UOS) means a face-to-face contact on a calendar day for Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential Substance Abuse Services, and Naltrexone Treatment Program services. For these services, only one unit of service per day is covered by DMC except for emergencies when additional face-to-face contact may be covered for unplanned crisis intervention. To count as a unit of service, the second contact shall not duplicate the services provided on the first contact, and the contact shall clearly be documented in the beneficiary's patient record. For Narcotic Treatment Program services,

State/Territory: California

Citation | Condition or Requirement

"Unit of Service" means each calendar day a client receives services, including take-home dosing.

"Legal entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with ADP.

B. REIMBURSEMENT METHODOLOGY

1. The reimbursement methodology for providers of DMC Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential Substance Abuse Services, and Naltrexone Treatment Program services, is based on the lowest of:

   a. The provider's published or customary charge to the general public for providing the same or similar services;

   b. The provider's allowable costs of rendering these services; or

   c. The SMA established in Section C below, as defined by ADP and approved by DHS.

   The above reimbursement limits are applied at the time of settlement of the year-end cost reports. Reimbursement is based on comparisons to each provider's total, aggregated allowable costs after application of SMA to total aggregated published charges, by legal entity.

2. The reimbursement methodology for providers of DMC Narcotic Treatment Program services is based on the lower of:

   a. The provider's published or customary charge to the general public for the same or similar services, or

   b. The uniform statewide monthly reimbursement rate established in Section D below, as defined by ADP and approved by DHS.

State/Territory: California

Citation	Condition or Requirement

C. SMA METHODOLOGY FOR DMC OUTPATIENT DRUG FREE TREATMENT, DAY CARE REHABILITATIVE TREATMENT, NALTREXONE TREATMENT, AND PERINATAL RESIDENTIAL SUBSTANCE ABUSE SERVICES

"SMA" are based on the statewide median cost of each type of service as reported in the year-end cost reports submitted by providers for the fiscal year, which is two years preceding the year for which SMA are published.

D. UNIFORM STATEWIDE MONTHLY REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS

The uniform statewide monthly reimbursement rate is based on the averaged daily cost of dosing and ingredients and ancillary services described in Section E, based on the annual cost per patient and a 365-day year, using the most recent and accurate data available, and in consultation with DHS, narcotic treatment providers, and county alcohol and drug program administrators.

E. ALLOWABLE SERVICES

Allowable services and units of service are as follows:

Service	Unit of Service
Day Care Rehabilitative Treatment	Minimum of three hours per day, three days per week.
Outpatient Drug Free Treatment	Individual (50-minute minimum session) or group (90-minute minimum session) counseling.
Perinatal Residential Substance Abuse Treatment	24-hour structured environment (excluding room and board).
Naltrexone Treatment	Face-to-face contact per calendar day for counseling and/or medication services

State/Territory: California

Citation	Condition or Requirement
Narcotic Treatment Programs (aggregate rate consisting of four (4) components)	
1. Core	Intake assessment, treatment planning, physical evaluation, drug screening, and physician supervision.
2. Laboratory Work	Tuberculin and syphilis tests, monthly drug screening, and monthly pregnancy tests of female LAAM patients.
3. Dosing	Ingredients and dosing fee for methadone and LAAM patients.
4. Counseling	Minimum of fifty (50) minutes to be provided and billed in ten (10) minute increments, up to a maximum of 200 minutes based on the medical needs of the patient.

Attachment 4.19-B, Page 42 has been deleted from the State Plan

Please refer to SPA 00-016

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

Reimbursement methodology for sign language interpreter services for the deaf or hearing-impaired as described in Title 22, California Code of Regulations, Section 51503.3.

1. Reimbursement rates have been established for sign language interpreter services, based on a specific unit of time and shall be reimbursed only when the sign language interpreter service has actually occurred on behalf of a Medi-Cal beneficiary, and when it is incident to another Medi-Cal covered service billed by a Medi-Cal enrolled provider that employs fewer than fifteen employees as a means of providing effective, accurate and impartial communication, as determined by the beneficiary and the provider, in a medical setting.

2. Reimbursement rates have been established and shall be paid on an hourly rate for a minimum of two hours. Services in excess of two hours shall be paid in 15 minute increments based on an hourly rate, exclusive of mileage as described in number 8. The two-hour minimum is the standard minimum currently charged by sign language interpreters. In order to ensure participation of this group in the Medi-Cal Program, it is necessary to meet this standard.

3. Sign language interpreters who provide interpreter services to the deaf or hearing-impaired can be either certified or non-certified interpreters. Certified sign language interpreters hold a current certification by one of the following: 1) The National Registry of Interpreters for the Deaf (RID); 2 The National Association of the Deaf (NAD)/California Association of the Deaf (CAD) at a competency Level IV or V only; or 3) The California Department of Rehabilitation at a competency Level III and posses a certificate from RID, NAD/CAD at a competency Level IV or V only. Non-certified sign language interpreters do not hold a certification in one of the areas noted above.

4. A separate and distinct rate has been established for the certified and the non-certified interpreter.

5. Only small Medi-Cal providers, who employ less than fifteen (15) employees, are eligible for reimbursement as a "medical assistance" cost for sign language interpreter services.

6. The certified sign language interpreter rate shall be calculated based on the State's civil service pay scale, using the civil service classification code number 9820 titled, Support Services Assistant (Interpreter,) and the maximum monthly salary rate for the classification of $2,760.00.

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

7. A 30 percent benefit factor of $828.00 consisting of Old Age Security Disability Insurance, Health Insurance and Retirement is added to the maximum monthly salary rate to equal $3,588.00. This amount is divided by the actual number of hours worked of 148 hours to equal $24.24.

The 148 hours is arrived at as follows:

40	Hours in a work week
52	Multiplied by the number of weeks in a year
2,080	Equals number of hours in a year
120	Less vacation hours @ three weeks per year
80	Less sick leave hours @ two weeks per year
104	Less holidays @ 13 days per year
1,776	Equals work hours per year
12	Divided by months per year
148	Equals work hours per month

8. Reimbursement for sign language interpreter services shall be for a minimum of two hours of service. The two hour rate is calculated as follows:

$24.24	Hourly salary & benefits
2.0	Multiplied by number hours/visit
$48.48	Equals salary & benefits/visit
$13.00	Plus estimated mileage @ 50 miles round trip--0.26 cents per mile
$61.48	Equals base rate/visit
$1.05	Multipled by agency referral add-on factor ($3.07)
$64.55	**Equals rate/visit, certified interpreter**
60%	Multipled by average fee differential
$38.73	**Equals rate/visit, noncertified interpreter**

Additional sign language interpreter services shall be billed in 15-minute increments as follows:

$6.06	Hourly salary & benefits—15 minute increments ($24.24 per hour)
1.05	Multipled by agency referral add-on factor ($0.30)
6.36	**Each additional 15-minutes, certified interpreter**
60%	Multiplied by average fee differential
$3.82	**Each additional 15-minutes, noncertified interpreter**

9. Only Medi-Cal enrolled providers that employ fewer than fifteen employees can bill Medi-Cal for sign language interpreter rates for deaf or hearing-impaired beneficiaries when another Medi-Cal service has been rendered, or for an adult who is deaf or hearing-impaired when necessary to facilitate medically necessary services to a beneficiary. Medi-Cal enrolled providers that employ fewer than fifteen employees are responsible for making payment to the sign language interpreter. Regulations governing reimbursement for sign language interpreter services will be amended to require that a Medi-Cal enrolled provider that employs fewer than fifteen employees, maintain files in accordance with Title 22, California Code of Regulations, Section 51476, which shall contain records of reimbursements made to sign language interpreters.

10. The Department will ensure "free care" and "third-party liability" requirements are met.

11. Limitations have been established to ensure that physicians and physician groups and other Medi-Cal enrolled providers do not claim for these charges inappropriately.

    Certified and non-certified sign language interpreter services for a basic, two-hour minimum are limited to one per day, per provider, per beneficiary. Each additional 15 minute increment when the interpreter service exceeds the basic two-hour minimum service due to lengthy or multiple medical appointments is limited to a total of 24 increments per provider, per beneficiary, per day. System changes have been established to track specific procedure codes entered on claims submitted for reimbursement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR PUBLIC OUTPATIENT HOSPITAL SERVICES

This program provides supplemental reimbursement for an outpatient department of a general acute care hospital that is owned by a city, county, city and county, the University of California, or health care district, which meets specified requirements and provides outpatient hospital services to Medi-Cal beneficiaries.

Supplemental reimbursement under this program is available only for costs that are in excess of the payments the hospital receives per visit or per procedure for outpatient hospital services from any source of Medi-Cal reimbursement.

A. Definition of an Eligible Hospital

A hospital is determined eligible only if the local agency continuously has all of the following additional characteristics during the Department's rate year beginning August 1, 2002, and subsequent rate years:

1. Provides services to Medi-Cal beneficiaries.

2. Is an acute care hospital providing outpatient hospital services. For purposes of this section, "acute care hospital" means the facilities described at subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

3. Is owned by a city, county, city and county, the University of California, or health care district organized pursuant to Chapter 1 of Division 23 (commencing with Section 32000) of the Health and Safety Code.

Local agencies of eligible hospitals must provide certification to the state that the amount claimed by them is eligible for federal financial participation.

B. Supplemental Reimbursement Methodology

Supplemental reimbursement provided by this program to an eligible hospital is intended to allow federal financial participation for certified public expenditures. The supplemental reimbursement methodology is as follows:

1. As described in paragraph A, the expenditures certified by the local agency to the State shall represent the payment eligible for federal financial participation. Allowable certified public expenditures shall determine the amount of federal financial participation.

2. In no instance shall the amount certified pursuant to paragraph C.1, when combined with the amount received and payable from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of the costs for outpatient hospital services at each hospital.

3. The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on outpatient hospital services provided to Medi-Cal patients at the eligible hospital. Pursuant to paragraph C.1, the hospital shall certify to the Department, on an annual basis, the amount of its eligible costs for providing Medi-Cal outpatient hospital services.

4. Costs for outpatient services that are otherwise payable by or reimbursable under the prospective payment reimbursement for federally qualified health centers and rural health clinics set forth earlier in this Attachment, or the cost based reimbursement methodology set forth in Supplement 5 to this Attachment, are not eligible as certified public expenditures under this supplemental reimbursement methodology.

5. The hospital's Medicaid outpatient costs for the subject year will be computed in a manner consistent with Medicare cost accounting principles and will not include any Medi-Cal program non-reimbursable cost centers.

6. The hospital Medicaid outpatient costs will be derived by reducing each hospital's Medicaid outpatient charges less any amounts not payable by Medicaid including but not limited to third party payments and co-payments made by patients. The data used for the computations will come from each hospital's most recently available completed HCFA 2552 Medicare/Medicaid cost report and survey data provided by each hospital. The Medi-Cal cost report data will be reported in a manner consistent with the methods used to complete the Medicare cost report.

   The State will reconcile annually, and for three years after the period for which the claim was submitted, cost information from filed hospital cost reports to cost information from settled/audited cost reports. In addition, the State will reconcile actual

expenditures and payments to any amounts used initially to determine the supplemental payment. When any reconciliation results in an underpayment or overpayment to a facility, no less than annually the State will adjust the affected facility's supplemental payment.

7. Consistent with Medicare cost accounting principles and excluding any Medi-Cal program non-reimbursable costs center, for the hospital facility component (excluding professional component costs but including the provider based component of physician costs determined under Medicare cost reporting), the following items will be identified at the hospital departmental level:

   - Total facility cost to total charges, regardless of payer type, ratios by department.

   - Total Medicaid outpatient charges less any amounts not payable by Medicaid including but not limited to third party payments and co-payments made by patients.

   The departmental cost to charge ratios will be multiplied by Medicaid outpatient hospital charges to derive cost. These departmental level totals will be added to yield the hospital's Medicaid outpatient costs. The cost-to-charge ratios, as reflected in the Medi-Cal Cost Report, will be used to reduce Medicaid outpatient charges to Medicaid outpatient costs by hospital department. A department is equivalent to a cost center on the Medicare Form 2552 hospital cost report.

8. The hospital's total Medi-Cal payments for outpatient hospital services for the facility component will be determined using Medi-Cal paid claims data for the same fiscal period. The hospital's total Medicaid outpatient costs determined under paragraph 7 will be reduced by the hospital's total Medi-Cal payments, less amounts paid by Medi-Cal for the professional component of the services, yielding the certified public expenditure amount.

C. Hospital Reporting Requirements

The local agency reporting on behalf of any eligible hospital must do all of the following:

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for hospital outpatient hospital services are eligible for federal financial participation.

2. Provide evidence supporting the certification as specified by the Department.

3. Submit data as specified by the Department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

4. Keep, maintain and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible hospital is entitled, and any other records required by the Centers for Medicare & Medicaid Services.

D. Standards for Supplemental Reimbursement

1. The Department may require that any general acute care hospital owned by a city, county, city and county, the University of California, or health care district receiving supplemental reimbursement under this program enter into a written interagency agreement with the Department for the purposes of implementing this program.

2. Supplemental reimbursement paid under this program must comply with the requirements of Section B. above.

E. Department's Responsibilities

1. The Department will submit claims for federal financial participation for the expenditures for services that are allowable expenditures under federal law.

2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

3. The State share of the supplemental reimbursement under this program will be equal to the amount of the federal financial participation of eligible expenditures paid by city, county, city and county, the University of California or health care district funds and certified to the state as specified in Section C.1, above.

4. Aggregate Medi-Cal reimbursement provided to State government-owned or operated hospitals and non-state government-owned or operated facilities will not exceed applicable federal upper payment limits (UPL) determined under 42 C.F.R.

§447.321. For purposes of determining the reasonable estimates of the amounts that would be paid for outpatient hospital services under Medicare payment principles required by the UPL, only the facility component of outpatient services will be considered. Medi-Cal payments for the facility component of hospital outpatient services, which will consist of the non-federal and federal share of the outpatient supplemental payments under this section for the facility component combined with all other Medi-Cal outpatient payments for the facility component, will be aggregated by hospital group and compared to the UPL determined for each group.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ENHANCED PAYMENTS TO PRIVATE TRAUMA HOSPITALS

This segment of the State Plan describes an enhanced Medi-Cal payment for outpatient hospital trauma and emergency services to private hospitals within Los Angeles County and Alameda County that have demonstrated a need for assistance in ensuring the availability of essential trauma services for Medi-Cal beneficiaries, and that meet the requirements in Section A, below.

A. DEFINITION OF AN ELIGIBLE TRAUMA HOSPITAL

A Trauma Hospital is eligible only if it is a privately owned hospital and continuously has all of the following characteristics during the period for which payments are made:

1. Is capable of treating one or more types of potentially seriously injured persons and has been designated as part of the regional trauma care system by the local Emergency Medical Service (EMS) agency, in accordance with Health & Safety Code section 1798.160.

2. Maintains specialized equipment and a panel of physician specialists available at all times to treat trauma patients, as required by California Code of Regulations, Title 22, sections 100259 [for Level I and Level II Trauma Centers], 100261 [for Level I and Level II Pediatric Trauma Centers], 100263 [for Level III Trauma Centers], and 100264 [for Level IV Trauma Centers].

3. Provides trauma and emergency medical services to Medi-Cal beneficiaries.

4. Has a contract in effect with the local EMS agency.

5. Has received certification from the local EMS agency that the enhanced trauma hospital payments would help ensure continued access to trauma services for Medi-Cal beneficiaries within Los Angeles County or Alameda County.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

6. Has a contract in effect with the California Department of Health Services (DHS) that complies with the requirements set forth in Section B, below.

B. ENHANCED TRAUMA HOSPITAL PAYMENTS -- AUTHORITY AND METHODOLOGY

Notwithstanding any other provision of this Attachment, DHS may contract to provide enhanced trauma payments to Eligible Trauma Hospitals pursuant to Welfare and Institutions Code sections 14087.3 or any similar or successor statutory authority.

1. The enhanced trauma hospital payments provided by DHS shall be specified in the contract and shall be based on negotiated amounts for Medi-Cal trauma and emergency room services provided in a hospital outpatient department of the Eligible Trauma Hospital, except when such services are immediately followed by an inpatient admission.

2. (a) The enhanced trauma hospital payments that are negotiated will take into account the recommendation of the local EMS agency and will not exceed the aggregate of all Eligible Trauma Hospitals' uncompensated costs of providing outpatient hospital services to Medi-Cal beneficiaries within the participating county. For purposes of determining this payment limit, each Eligible Trauma Hospital's uncompensated costs for Medi-Cal outpatient hospital services will be determined for the immediately prior fiscal year (based on the hospital's most recently filed Medi-Cal cost report, in a format specified by DHS), and will include the uncompensated costs of trauma and emergency services, and all other Medi-Cal outpatient hospital services rendered to Medi-Cal beneficiaries.

(b) A Trauma Hospital's uncompensated costs will also include Medi-Cal's proportionate share of the uncompensated costs incurred for physician availability for trauma and emergency services,

whether or not such costs are recognized as allowable under Medicare reasonable cost principles.

(c) The Uncompensated costs described in Paragraph B. 2(a), will be determined in accordance with cost reimbursement principles identified in 42 C.F.R. Part 413, and to the extent not governed by Part 413, by Generally Accepted Accounting Principles.

(d) Subject to the payment limits set forth in Paragraph B.2(a), an Eligible Trauma Hospital may receive enhanced trauma hospital payments in excess of its individual uncompensated costs, as calculated pursuant to Paragraph B.2(a)-(c), so long as the aggregate Medi-Cal payments to all private hospitals do not exceed the applicable upper payment limit established in 42 C.F.R. section 447.321.

3. Differences between the cost data used for purposes of determining the enhanced trauma hospital payment amounts and the final cost information from the settled/audited cost reports will not be reconciled.

4. Any administrative fees imposed by DHS, associated with administering the Enhanced Payments to Private Trauma Hospitals program, may not be considered in the calculation of the uncompensated Medi-Cal costs.

5. Payments will be made on a quarterly, semi-annual or annual lump sum basis or may be made on any other federally allowable basis provided for in the Eligible Trauma Hospital's contract with DHS. Payments will be directly related to the fiscal year in which services are rendered.

6. (a) In no event will total enhanced trauma hospital payments in each County exceed the funds made available by that County for purposes of enhanced Medi-Cal trauma hospital payments plus the related federal reimbursement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

(b) Total supplemental payments will be the lesser of the amount of the total county funds (plus federal reimbursement), or the amount of allowable uncompensated costs in the aggregate of all the Eligible Trauma Hospitals within the participating county.

For example, if uncompensated costs, calculated as specified in Paragraph B.2, for the eligible hospitals, are $1,100,000 in the aggregate, and the counties transfer $600,000 in eligible funds to DHS, DHS will make supplemental payments of $1,100,000 to the eligible hospitals.

Conversely, if the uncompensated costs are $1,100,000, and the counties transfer $500,000 to DHS, DHS will make supplemental payments totaling $1,000,000 (assuming a 50 percent Federal Medical Assistance Percentage) to the eligible hospitals.

7. The enhanced trauma hospital payments will supplement, and will not supplant, any current Medi-Cal payments for trauma or emergency services.

8. Total Medi-Cal reimbursement provided to an Eligible Trauma Hospital will not exceed applicable federal upper payment limits as described in 42 C.F.R. 447.321.

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 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
Arrowhead Regional Medical Center
Contra Costa Regional Medical Center
Kern Medical Center
Natividad Medical Center
Riverside County Regional Medical Center
San Francisco General Hospital
San Joaquin General Hospital
San Mateo County General Hospital
Santa Clara Valley Medical Center
Tuolumne General Hospital (for the period July 1, 2005-June 30, 2007 only)
Ventura County Medical Center

Non-State Government-operated:

Los Angeles County (LA Co.) Hospitals:

LA Co. Harbor/UCLA Medical Center
LA Co. Martin Luther King Jr./Drew Medical Center (for the period July 1, 2005-August 15, 2007 only)

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)

2. Government-operated hospitals must maintain a Selective Provider Contracting Program (SPCP) contract with the Department of Health Services (Department) in order for it and its affiliated government entities to participate in the cost-based reimbursement methodology under this segment of Attachment 4.19-B. The services described in this segment of Attachment 4.19-B are not required to be provided under the SPCP contract.

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)

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/Territory: California

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in items 1&2 of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A SP Deductibles SP Coinsurance	
	Part B SP Deductibles SP Coinsurance	
Other Medicaid Recipients	Part A SP Deductibles SP Coinsurance	
	Part B SP Deductibles SP Coinsurance	
Dual Eligible (QMB Plus)	Part A SP Deductibles SP Coinsurance	
	Part B SP Deductibles SP Coinsurance	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

1. Payments for nursing facilities services are made up to the full amount of the Medicare rates, and are to be considered as designated "MR."

2. For Medicare Part B psychiatric services payments are limited to the State Plan rates considering the full difference, if any, between the actual Medicare payments and the Medicare allowable and are not limited to the Medicare "cost sharing amounts", and are to be considered as designated "SP."

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part C Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State Plan, the Medicaid agency uses the Medicare payment rates unless a special rate or method is set out on Page 3 in item of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".

3. ☒ Payments are up to the amount of a special rate, or according to a special method, described on Page 6 in items 1-2 of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item(s) _ of this attachment (see 3. above).

TN No. 06-007
Supersedes
TN No. _____

Approval Date FEB - 5 2007

Effective Date April 1, 2006

HFCA ID:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part C Deductible/Coinsurance

QMBs:	Part A	_____	Deductibles	_____	Coinsurance
	Part B	_____	Deductibles	_____	Coinsurance
	Part C	NR	Deductibles	NR	Coinsurance
Other Medicaid Recipients	Part A	_____	Deductibles	_____	Coinsurance
	Part B	_____	Deductibles	_____	Coinsurance
	Part C	NR	Deductibles	NR	Coinsurance
Dual Eligible (QMB Plus)	Part A	_____	Deductibles	_____	Coinsurance
	Part B	_____	Deductibles	_____	Coinsurance
	Part C	NR	Deductibles	NR	Coinsurance

TN No. 06-007

Approval Date FEB - 5 2007

Supersedes
TN No._____

Effective Date April 1, 2006

HFCA ID.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part C Deductible/Coinsurance

1. For Qualified Medicare Beneficiaries (QMB) and other Medicaid recipients enrolled in Medicare Part C (Medicare Advantage) managed health care plans, the department will pay the difference of the Medicare plan's payment to the provider for a service or services identified, including any billed charges for deductibles, coinsurance, and/or co-payments, and the maximum allowable reimbursement rate under the Medicaid State Plan for the same identified service or services only if the maximum allowable reimbursement rate under the Medicaid State Plan exceeds the Medicare plan's payment.

2. For QMB and QMB Plus recipients enrolled in Medicare Advantage managed care health plans, the department will pay no more than the Medicare fee-for-service payment for the same identified service or services if the service is not allowable under the Medicaid State Plan.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -PRESCRIBED DRUGS

PAYMENT METHODOLOGY FOR PRESCRIPTION DRUGS

The policy of the State Agency is that reimbursement for Pharmaceutical Services and Prescribed Drugs, as one category of health care or service from among those listed in Section 1905(a) of the Social Security Act that are included in the program under the plan, will be at the provider pharmacy's current charges to the general public, up to the State Agency's limits. The price providers charge to the program shall not exceed that charged to the general public. The pharmacist, to the extent permitted by law, shall dispense the lowest cost, therapeutically equivalent drug product that the pharmacy has in stock, which meets the medical needs of the beneficiary.

The methodology utilized by the State Agency, in compliance with 42 C.F.R. §§ 447.331 and 447.332, in establishing payment rates for Pharmaceutical Services (pharmacy dispensing fees) and Prescribed Drugs (dispensed drug products) to implement the policy is as follows:

A. The method used to establish maximum drug product payments is that payments for drugs dispensed by pharmacists shall consist of the state's Estimated Acquisition Cost (EAC) of the drug product dispensed plus a dispensing fee that is added to the drug product payment (see paragraph B below). The EAC is the lowest of the Average Wholesale Price (AWP) minus 17 percent, the Maximum Allowable Ingredient Cost (MAIC); the federal upper limit of reimbursement for listed multiple source drugs (called "Federal Upper Limit," or FUL), or the charges to the general public.

B. The professional fee for dispensing is seven dollars and 25 cents ($7.25) per dispensed prescription. The professional fee for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility is eight dollars ($8.00) per dispensed prescription. For the purposes of this paragraph B, "skilled nursing facility" and "intermediate care facility" mean as defined in Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations.

C. For purposes of this Supplement 2, the following definitions apply:

- "Average wholesale price" means the price for a drug product listed in the department's primary price reference source.

- "Direct price" means the price for a drug product purchased by a pharmacy directly from a drug manufacturer listed in the department's primary reference source.

- "Federal upper limit" means the maximum per unit reimbursement when established by the Centers for Medicare and Medicaid Services and published by the department in Medi-Cal pharmacy provider bulletins and manuals.

- "Generically equivalent drugs" means drug products with the same active chemical ingredients of the same strength, quantity, and dosage

form, and of the same generic drug name, as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), as those drug products having the same chemical ingredients.

- "Legend drug" means any drug whose labeling states "Caution: Federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

- "Maximum Allowable Ingredient Cost" (MAIC) means the maximum amount the department will reimburse Medi-Cal pharmacy providers for generically equivalent drugs.

- "Innovator multiple source drug," "noninnovator multiple source drug," and "single source drug" have the same meaning as those terms are defined in Section 1396r-8(k)(7) of Title 42 of the United States Code, the National Rebate Agreement, and other Federal instructions.

- "Nonlegend drug" means any drug whose labeling does not contain one or more of the statements required to be a "legend drug".

- "Wholesale Selling Price" (WSP) means the weighted (by unit volume) mean price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor.

D. For purposes of paragraph A, the department shall establish a list of MAICs for generically equivalent drugs, which shall be published in Medi-Cal pharmacy provider bulletins and manuals. The department will update the list of MAICs and establish additional MAICs in accordance with the following:

- The department will base the MAIC on the mean of the wholesale selling prices of drugs generically equivalent to the particular innovator drug that are available in California from wholesale drug distributors selected by the department.

- The department will update MAICs at least every three months and notify Medi-Cal providers at least 30 days prior to the effective date of a MAIC.

E. The federal upper limits of reimbursement, FUL, are initiated by CMS and provided to the State Agency for implementation in the State Medicaid Manual of Instructions. Periodic revisions to Addendum A of Section 6305.3 of the Manual, which is the list of multiple source drugs and the FUL prices, are implemented by the State Agency following notice by CMS of new FUL prices. New FUL prices are implemented within the timeframe required by the CMS notice and as required by applicable California statutes and regulations.

F. Overrides to both the state and federal price ceilings are available only through a state prior approval mechanism. Prior approval is limited to

those cases where the medical necessity of a specific manufacturer's brand of a drug, priced above the ceiling, is adequately demonstrated to a state consultant. The documentation of the approval is linked to the claims payment system assuring correct reimbursement for the brand dispensed. The same system is used for approval and payment for drugs not on the state Medicaid Drug Formulary, known as the Medi-Cal List of Contract Drugs.

G. The Medi-Cal List of Contract Drugs (List), a preferred drug list, is established pursuant to Section 1927 of the Social Security Act with prior authorization required for drugs not included on the List. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations. Prior authorization is applied to certain drug classes, particular drugs, or medically accepted indications for use and doses. The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

H. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by telephone, fax, or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a 72-hour supply of medications in accordance with the provisions of Section 1927(d)(5) of the Social Security Act.

l. The State Agency believes reimbursement to long-term pharmacy providers to be consistent and reasonable with costs reimbursed to other providers. The State Agency maintains an advisory committee known as the Medi-Cal Contract Drug Advisory Committee in accordance with Federal law.

DRUG REBATE PROGRAM

The State Agency is in compliance with Section 1927 of the Social Security Act. The State Agency reimburses providers of drugs of manufacturers participating in the drug rebate program and is in compliance with reporting requirements for utilization and restrictions to coverage. Pharmaceutical manufacturers can audit utilization data to the extent allowed under the Health Insurance Portability and Accountability Act (HIPAA) in order to ensure that the Department is protecting information in accordance with HIPAA. The unit rebate amount is confidential and is not disclosed to anyone not entitled to the information for purposes of rebate contracting, invoicing and verification.

SUPPLEMENTAL REBATE PROGRAM

The State Agency negotiates supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer are separately identified from the federal rebates.

Supplemental rebates received by the State Agency in excess of those required under the national drug rebate agreement are shared with the Federal government on the same percentage basis as applied under the national rebate agreement. CMS has

authorized the State of California to enter into the Medi-Cal Supplemental Drug Rebate Average Manufacturer Price (AMP) Agreement. This supplemental drug rebate agreement was submitted to CMS on December 30, 2005 and has been authorized by CMS. CMS has authorized the State of California to enter into the Medi-Cal Net Cost Supplemental Drug Rebate Agreement. This supplemental drug rebate agreement was submitted to CMS on December 30, 2005 and has been authorized by CMS.
All drugs covered by the program, notwithstanding a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

MEDI-CAL AVERAGE MANUFACTUER PRICE SUPPLMENTAL DRUG REBATE AGREEMENT

This Agreement is made and entered into this ____ day of _____ **(Insert Year)**, by and between the State of California (State), represented by the Department of Health Services (Department), and **(FULL, LEGAL NAME OF COMPANY)** (Contractor), Labeler Code **00000**. The parties, in consideration of the covenants, conditions, agreements, and stipulations expressed in this Agreement, do agree as follows:

ARTICLE I - PREAMBLE

1.1 It is the intent of this Agreement that, pursuant to Welfare and Institutions Code Sections 14105.31 and 14105.33, the Department will receive a Rebate for Contractor's Covered Product(s), including a State Supplemental Rebate, and that the Department will **(Add/Retain)** Contractor's Covered Product(s) **(to/on)** the Medi-Cal List of Contract Drugs. The parties also intend for this Agreement to meet the requirements of federal law at Title 42 United States Code Section 1396r-8.

ARTICLE II - DEFINITIONS

2.1 'Average Manufacturer Price' (AMP) and 'Best Price' means the Contractor's price(s) for the Covered Product(s) as these terms are defined pursuant to Section 1927 of the Social Security Act [42 USC 1396r-8] and calculated as specified in Contractor's CMS Agreement.

2.2 'Covered Product(s)' means the pharmaceutical product(s) **[CHEMICAL ENTITY (REGISTERED TRADEMARK NAME®), DOSAGE FORM, STRENGTH].**

2.3 'CMS Agreement' means the Contractor's drug rebate contract with the Centers for Medicare and Medicaid Services (CMS), entered pursuant to Section 1927 of the Social Security Act (42 USC 1396r-8).

2.4 'CMS Basic Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Contractor's CMS Agreement, made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act [42 USC 1396r-8(c)(1) and 42 USC 1396r-8(c)(3)].

2.5 'CMS CPI Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Contractor's CMS Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act [42 USC 1396r-8(c)(2)].

2.6 'Medi-Cal Utilization Data' means the data used by the Department to reimburse providers under all programs eligible to receive the CMS Basic Rebate. Medi-Cal Utilization Data excludes data from covered entities identified in Title 42 USC 256b(a)(4) in accordance with Title 42 USC 256b(a)(5)(A) and 1396r-8(a)(5)(C), and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

2.7 'Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Article III, Sections 3.1 and 3.2 of this Agreement.

2.8 'Rebate Summary' means the report itemizing the Medi-Cal Utilization Data supporting the Department's invoice for Rebates. The Rebate Summary will comply in all respects with requirements for Medicaid Utilization Information in the CMS Agreement.

2.9 'State Supplemental Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Article III, Section 3.2 of this Agreement.

ARTICLE III - CONTRACTOR'S RESPONSIBILITIES

3.1 Contractor will provide the Department a Rebate for the Covered Product(s), which includes the CMS Basic Rebate and CMS CPI Rebate, as appropriate. The CMS rebates represent the discount obtained by multiplying the units of the Covered Product(s) reimbursed by the Department in the preceding quarter by the per unit rebate amount provided to the Department by CMS. CMS will calculate the rebate amount in accordance with Contractor's CMS Agreement. Contractor's obligation for Rebates will continue for the duration of the Contractor's CMS Agreement.

3.2 In addition to the Rebates described in Section 3.1 of this Agreement, Contractor will remit to the Department a State Supplemental Rebate for the Covered Product(s) calculated as ___ **percent** of Contractor's AMP for the Covered Product(s). Contractor shall submit to the Department, on a quarterly basis, the AMP for each National Drug Code (NDC) number for each Covered Product. Such data shall be provided in the format and timeframe specified by the Department. Contractor agrees, pursuant to Welfare and Institutions Code Section 14105.332, that Rebates payable under this section shall not be reduced if the Contractor reports to CMS or the Department, a revised AMP or Best Price for any calendar quarter in which the rebate was due. In addition, the Contractor will remit an additional supplemental rebate payment equal to the difference between the initial CMS rebate paid and any revised CMS rebate amounts, as described in 3.1, should the rebate revision result in a reduction in the amount payable. as these terms are defined pursuant to Section 1927 of the Social Security Act [42 USC 1396r-8] The State Supplemental Rebate represents the discount obtained by multiplying the units of each Covered Product reimbursed by the Department in the preceding quarter by the applicable per unit amount specified above for each Covered Product for the same quarter. Contractor's obligation for State Supplemental Rebates will begin with the rebate billing period for **first, second, third, fourth** quarter **(Insert Year)** which begins **DATE GENERALLY SHOULD BE THE START OF A CALENDAR QUARTER**, and will continue through the quarter that ends **DATE GENERALLY COINCIDES WITH THE END DATE OF THE CONTRACT IN SECTION 5.9.**.

3.3 The quarters to be used for calculating the Rebates in Sections 3.1. and 3.2. of this Agreement will be those ending on March 31, June 30, September 30, and December 31 of each calendar year during the term of this Agreement.

3.4 Contractor will assist the Department in developing annual estimates of aggregate Rebates for the Department's budgetary purposes.

3.5 Contractor will pay the Rebates, including any applicable interest in accordance with Welfare and Institutions Code Sections 14105.31 and 14105.33(k) - (u), and federal laws, regulations, and/or guidelines. Interest on the Rebates payable under Section 3.1 and 3.2 of this Agreement begins accruing 38 calendar days from the postmark date of the Department's invoice and supporting utilization data sent to the Contractor and interest will continue to accrue until the postmark date of the Con· ·actor's payment. For Rebates invoiced for **first, second, third, fourth** calendar quarter **(Insert Year)**, and thereafter, if the date of mailing of the Rebate payable under Section 3.2 of this Agreement is 69 days or more from the date of mailing of the invoice, the interest rate will be calculated as required under federal guidelines, but will be increased by ten percentage points. For Rebates invoiced for **first, second, third, fourth** calendar quarter **(Insert Year)**, and thereafter, if the Department has not received the Rebates payable under Section 3.1 or 3.2 of this Agreement, including interest, within 180 days of the postmark date of the Department's invoice and supporting utilization data sent to the Contractor, this Agreement will be deemed to be in default and will be terminated in accordance with Section 5.11 of this Agreement.

3.6 With each quarterly remittance, Contractor will submit a Form CMS-304 (Reconciliation of State Invoice), consistent with federal requirements, and a separate Form CMS-304 for the State Supplemental Rebate. In the event that in any quarter any material discrepancy is discovered by Contractor, which Contractor in good faith is unable to resolve, Contractor will provide written notice of the discrepancy to the Department. The Department and Contractor will use their best efforts to resolve the discrepancy within 90 days of receipt by the Department of the notification.

3.7 If Contractor in good faith believes the amount claimed in the Rebate Summary is erroneous, Contractor may pay the Department only that portion of the amount claimed which is not disputed.

Upon resolution of the dispute, any balance will be paid by Contractor promptly; any overpayment will be credited against the next payment due, if any.

3.8 Contractor agrees to continue to pay a Rebate on the Covered Product(s) for as long as this Agreement is in force, and Medi-Cal Utilization Data shows that payment was made for that drug, regardless of whether the Contractor continues to market that drug.

3.9 Unless notified otherwise, Contractor will send Rebate payments to the following address:

Department of Health Services
Accounting Section
1501 Capitol Avenue, Suite 2048, MS 1101
Sacramento, CA 95814

ARTICLE IV - DEPARTMENT RESPONSIBILITIES

4.1 The Department will add the Covered Product(s) to the Medi-Cal List of Contract Drugs. **(ADD STATEMENT REGARDING EXCLUSIVITY OR CODE I RESTRICTIONS, IF APPLICABLE).**

4.2 The Department will provide Medi-Cal Utilization Data to Contractor on a quarterly basis. This data will be based on paid claims data (data used to reimburse pharmacy providers) under the Medi-Cal program, will be consistent with any applicable Federal or State guidelines, regulations and standards for such data, and will be the basis for the Department's calculation of the Rebate.

4.3 The Department will maintain those data systems and audits as are necessary to ensure the accuracy of the data used to calculate the Rebate. In the event material discrepancies are discovered, the Department will promptly justify its data or make an appropriate adjustment which may include a credit as to the amount of the Rebate or a refund to Contractor as the parties may agree.

4.4 Upon implementation of this Agreement, and from time to time thereafter, the Department and Contractor will meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Department to Contractor are adequate for the purposes of this Agreement.

4.5 The Department will provide Contractor with a copy of the independent auditor's report of the Electronic Data Processing Application Systems Audit of the Department's fiscal intermediary for Medi-Cal Utilization Data. In the event material discrepancies are discovered by the auditor, the Department will promptly justify its data or make an appropriate adjustment.

ARTICLE V - GENERAL PROVISIONS

5.1 This Agreement will be governed and construed in accordance with: (a) Part 3, Division 9 of the Welfare and Institutions Code; Division 3 of Title 22 of the California Code of Regulations; and all other applicable State law and regulations; and (b) Title 42 United States Code Section 1396; Title 42 of the Code of Federal Regulations; and all other applicable federal law and regulations.

5.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested. Notice to the Department will be sent to:

California Department of Health Services
Pharmacy Policy and Contracting Section
1501 Capitol Avenue, Suite 3041, MS 4604
Sacramento, CA 95814

Notice to Contractor will be sent to:

_____**(NAME)**

_____**(TITLE)**

_____**(COMPANY NAME)**

_____**(ADDRESS)**

5.3 Pursuant to 42 USC 1396r-8(b)(3)(D), the parties agree that confidential information will not be disclosed. Pursuant to Welfare and Institutions Code Section 14105.33(h) and Evidence Code Section 1060, the parties agree that the terms of this Agreement are confidential and exempt from disclosure under the California Public Records Act at Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code. Each party will treat trade secrets and other confidential information as confidential, will preserve the confidentiality and will not duplicate, disclose or use the information, except in connection with this Agreement or as may be required by judicial order. Notwithstanding the termination of this Agreement for any reason, these confidentiality provisions will remain in full force and effect.

5.4 Contractor and the agents and employees of Contractor in the performance of this Agreement, will act in an independent capacity and not as officers or employees or agents of the State of California.

5.5 This Agreement is not assignable either in whole or in part without the written consent of the Department, which will not unreasonably be withheld.

5.6 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision. The parties agree to negotiate replacement provisions, to afford the parties as much of the benefit of their original bargain as is possible.

5.7 The Department and Contractor declare that this Agreement, including attachments, contains a total integration of all rights and obligations of both parties. There are no extrinsic conditions or

collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of both parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind.

5.8 The introductory paragraph and sections 1.1, 2.2, 3.2, 3.5, 4.1, 5.2, and 5.9 of this Agreement will not be altered except by an amendment in writing signed by both parties and approved by the appropriate State control agencies. All other numbered sections of this Agreement will not be altered except by an amendment in writing signed by both parties and approved by the appropriate State control agencies and authorized by the Centers for Medicare and Medicaid Services. No person is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the State and Contractor and approved by the appropriate State control agencies.

5.9 This Agreement will be in effect from date of execution through **(Insert Date)**.

5.10 The Department intends to implement this contract through a single administrator, called the "Contracting Officer". The Contracting Officer will be appointed by the Director of the Department. The Contracting Officer will make all determinations and take all actions as are appropriate under this contract on behalf of the Department, subject to the limitations of California law.

5.11 This Agreement may be terminated by either party by giving written notice to the other party at least 90 days prior to the effective date of the termination. Termination of this Agreement will result in Contractor's Covered Product being available to Medi-Cal beneficiaries only through prior authorization.

5.12 Neither party contemplates any circumstances under which indemnification of the other party would arise. Nevertheless, should such circumstances arise, Contractor agrees to indemnify, defend and hold harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this Agreement.

5.13 Inasmuch as the State Supplemental Rebate required by this Agreement is only for Medi-Cal beneficiaries, the State Supplemental Rebate does not establish a new 'Best Price' for purposes of Contractor's CMS Agreement.

5.14 In the event that the Department determines, as a result of a therapeutic category review, that a Covered Product of the Contractor included on the Medi-Cal list of contract drugs as a consequence of this Agreement should be removed from the list of contract drugs and require prior approval, the parties agree that the terms of Section 5.11 shall apply.

As evidence of their Agreement to the foregoing terms and conditions the parties have signed below.

_____	_____
Sandra Shewry	_____**(NAME)**
Director	_____**(TITLE)**
Department of Health Services,	
(COMPANY NAME)	
for the State of California	
Dated:_____	Dated:_____

MEDI-CAL NET COST DRUG REBATE AGREEMENT

This Agreement is made and entered into this _____ day of _____ **(Year)**, by and between the State of California (State), represented by the Department of Health Services (Department), and **(ENTER FULL, LEGAL NAME OF COMPANY)** (Contractor), Labeler Code **00000**. The parties, in consideration of the covenants, conditions, agreements, and stipulations expressed in this Agreement, do agree as follows:

ARTICLE I - PREAMBLE

1.1 It is the intent of this Agreement that, pursuant to Welfare and Institutions Code Sections 14105.31 and 14105 33, the Department will receive a Rebate for Contractor's Covered Product(s), including a State Supplemental Rebate, and that the Department will **(add/retain)** Contractor's Covered Product(s) **(to/on)** the Medi-Cal List of Contract Drugs. The parties also intend for this Agreement to meet the requirements of federal law at Title 42 United States Code Section 1396r-8.

ARTICLE II - DEFINITIONS

2.1 'Estimated Acquisition Cost' (EAC) means the highest cost of the drug, pursuant to Welfare and Institutions Code, Section 14105.45, during the the calendar quarter that corresponds to the calendar quarter for which the Medi-Cal Utilization Data for the Covered Product(s) is reported to Contractor by the Department in the applicable Rebate Summary.

2.2 'Covered Product(s)' means the pharmaceutical product(s) **[CHEMICAL NAME (REGISTERED TRADEMARK NAME), DOSAGE FORM, STRENGTH].**

2.3 'CMS Agreement' means the Contractor's drug rebate contract with the Centers for Medicare and Medicaid Services (CMS), entered pursuant to Section 1927 of the Social Security Act (42 USC 1396r-8).

2.4 'CMS Basic Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Contractor's CMS Agreement, made in accordance with Section 1927(c)(1) or Section 1927(c)(3) of the Social Security Act (42 USC 1396r-8(c)(1) and 42 USC 1396r-8(c)(3)).

2.5 'CMS CPI Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Contractor's CMS Agreement, made in accordance with Section 1927(c)(2) of the Social Security Act (42 USC 1396r-8(c)(2)).

2.6 'Medi-Cal Net Cost' means the prescription drug ingredient reimbursement by NDC for the Covered Product(s) paid by the Department to Medi-Cal providers during a calendar quarter calculated as the EAC of the drug, minus the sum of all Rebates paid by Contractor to the Department for the Covered Product(s) for the same calendar quarter pursuant to Article III, Section 3.1. and 3.2. of this Agreement. In the event of any change to the calculation used by the Department to determine drug ingredient reimbursement paid by the Department to Medi-Cal providers, the parties may elect to renegotiate the terms of this Agreement pursuant to Section 5.8.

2.7 'Medi-Cal Utilization Data' means the data used by the Department to reimburse providers under all programs eligible to receive the CMS Basic Rebate . Medi-Cal Utilization Data excludes data from covered entities identified in Title 42 USC 256b(a)(4) in accordance with Title 42 USC 256b(a)(5)(A) and 1396r-8(a)(5)(C), and those capitated plans that include a prescription drug benefit in the capitated rate and that have negotiated contracts for rebates or discounts with manufacturers.

2.8 'Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Article III, Sections 3.1 and 3.2 of this Agreement. It also means equalization payment as used in Welfare and Institutions Code Section 14105.31(c).

2.9 'Rebate Summary' means the report itemizing the Medi-Cal Utilization Data supporting the Department's invoice for Rebates. The Rebate Summary will comply in all respects with requirements for Medicaid Utilization Information in the CMS Agreement.

2.10 'State Supplemental Rebate' means, with respect to the Covered Product(s), the quarterly payment by Contractor pursuant to Article III, Section 3.2 of this Agreement.

ARTICLE III - CONTRACTOR'S RESPONSIBILITIES

3.1 Contractor will provide the Department a Rebate for the Covered Product(s), which includes the CMS Basic Rebate and CMS CPI Rebate, as appropriate. The CMS rebates represent the discount obtained by multiplying the units of the Covered Product(s) reimbursed by the Department in the preceding quarter by the per unit rebate amount provided to the Department by CMS. CMS will calculate the rebate amount in accordance with Contractor's CMS Agreement. Contractor's obligation for Rebates will continue for the duration of the Contractor's CMS Agreement.

3.2 In addition to the Rebates described in Section 3.1. of this Agreement, Contractor will remit to the Department a State Supplemental Rebate for the Covered Product(s) such that the Medi-Cal Net Cost of the Covered Product(s) will be **($x.xx)** per **(Dollars & cents)** or a lower Medi-Cal Net Cost which may be generated by Contractor's CMS Agreement. Contractor's obligation for State Supplemental Rebates will begin with the rebate billing period for **first, second, third, fourth** quarter **year** which begins **DATE GENERALLY SHOULD BE THE START OF A CALENDAR QUARTER**, and will continue through the quarter that ends **DATE GENERALLY COINCIDES WITH THE END DATE OF THE CONTRACT IN SECTION 5.9**.

3.3 The quarters to be used for calculating the Rebates in Section 3.1. and 3.2. of this Agreement will be those ending on March 31, June 30, September 30, and December 31 of each calendar year during the term of this Agreement.

3.4 Contractor will assist the Department in developing annual estimates of aggregate Rebates for the Department's budgetary purposes.

3.5 Contractor will pay the Rebates, including any applicable interest on late Rebate payments, in accordance with Welfare and Institutions Code Sections 14105.31 and 14105.33(k) - (u), and

federal laws, regulations, and/or guidelines. Interest on Rebates payable under Section 3.1 of this Agreement begins accruing 38 calendar days from the postmark date of the Department's invoice and supporting utilization data sent to the Contractor, and interest will continue to accrue until the postmark date of the Contractor's payment. For State Supplemental Rebates payable under Section 3.2 of this Agreement, interest is only applicable to invoices for **first, second, third, fourth** calendar quarter **year**, and thereafter, and if the date of mailing of the Rebate payable under Section 3.2 of this Agreement is 69 days or more from the date of mailing of the invoice, the interest rate will be calculated as required under federal guidelines, but will be increased by ten percentage points. For Rebates invoiced for **first, second, third, fourth** calendar quarter **year**, and thereafter, if the Department has not received the Rebates payable under Section 3.1 or 3.2 of this Agreement, including interest, within 180 days of the postmark date of the Department's invoice and supporting utilization data sent to the Contractor, this Agreement will be deemed to be in default and will be terminated in accordance with Section 5.11 of this Agreement.

3.6 With each quarterly remittance, Contractor will submit a Form CMS-304 (Reconciliation of State Invoice), consistent with federal requirements, and a separate Form CMS-304 for the State Supplemental Rebate. In the event that in any quarter any material discrepancy is discovered by Contractor, which Contractor in good faith is unable to resolve, Contractor will provide written notice of the discrepancy to the Department. The Department and Contractor will use their best efforts to resolve the discrepancy within 90 days of receipt by the Department of the notification.

3.7 If Contractor in good faith believes the amount claimed in the Rebate Summary is erroneous, Contractor may pay the Department only that portion of the amount claimed which is not disputed. Upon resolution of the dispute, any balance will be paid by Contractor promptly; any overpayment will be credited against the next payment due, if any.

3.8 Contractor agrees to continue to pay a Rebate on the Covered Product(s) for as long as this Agreement is in force, and Medi-Cal Utilization Data shows that payment was made for that drug, regardless of whether the Contractor continues to market that drug.

3.9 Unless notified otherwise, Contractor will send Rebate payments to the following address:

Department of Health Services
Accounting Section
1501 Capitol Avenue, Suite 2048, MS 1101
Sacramento, CA 95814

ARTICLE IV - DEPARTMENT RESPONSIBILITIES

4.1 The Department will add the Covered Product(s) to the Medi-Cal List of Contract Drugs. **(ENTER HERE A STATEMENT REGARDING EXCLUSIVITY OR CODE I RESTRICTIONS, IF APPLICABLE).**

4.2 The Department will provide Medi-Cal Utilization Data to Contractor on a quarterly basis. This data will be based on paid claims data (data used to reimburse pharmacy providers) under the Medi-Cal program, will be consistent with any applicable Federal or State guidelines, regulations and standards for such data, and will be the basis for the Department's calculation of the Rebate.

4.3 The Department will maintain those data systems and audits as are necessary to ensure the accuracy of the data used to calculate the Rebate. In the event material discrepancies are discovered, the Department will promptly justify its data or make an appropriate adjustment which may include a credit as to the amount of the Rebate or a refund to Contractor as the parties may agree.

4.4 Upon implementation of this Agreement, and from time to time thereafter, the Department and Contractor will meet to discuss any data or data system improvements which are necessary or desirable to ensure that the data and any information provided by the Department to Contractor are adequate for the purposes of this Agreement.

4.5 The Department will provide Contractor with a copy of the independent auditor's report of the Electronic Data Processing Application Systems Audit of the Department's fiscal intermediary for

Medi-Cal Utilization Data. In the event material discrepancies are discovered by the auditor, the Department will promptly justify its data or make an appropriate adjustment.

ARTICLE V - GENERAL PROVISIONS

5.1 This Agreement will be governed and construed in accordance with: (a) Part 3, Division 9 of the Welfare and Institutions Code; Division 3 of Title 22 of the California Code of Regulations; and all other applicable State law and regulations; and (b) Title 42 United States Code Section 1396; Title 42 of the Code of Federal Regulations; and all other applicable federal law and regulations.

5.2 Any notice required to be given pursuant to the terms and provisions of this Agreement will be in writing and will be sent by certified mail, return receipt requested. Notice to the Department will be sent to:

California Department of Health Services
Pharmacy Policy and Contracting Section
1501 Capitol Avenue, Suite 3041, MS 4600
Sacramento, CA 95814

Notice to Contractor will be sent to:

_____(ENTER NAME)
_____(ENTER TITLE)
_____(ENTER COMPANY NAME)
_____(ENTER ADDRESS)

5.3 Pursuant to 42 USC 1396r-8(b)(3)(D), the parties agree that confidential information will not be disclosed. Pursuant to Welfare and Institutions Code Section 14105.33(h) and Evidence Code Section 1060, the parties agree that the terms of this Agreement are confidential and exempt from disclosure under the California Public Records Act at Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code. Each party will treat trade secrets and other confidential information as confidential, will preserve the confidentiality and will not duplicate, disclose or use the information, except in connection with this Agreement or as may be

required by judicial order. Notwithstanding the termination of this Agreement for any reason, these confidentiality provisions will remain in full force and effect.

5.4 Contractor and the agents and employees of Contractor in the performance of this Agreement, will act in an independent capacity and not as officers or employees or agents of the State of California.

5.5 This Agreement is not assignable either in whole or in part without the written consent of the Department, which will not unreasonably be withheld.

5.6 Nothing in this Agreement will be construed so as to require the commission of any act contrary to law. If any provision of this Agreement is found to be invalid or illegal by a court of law, or inconsistent with federal requirements, this Agreement will be construed in all respects as if any invalid, unenforceable, or inconsistent provision were eliminated, and without any effect on any other provision. The parties agree to negotiate replacement provisions, to afford the parties as much of the benefit of their original bargain as is possible.

5.7 The Department and Contractor declare that this Agreement, including attachments, contains a total integration of all rights and obligations of both parties. There are no extrinsic conditions or collateral agreements or undertakings of any kind. In regarding this Agreement as the full and final expression of their contract, it is the express intention of both parties that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period of time governed by this Agreement which are not expressly set forth herein are to have no force, effect, or legal consequences of any kind.

5.8 The introductory paragraph and sections 1.1, 2.2, 3.2, 3.5, 4.1, 5.2, and 5.9 of this Agreement will not be altered except by an amendment in writing signed by both parties and approved by the appropriate State control agencies. All other numbered sections of this Agreement will not be altered except by an amendment in writing signed by both parties and approved by the appropriate State control agencies and authorized by the Centers for Medicare and Medicaid Services. No person is authorized to alter or vary the terms or make any representation or inducement relative to

it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the State and Contractor and approved by the appropriate State control agencies.

5.9 This Agreement will be in effect from date of execution through **(Insert contract end date)**.

5.10 The Department intends to implement this contract through a single administrator, called the "Contracting Officer". The Contracting Officer will be appointed by the Director of the Department. The Contracting Officer will make all determinations and take all actions as are appropriate under this contract on behalf of the Department, subject to the limitations of California law.

5.11 This Agreement may be terminated by either party by giving written notice to the other party at least 90 days prior to the effective date of the termination. Termination of this Agreement will result in Contractor's Covered Product(s) being available to Medi-Cal beneficiaries only through prior authorization.

5.12 Neither party contemplates any circumstances under which indemnification of the other party would arise. Nevertheless, should such circumstances arise, Contractor agrees to indemnify, defend and hold harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of this Agreement.

5.13 Inasmuch as the State Supplemental Rebate required by this Agreement is only for Medi-Cal beneficiaries, the State Supplemental Rebate does not establish a new 'Best Price' for purposes of Contractor's CMS Agreement.

5.14 In the event that the Department determines, as a result of a therapeutic category review, that a Covered Product of the Contractor included on the Medi-Cal list of contract drugs as a consequence of this Agreement should be removed from the list of contract drugs and require prior approval, the parties agree that the terms of Section 5.11 shall apply.

As evidence of their Agreement to the foregoing terms and conditions the parties have signed below.

Sandra Shewry	_____(NAME)
Director	_____(TITLE)
Department of Health Services,	_____(COMPANY
NAME)	
for the State of California	
Dated:_____	Dated:_____

State/Territory: California

To assure federal financial participation in California under the new federal drug rebate program, California is modifying its State Plan to bring it in compliance with Sections 1902(a)(54) and 1927 of the Social Security Act.

Effective April 1, 1991, the State Agency will adjust its federal claiming process to reflect only those pharmaceutical manufacturers which have a signed rebate agreement with the Health Care Financing Administration.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

__X__ Rehabilitative mental health services for seriously emotionally disturbed children screened under the early periodic diagnosis, screening and treatment program and served through the Short-Doyle/Medi-Cal Program.

Units of service, offered to eligible children at the clinic site, the home, or in the community, shall be billed per client contact using rates and procedures described in the interagency agreement between the Department of Health Services and the Department of Mental Health. No increase in reimbursement will be made for expense incurred by taking services to eligible children.

The state assures that it shall conform to the requirements of 42 CFR 447.325 regarding upper limits of payment for services.

STATE PLAN AMENDMENT
COST-BASED REIMBURSEMENT

A. General Applicability

Notwithstanding any other provision of this State Plan, reimbursement for the types of services described in paragraph B.3, below, that are provided by facilities operated by, or contracting with, a county participating in a sub-state Medicaid Demonstration Project authorized under Section 1115 of the Social Security Act, shall be made as set forth below. This Supplement shall apply only for Medi-Cal services rendered to Medi-Cal beneficiaries on or after July 1, 2000, and only in conjunction with a Medicaid Demonstration Project, as referenced above. The providers or groups of providers who receive cost-based reimbursement under this Supplement will utilize the same cost reporting forms currently used by Federally Qualified Health Centers (FQHCs) in California, except hospital outpatient departments shall utilize the acute care hospital cost report form (HCFA 2552/most current version). This Supplement does not apply to those FQHCs and FQHC look-alikes described in Section 1905(l)(2)(B) of the Act.

B. Cost-Based Reimbursement

1. Methodology

(a) Reimbursement to eligible facilities shall be at 100 percent of reasonable and allowable costs for Medicaid services rendered to Medicaid beneficiaries enrolled in managed care or fee-for-service programs. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications (except for modifications described in this Supplement or otherwise approved by the Health Care Financing Administration (HCFA)):

(i) The Medicare reimbursement methodology for Rural Health Clinic and FQHC Services specified at 42 C.F.R. § 405.2460 through § 405.2470 (together with applicable definitions in Subpart X of Part 405 to the

extent those definitions are applied by the State in connection with FQHCs in California) and 42 C.F.R. Part 413. In the event of a conflict between the provisions of Part 405 and Part 413, the provisions of Part 405 will govern.

(ii) "The Provider Reimbursement Manual" (HCFA 15-1).

(iii) "Cost Principles for State, Local, and Indian Tribe Governments" (HCFA Circular A-87).

(iv) Rural Health Clinic and FQHC Manual (HCFA Publication 27).

(v) Welfare and Institutions Code, Section 14087.325, Subdivision(e), and any implementing regulations.

(vi) Other applicable federal directives.

(b) The provisions of paragraph B.1(a) and the regulations and publications referenced therein shall be subject to all of the following:

(i) Sections 405.2462(b)(2) through (b)(4), 405.2466(c)(2), and 405.2468(f), shall not be applicable.

(ii) Notwithstanding the provisions of the regulations and publications referenced in paragraph B.1(a), any dollar limit on otherwise allowable costs shall not be applicable.

(iii) Provisions of the regulations and publications referenced in paragraph B.1(a) that are not generally applied by the State to FQHCs in California shall likewise not be applied to eligible facilities subject to this Supplement.

(iv) Clinic visits shall be the basis for apportioning hospital outpatient costs among clinic payers regardless of the provisions of the regulations and publications referenced in paragraph B.1(a).

(v) The time for submitting the annual report specified in 42 C.F.R. § 405.2470(c)(2) shall be five months rather than 90 days.

(c) The methodology for reimbursement adopted by the State to comply with Section 1902(aa) of the Act shall not be applicable to facilities that are paid under this Supplement.

2. Facilities Eligible for Cost-Based Reimbursement

(a) For participating counties as defined in Section A above, county operated hospital outpatient departments (excluding hospital emergency departments), county comprehensive health centers (CHCs), county health centers (excluding clinics that provide predominately public health services), and, to the extent specified in the particular Medicaid Demonstration Project, private clinics that provide health services to the indigent (including General Relief recipients) under a contract with a participating county and that elect to be paid under this Supplement.

(b) Notwithstanding paragraph 2(a), no off-site contracted services shall be subject to cost-based reimbursement. However, this limitation does not apply to reimbursement for services furnished off-site when rendered by a physician or other qualified health professional of the eligible facility's staff. Further, off-site contracted services do not include services ordered by a physician or other qualified health professional at one eligible facility and provided at another eligible facility.

3. Services Eligible for Cost-Based Reimbursement

(a) Subject to paragraph (b), below, the services that are subject to cost-based reimbursement in eligible facilities (as defined in paragraph B.2, above) include only Medi-Cal-covered ambulatory care services rendered to Medi-Cal beneficiaries as described in applicable State law and this State Plan, including, but not limited to, Rural Health Clinic services defined in Section 1861(aa)(1)(A)-(C) of the Social Security Act and preventive primary health services that are required under Section 330 of the Public Health Services Act.

(b) For the purposes of cost-based reimbursement of services that are paid on a per visit basis, a "visit" is defined as a face-to-face encounter between a clinic Medicaid patient and a health care professional. Multiple visits may be billed on the same day of services if a clinic Medicaid patient receives services from more than one health care professional and the nature of the services or the patient diagnoses are unrelated (e.g., a medical and dental visit on the same day could be two visits).

Eligible facilities may bill one visit per group education session such as health education. Eligible facilities under this Supplement will likewise bill one visit per session regardless of the number of participants in the session.

For the first year of the Medicaid Demonstration Project, the county operated facilities may use their current system to claim visits. The State may extend the right to use the current system up to an additional 12 months.

(c) The following services are not subject to cost-based reimbursement under this Supplement nor may a visit be billed for such services:

(i) Medi-Cal specialty mental health services under the State's consolidated Section 1915(b) waiver.

(ii) Medi-Cal Short-Doyle and Medi-Cal alcohol and drug program services paid through the State Department of Alcohol and Drug Programs.

(iii) Adult Day Health Care services.

REIMBURSEMENT FOR INDIAN HEALTH SERVICES AND TRIBAL 638 HEALTH FACILITIES

California will reimburse federally recognized tribal "638" facilities in accordance with the most recent rate published in the Federal Register, ~~Vol. 66, No. 16, Wednesday, January 24, 2001~~. A visit is a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse,...clinical psychologist, clinic social worker, or other health professional for mental health services. The IHS/MOA clinics may bill for up to two visits a day for one patient, if one is a 'medical' visit and the other is an 'other health visit'. A 'medical visit' is defined as a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, or visiting nurse (in certain circumstances). An 'other health visit' is defined as a face-to-face encounter between an IHS/MOA patient and a clinical psychologist, clinical social worker, or other health professional for therapeutic mental health services

PSO

In accordance with 42 CFR Section 405.2446 "Scope of Services," a face-to-face visit is recognized when services are provided in outpatient settings including a patient's place of residence, which may be a skilled nursing facility or other institution used as a patient's home.

A face-to-face visit is also recognized for services furnished in a hospital or other facility under the IHS/MOA provider number if the visit is necessary for continuity of care providing 1) the provider has a written contract with the IHS/MOA to provide the services, 2) the services were furnished only to IHS/MOA patients at the hospital or other location, 3) the patient is treated at that location other than at the IHS clinic for health or medical reasons, and 4) the services provided are of a type commonly furnished in a clinic setting. A September 10, 1996 HCFA letter provided DHS with the above guidelines.

REIMBURSEMENT FOR INDIAN HEALTH SERVICES AND TRIBAL 638 HEALTH FACILITIES

Below is a list of services that may be billed under the IHS all-inclusive rate:

- Physician
- Physician Assistant
- Nurse Practitioner
- Nurse Midwife
- Clinical Psychologist
- Clinical Social Worker
- Visiting Nurse
- Comprehensive Perinatal Services Program (CPSP): Registered Nurse, Dietitian, Health Educator, Childbirth Educator, Licensed vocational nurse, and comprehensive perinatal health worker. A September 17, 1985 HCFA letter allows these services as a physician or clinic service.
- Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), the services of Licensed Marriage, Family and Child Counselors are available as 'other health visit' to persons under 21 years of age, as a result of an EPSDT screening which identifies the need for a service which is necessary to correct or ameliorate a mental illness or condition.

Below is a list of other ambulatory services to include but not limited to billing under the IHS all-inclusive rate.

- Optometry
- Dental: Dental services are limited to that specified in Title *22 of the California Code of Regulations* and the *Manual of Criteria for Medi-Cal Authorization.*
- Physical Therapy
- Occupational therapy
- Speech Pathology
- Audiology
- Podiatry
- Drug and Alcohol visits (Subject to Medi-Cal provider participation requirements)
- Adult Day Health Care
- Telemedicine

REIMBURSEMENT FOR INDIAN HEALTH SERVICES AND TRIBAL 638 HEALTH FACILITIES

The Implantable contraceptive kit (Norplant) will continue to be reimbursed on a fee-for-service basis.

Non-medical transportation and pharmacy are not included as part of the IHS/MOA visit rate and are reimbursed separately under Medi-Cal fee-for-service.

State / Territory: California

Provider Based Rural Health Clinics

Provider Based Rural Health Clinics with 50 or more beds will be reimbursed their reasonable costs of covered core outpatient services and other ambulatory outpatient services (Public Law 95-210). Reasonable costs shall be determined in accordance with applicable Medicaid provisions specified in Title 42 Code of Federal Regulations (CFR) §447.300 through §447.371 and in accordance with the Principles of Reasonable Cost Reimbursement provided in Title 42 CFR PART 413. Such methodology and principles includes any screening guidelines, tests of reasonableness, or payment limitations applicable to Medicaid Rural Health Clinics outpatient services as required by federal law or regulation with the exception of Title 42 CFR §413.13(b) – "Application of the principle of lesser of cost or charges." The lesser of costs or charges limitation will continue to be applied to hospital inpatient services.

Provider Based Rural Health Clinics with less than 50 beds will be reimbursed at 100 percent of reasonable costs of covered core outpatient services and other ambulatory outpatient services (Balanced Budget Act of 1997). Such clinics will not be subject to cost-per-visit payment limitations or other rate limitations. Reasonable costs shall be determined in accordance with applicable Medicaid provisions specified in Title 42 Code of Federal Regulations (CFR) §447.300 through §447.371 and in accordance with the Principles of Reasonable Cost Reimbursement provided in Title 42 CFR PART 413. Such methodology and principles includes any screening guidelines, tests of reasonableness, or payment limitations applicable to Medicaid Rural Health Clinics outpatient services as required by federal law or regulation.

Providers are required to submit annual cost reports using standard Health Care Financing Administration Form 2552 Cost Report. All providers will be paid interim rates based on such cost reports.

Freestanding Rural Health Clinics

Freestanding Rural Health Clinics will be reimbursed their reasonable costs of covered core outpatient services and other ambulatory outpatient services. Reasonable costs shall be determined in accordance with applicable Medicaid provisions specified in Title 42 CFR §447.300 through §447.371 and in accordance with the Principles of Reasonable Cost Reimbursement provided in Title 42 CFR PART 413. Such methodology and principles includes any screening guidelines, tests of reasonableness, or payment limitations applicable to Medicaid Rural Health Clinics outpatient services as required by federal law or regulation. Providers are required to submit annual cost reports using standard Health Care Financing Administration Form 222 Cost Report. All providers will be paid interim rates based on such cost reports.

Overview

This supplement describes (1) the methodology for establishing the rates used for the interim reimbursement of Local Education Agency (LEA) assessment and treatment services, (2) the process used to certify that expenditures attributed to LEA services are eligible for federal financial participation, and (3) the process for reconciliation of the interim payments to the certified costs. Sections A-D include both the general methodology regarding costs and service times, along with specific considerations for IEP/IFSP assessments and treatment services. Sections E-G address specific considerations for Non-IEP/IFSP assessments. Sections H-K cover the certification process, including the process for reconciliation. The terms "IEP," and "IFSP" are defined under the federal Individuals with Disabilities Education Act (IDEA).

Payment for Local Education Agency (LEA) Services

LEAs providing assessment and treatment services as defined in Attachment 3.1-A and Attachment 3.1-B will be reimbursed on an interim basis according to a statewide prospective fee schedule that reflects the LEAs' cost of providing services, determined as specified in Sections A through G, below.

IEP/IFSP Assessments and Treatment Services

A. Interim Payment Methodology Overview

1. Interim reimbursement rates for treatment and IEP/IFSP assessment services for the period April 1, 2003, through June 30, 2004, were developed from data reported in cost and time surveys from a sample of LEA providers. As described in paragraphs B.1 through B.3, median hourly costs for each type of qualified practitioner (e.g., psychologist, speech therapist, audiologist, etc.) were developed from data reported in the cost survey.

2. Median treatment and IEP/IFSP assessment times by service type (e.g., psychology and counseling, speech therapy, and audiology, etc.) were developed from data reported in a time survey consisting of two instruments, a Treatment Service Questionnaire and an IEP Time Survey. Median treatment and IEP/IFSP assessment times by service type were applied to the median hourly costs for the corresponding practitioners to develop the fee schedule.

3. Rates for IEP/IFSP assessments and treatment services will be annually adjusted in subsequent periods by applying the Implicit Price Deflator, which is published by the U.S. Department of Commerce. The interim rates will be rebased at least once every three years using a methodology similar to that

described in Sections B-G. Rebasing will not occur until July 1, 2007, at the earliest.

B. Hourly Costs

1. Health care-related costs were identified by type of practitioner from the cost survey and included salary, benefits and other personnel expenses for SFY 2000-01. Indirect costs were calculated by applying the LEA's approved indirect cost rate to the health-care related costs. Education-related costs were excluded. The hourly basis for the costs was based on total annual hours required to work. Each cost survey received a desk or field review to evaluate the reasonableness of the data provided. All costs used in the calculation were in compliance with OMB Circular A-87.

2. Costs for SFY 2001-02 were determined by adjusting cost for SFY 2000-01 for inflation. The inflation adjustment was accomplished by applying the annual percentage increase in certificated salaries to the salary component of reported costs and the Implicit Price Deflator for State and Local Government Purchases of Goods and Services (Implicit Price Deflator) to the remaining cost components (i.e., benefits, other personnel expenses, facility costs, and administrative costs). The annual percentage increase in certificated salaries for each LEA is published by the California Department of Education. The Implicit Price Deflator, published by the U.S. Department of Commerce, is an inflation index that measures the change in the prices of goods and services that governments purchase. Median hourly costs for each type of practitioner were developed from these adjusted costs.

3. Median hourly costs for each type of practitioner were adjusted to the midpoint of the implementation period of April 1, 2003, through June 30, 2004, by applying the LEA Cost of Living Adjustment based on the Implicit Price Deflator. The Cost of Living Adjustment is an inflation percentage designated by the legislature to adjust state apportionments for K-12 Education on an annual basis.

C. IEP/IFSP Assessments

1. Median assessment times for IEP/IFSP assessments were developed using time reported in the IEP Time Survey and validated in interviews with health service practitioners.

2. Service Categories

Assessment time from the IEP Time Survey was evaluated by service type (psychology, health, speech therapy, audiology, occupational therapy, and physical therapy) and IEP/IFSP type of review (initial, annual, triennial, and

amended). Two versions of IEP/IFSP assessment rates for each service type were developed:

(a) Assessment conducted for an initial or triennial IEP/IFSP review

The initial review is conducted for a student that has not yet been determined to be eligible for services under IDEA. The triennial review occurs every 36 months.

(b) Assessment conducted for an annual or amended IEP/IFSP review

The annual review occurs every year to determine whether the existing IEP/IFSP is appropriately meeting the needs of the child. The amended review occurs periodically when requested by a parent, guardian or professional working with the student or when a student transfers from one LEA to another.

3. Rates for IEP/IFSP assessments provided by social workers and counselors will be based on the time incremental cost of these practitioners and billed in service units representing 15-minute increments. Rates for IEP/IFSP assessments provided by physicians will be based on the time incremental cost of school nurses (used as a proxy) and billed in service units representing 15-minute increments. The use of the school nurse cost as a proxy for physician cost is described in paragraph F.2. in "Non-IEP/IFSP Assessments" on page 5. Rates for physical therapists, speech therapists, psychologists, nurses, audiologists and occupational therapists will be billed on a flat rate basis, regardless of service time spent.

D. Treatment Services

1. Median treatment times for psychology and counseling, speech therapy, audiology, occupational therapy, and physical therapy were developed using time reported in the Treatment Service Questionnaire. Each Treatment Service Questionnaire was subjected to a desk review to evaluate the reasonableness of the data provided.

(a) Treatment service rates for psychology and counseling, speech therapy, audiology, occupational therapy and physical therapy were developed based on an initial service increment range of 15 to 45 minutes as well as additional rate increments of 15 minutes. Time spent by health service practitioners for preparation and completion activities and travel have been included in the development of initial service rates (but not the additional 15-minute increment rates) for these services. The initial service billed for these practitioners represents any amount of treatment time between 15 and 45 minutes. Additional treatment time beyond the initial 45 minutes will be billed as one unit for each 15-minute increment of treatment time.

(b) Individual treatment service rates were developed for psychology and counseling, speech therapy, audiology, occupational therapy, and physical therapy. Group treatment service rates were developed for psychology and counseling and speech therapy.

2. A rate for hearing checks that do not meet the minimum treatment time of 15 minutes for the initial service increment (described in paragraph D.1.a.) was developed. This rate is based on 10 minutes of direct service time for audiologists plus the time spent by audiologists for preparation and completion activities and travel time. This treatment will be billed as one unit for each hearing check that requires less than 15 minutes of treatment time.

3. Individual treatment service rates for nursing or trained health care aides were based on 15 minute increments and do not include indirect service time. Indirect service time for nurses or trained health care aides will not be billed. Individual treatment service rates for nursing or trained health care aides will be billed as one unit representing up to 15 minutes of treatment time.

Non-IEP/IFSP Assessments

E. Providers may bill for six assessment types: hearing, vision, health (including assessment of nutritional status), psychosocial, developmental, and health education/anticipatory guidance appropriate to age and health status. The cost survey described in "A. Methodology Overview" on page 1 was used to develop reimbursement rates for five of the six specific non-IEP/IFSP assessments, excluding the hearing assessment. These five non-IEP/IFSP assessment rates are based on the time incremental costs of the practitioners qualified to provide each assessment type.

F. The cost survey resulted in the use of proxies for physician, optometrist or audiometrist services for the following non-IEP/IFSP assessments:

1. Specific audiometry rates from the Medi-Cal Fee Schedule will be used for hearing assessments.

2. School nurses are qualified to perform the same LEA assessments as optometrists (vision) and physicians (vision, health, and health education/anticipatory guidance). The school nurse hourly cost will be used as a proxy for physician and optometrist services.

G. Rates for hearing and vision assessments will be encounter-based, and billed regardless of assessment time spent. The flat rate for vision assessments will be calculated based on five minutes of the school nurse hourly cost. Rates for the remaining four non-IEP/IFSP assessments (health, psychosocial, developmental and health education/anticipatory guidance) will be billed in units representing 15-minute increments of assessment time. Rates for non-IEP/IFSP assessments will be adjusted in the same manner as are IEP/IFSP assessments as described in paragraph A.3.

Certification of Expenditures Eligible for Federal Financial Participation

H. LEAs are required to provide certification to the State that the amount reported by them for LEA services represent total actual expenditures incurred (both state and federal share) eligible for federal participation. Expenditures certified by the LEA to the State will represent the amount eligible for federal financial participation. Such allowable certified public expenditures will determine the amount of federal financial participation claimed by the State.

I. Each LEA will certify to the Department, on an annual basis, the amount of its eligible costs to provide LEA services pursuant to Section H, and will compare its total computable eligible costs to the interim Medi-Cal reimbursement ("Cost and Reimbursement Comparison Schedule" as specified by the Department and approved by the Centers for Medicare & Medicaid Services) using the following methodology:

1. Total personnel costs, consisting of salaries, benefits and other costs such as materials and supplies and contractor costs, necessary for the provision of health services will be reported for personnel providing health services by practitioner type (psychologist, speech therapist, etc.). The Department will specify allowable codes from the Standardized Account Code Structure (SACS), a comprehensive system of accounting and reporting school district revenues and expenditures. Personnel costs that are funded by federal revenues other than Medicaid will be excluded. All costs used to determine the certified actual costs must be in compliance with OMB Circular A-87, and, to the extent not governed by Circular A-87, by Generally Accepted Accounting Principles.

2. Total personnel costs by practitioner type (from paragraph I.1.) will be multiplied by the percent of hours worked by corresponding practitioners to provide LEA Medi-Cal services to calculate the Medi-Cal direct cost of providing LEA services by practitioner type. The percent of hours worked will be based on the number of units paid by Medi-Cal for each LEA service multiplied by the time worked by practitioners to provide one unit of service (numerator), divided by the total annual hours each practitioner type were required to work (denominator). The time worked by practitioners to provide one unit of service will include face-to-face as well as preparatory and follow-up time.

3 The Medi-Cal direct cost of providing LEA services for all practitioners (from paragraph I.2) will be multiplied by one plus the LEA's approved indirect cost rate to calculate the total Medi-Cal cost of (expenditures for) providing LEA services.

4. The total Medi-Cal cost of providing LEA services will be multiplied by the applicable federal medical assistance percentage (FMAP) and compared to total interim Medi-Cal reimbursement paid in accordance with Sections A through G, above. Interim Medi-Cal reimbursement and units paid will be determined from Medi-Cal paid claims data.

5. State-mandated screens are not billable by LEAs or reimbursable by Medi-Cal.

6. If the LEA bills for non-State-mandated, non-IEP/IFSP services, a separate Cost and Reimbursement Comparison Schedule will be similarly prepared that is distinct from the Medi-Cal IEP/IFSP schedule. This separate non-IEP/IFSP schedule will follow the same methodology outlined in paragraphs I.1 through I.5.

J. LEA Reporting Requirements

Each LEA will be required to do all of the following:

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for LEA services are eligible for federal financial participation. LEAs are required to certify that all expenditures are in compliance with OMB Circular A-87 (and, to the extent not governed by OMB Circular A-87, by Generally Accepted Accounting Principles). The expenditures certified must be total expenditures (both State and federal share). The required certifications will be in accordance with instructions and forms issued by the Department. The first certification, including the Cost and Reimbursement Comparison Schedule will be due by November 30 after the close of the fiscal year during which the cost-based rate methodology approved

in State Plan Amendment 03-024 was implemented. In subsequent years, the certification and schedule will be due by November 30 after the close of each fiscal year.

2. Keep, maintain and have readily retrievable, such records to fully disclose its LEA costs eligible for federal financial participation. Such documentation must be maintained for a period of no less than three years.

K. Department's Responsibilities

1. The Department will reconcile the total expenditures (both State and federal share) for LEA services to the interim Medi-Cal amounts paid for the fiscal year period. LEAs will complete the Cost and Reimbursement Comparison Schedule (CRCS) and submit the schedule no later than 5 months after the June 30 fiscal year period. The Department will initiate final reconciliation (settlement) of the Medi-Cal share of each LEA's cost for the period, no earlier than 12 months from the end of the June 30 fiscal year period. The CRCS reported expenditures will be compared against the Electronic Data Systems (EDS) payment claim data. Based on the interim payments received by the LEA during the fiscal year period, the Department will calculate the final settlement amount.

2. The LEAs will submit claims/billings in accordance with California Welfare and Institutions Code section 14115. The Department will adjust the affected LEA's payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA. If the interim Medi-Cal payments exceed the actual, certified costs of an LEA's Medi-Cal services, the Department will offset future claims from the affected LEA until the amount of the overpayment is recovered. If the actual certified costs of an LEA's Medi-Cal services exceed interim Medi-Cal payments, the Department will pay this difference to the LEA. By performing the reconciliation and final settlement process, there will be no instances where total Medi-Cal payments for services exceed 100 percent of actual, certified expenditures for providing LEA services for each LEA.

3. As part of its financial oversight responsibilities, the Department will develop audit and review procedures to reconcile and process final settlements for each LEA. The audit plan will include a risk assessment of the LEAs using paid claim data available from the Department to determine the appropriate level of oversight. The financial oversight of all LEAs will include reviewing the allowable costs in accordance with OMB Circular A-87 (and to the extent not governed by Circular A-87, Generally Accepted Accounting Principles will be applied), performing desk audits, and conducting limited reviews. For example, field audits will be performed when the Department finds a substantial difference

between filed cost information and the Department's payment data for particular LEAs. These activities will be performed within the timeframe in accordance with Welfare and Institutions Code section 14170, that requires the Department to audit and perform final settlement no later than 3 years from the date the CRCS is submitted. LEAs may appeal audit findings in accordance with Welfare and Institutions Code section 14171.

4. If the Department becomes aware of potential instances of fraud, misuse, or abuse of LEA services and Medi-Cal funds, it will perform timely audits and investigations to identify and take the necessary actions to remedy and resolve the problems.

State California

POLICY CONCERNING PAYMENT FOR RESERVING BEDS DURING A BENEFICIARY'S ABSENCE FROM AN INPATIENT FACILITY

I Leaves of Absence

(a) Payment may be made to skilled nursing facilities, swing bed facilities, intermediate care facilities, intermediate care facilities for the developmentally disabled and intermediate care facilities for the developmentally disabled/habilitative, for patients who are on approved leave of absence. Payment for leave of absence shall not exceed the maximum number of days per calendar year indicated below:

(1) Developmentally disabled and developmentally disabled habilitative patients: 73 days

(2) Patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic and rehabilitative program approved and certified by a local mental health director: 30 days.

(3) All other patients: 18 days. Up to 12 additional days of leave per year may be approved when the request for additional days of leave is in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.

(b) Leave of absence may be approved for:

(1) A visit with relatives or friends.

(2) Participation by developmentally disabled and developmentally disabled habilitative patients in an organized summer camp for developmentally disabled persons.

(c) All of the following requirements shall be met:

(1) Written approval and instructions for leave of absence shall be provided as follows:

(A) In the individual program plan for developmentally disabled patients in intermediate care facilities for the developmentally disabled and developmentally disabled habitative.

(B) In the individual patient care plan for patients in a certified special treatment program for mentally disordered persons, or patients in a mental health therapeutic and rehabilitative program approved and certified by a local mental health officer.

(C) By the person's attending physician for all other patients and in the individual patient care plan for those leaves involving the up to 12 additional days described in (a)(3).

(2) The facility shall hold the bed vacant during leave.

(3) The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.

(4) Leave shall be terminated on the day of the death of the patient. Leave shall be terminated if the patient is admitted as an inpatient to any other facility, or if the patient exceeds the approved period of leave of absence and is determined to be absent without leave.

(5) Payment shall not be made for the last day of leave if the patient dies or fails to return from leave within the period of approved leave.

(6) Payment shall not be made for the period of leave of absence if the patient is discharged within 24 hours of return from leave, or if the patient is discharged while on leave of absence, except as provided in (c)(5).

(7) Failure to return from leave of absence within the approved period shall not invalidate an approved treatment authorization request. There shall be no requirement to file a new treatment authorization request if the patient fails to return from leave within the approved period.

(8) Facility claims shall identify the inclusive dates of leave.

(9) The patient's records maintained in the skilled nursing facility, intermediate care facility, intermediate care facility for the developmentally disabled habilitative shall show the address of the intended leave destination and the inclusive dates of leave.

(d) Payment to skilled nursing facilities, swing bed facilities, intermediate care facilities, intermediate care facilities for the developmentally disabled, and intermediate care facilities for the developmentally disabled/habilitative for patients who are on approved leave of absence shall be at the appropriate facility daily rate less raw food costs.

II Periods of Acute Hospitalization

(a) Payment shall be made to skilled nursing facilities, swing bed facilities, intermediate care facilities, intermediate care facilities for the developmentally disabled, and intermediate care facilities for the developmentally disabled habilitative for bed hold days for any beneficiary who exercises the bed hold option. Upon admission to the long-term care facility and upon transfer to an acute care hospital each facility shall notify the patient or the patient's representative in writing of the right to exercise the bed hold option for seven days.

(b) Payment for bed hold days shall be limited to a maximum of seven days for each period of acute hospitalization.

(c) The following requirements shall be met:

(1) Acute hospitalization for the beneficiary shall be ordered by the attending physician.

(2) The facility shall hold a bed vacant during the entire bed hold period except when notified, in writing by the attending physician that the patient requires more than seven days of hospitalization. If so notified, the facility is no longer required to hold the bed available and shall not bill Medi-Cal for any remaining days of bed hold.

(3) The day of departure shall be counted as one day of bed hold and the day of return shall be counted as one day of inpatient care.

(4) Bed hold shall be terminated and payment shall not be made on the day of death of the beneficiary.

(5) Facility claims shall identify the inclusive dates of bed hold.

(6) A new treatment authorization request shall be required for Medicare-eligible beneficiaries who have returned from a Medicare-qualifying stay in an acute care hospital.

(7) The beneficiary's records maintained in the facility shall show the name and address of the acute care hospital to which the beneficiary has been admitted.

(d) Payment to skilled nursing facilities, swing bed facilities, intermediate care facilities for the developmentally disabled, intermediate care facilities for beneficiaries who are on bed hold for acute hospitalization shall be at the appropriate facility daily rate less raw food costs.

STATE PLAN UNDER TITLE XIX OF SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT FOR ALL CATEGORIES OF NURSING FACILITIES AND

INTERMEDIATE CARE FACILITIES FOR THE DEVELOPMENTALLY DISABLED

The purpose of this State Plan is to (1) establish the principles of the State of California's reimbursement system for providers of long-term care services to assure compliance with the requirements of Title XIX of the Federal Social Security Act and the Code of Federal Regulations, and (2) describe the procedures to be followed by the single State agency, the Department of Health Services (herein called the Department), in determining long-term care reimbursement rates.

Beginning with the 2005/06 rate year, the reimbursement rate methodology applicable to long-term care freestanding nursing facilities level-B and subacute facilities will be described in Supplement 4 to Attachment 4.19-D. Assembly Bill (AB) 1629 (Statutes 2004, Chapter 875) mandates a facility-specific reimbursement methodology to be effective on August 1, 2005. This legislation will become inoperative on July 31, 2008. Provisions of AB 1629 mandate that the new facility-specific rates during rate years 2005/06 and 2006/07, shall not be less than the rate methodology in effect as of July 31, 2005. Therefore, the rate methodology in effect as of July 31, 2005, continues to be described in Attachment 4.19-D, Pages 1 through 22 of this State Plan.

I. GENERAL PROVISIONS

A. The State shall set prospective rates for services by various classes of facilities, including special programs.

B. Reimbursement shall be for routine per diem services, exclusive of ancillary services, except for state-owned facilities where an ancillary per diem rate shall be developed by another State agency, and for county facilities operating under a special agreement with the Department. These ancillary rates are reviewed and audited by the Department and, together with the routine service per diem, form an all-inclusive rate. The routine service per diem shall be based on Medicare principles of reimbursement. Ancillary services for all other facilities are reimbursed separately on a fee for service basis as defined in the California Code of Regulations (CCR), except for facilities providing subacute, pediatric subacute and transitional care.

C. The routine service per diem includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care patients or intermediate care for the developmentally disabled, except those items listed as separately payable or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility as part of patient care and periodic hair cuts), and television rental.

D. Not included in the payment rate and to be billed separately by the provider thereof,

subject to the utilization controls and limitations of Medi-Cal regulations covering such services and supplies, are:

1. Allied health services ordered by the 'attending physician, excluding respiratory therapy.
2. Alternating pressure mattresses/pads with motor.
3. Atmospheric oxygen concentrators and enrichers and accessories.
4. Blood, plasma and substitutes.
5. Dental services.
6. Durable medical equipment as specified in Section 51321(g).
7. Insulin.
8. Intermittent positive pressure breathing equipment.
9. Intravenous trays, tubing and blood infusion sets.
10. Laboratory services.
11. Legend drugs.
12. Liquid oxygen system.
13. MacLaren or Pogon Buggy.
14. **Medical supplies.**
15. Nasal cannula.
16. Osteogenesis stimulator device.
17. Oxygen (except emergency).
18. Parts and labor for repairs of durable medical equipment if originally separately payable or owned by beneficiary.
19. Physician services.
20. Portable aspirator.
21. Portable gas oxygen system and accessories.
22. Precontoured structures (VASCO-PASS, cut out foam).
23. Prescribed prosthetic and orthotic devices for exclusive use of patient.
24. Reagent testing sets.
25. Therapeutic aid fluid support system/Beds.
26. Traction equipment and accessories.
27. Variable height beds.
28. X-rays.

For subacute, pediatric subacute, and transitional levels of care, items can be separately billed as specified in Title 22 CCR, Sections 51511.5(d), 51511.6(f) and 51511.3(f) respectively (see Appendix 4).

E. The application of the methodology described in this Attachment, with the most recent update factors and constants used to project costs, is included in an annual rate study conducted by the Department prior to August 1st each year and required by the CCR as an evidentiary base for the filing of new and/or revised regulations. This annual rate study is designated as Supplement 1, and will be provided to the Centers for Medicare and Medicaid Services (CMS) by December 31st of the rate year. The rates will become effective as provided for by the State's Budget Act, typically on August 1 of each year.

F. If a freestanding facility's change in bedsize has an impact on the reimbursement rate, the lesser of the existing rate or the new rate shall prevail until the next general rate change. This is to deter a facility from changing bedsize groupings for the purpose of maximizing reimbursement.

G. Notwithstanding any other provisions of this State Plan, the reimbursement rate shall be limited to the usual charges made to the general public, not to exceed the maximum reimbursement rates set forth by this Plan.

H. Within the provisions of this Plan, the following abbreviations shall apply: NF-nursing facility; ICF/DD-intermediate care facility for the developmentally disabled; ICF/DD-H-intermediate care facility for the developmentally disabled habilitative; ICF/DD-N-intermediate care facility for the developmentally disabled nursing; STP-special treatment program; and DP-distinct part.

I. All long term care providers shall be required to be certified as qualified to participate in the Medi-Cal program and must also meet the requirements of Section 1919 of the Social Security Act. In order to assure that reimbursement takes into account the cost of compliance with statutory requirements, NFs shall be reimbursed based on the following criteria: (Refer to Table 1 for a specific list)

1. Resident acuity:

NFs shall be reimbursed based on the provision of the following services: level A; level B; subacute -- ventilator and non-ventilator dependent; pediatric subacute -- ventilator and non-ventilator dependent; and transitional inpatient care -- rehabilitative and medical. Level A services are provided to a NF resident who requires medically necessary services of relatively low intensity. Level B, subacute, pediatric subacute, and

transitional inpatient care services are provided to a NF resident who requires medically necessary services of varying degrees of higher intensity. The criteria for the acuity of NF services and staffing standards are contained in state regulations and policy manuals.

2. Organization type:

(a) Freestanding facilities.
(b) DP/NFs - A distinct part nursing facility is defined as any nursing facility (level A or B) which is licensed together with an acute care hospital.
(c) Swing-beds in rural acute care facilities.
(d) Subacute units of freestanding or distinct part NFs - A subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
(e) Pediatric subacute units of freestanding or distinct part NFs - A pediatric subacute care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).
(f) Transitional inpatient care units of freestanding or distinct part NFs -- A transitional inpatient care unit is a specifically designated and identifiable area of a NF-B (either freestanding or distinct part).

3. Bedsize:

As listed below, in determining the appropriate bedsize categories for reimbursement purposes, a facility's total number of beds shall be used, irrespective of patient acuity level or licensure. A single facility licensed as a distinct part to provide two or more patient acuity levels, or a single facility that has separate licenses for different patient acuity levels, shall have the bedsize for each patient acuity level determined by total beds within the actual physical plant. The bedsize used to establish rates shall be based upon the data contained in the cost report(s) included in the rate study.

(a) NF level B...1-59, and 60+
(b) DP/NF level B...no bedsize category
(c) NF level B/subacute...no bedsize category
(d) DP/NF level B/subacute...no bedsize category
(e) NF level B/pediatric subacute...no bedsize category

(f) DP/NF level B/pediatric subacute...no bedsize category
(g) NF level A... no bedsize category
(h) DP/NF level A ... no bedsize category
(i) ICF/DD...1-59, 60+ and 60+ with a distinct part
(j) ICF/DD-H...4-6 and 7-15
(k) ICF/DD-N...4-6 and 7-15
(l) Swing-beds...no bedsize category
(m) Transitional inpatient care...no bedsize category

4. Geographical location:

(a) Freestanding NF levels A and B and DP/NF level A:
(1) Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, and Sonoma counties.
(2) Los Angeles county.
(3) All other counties.
(b) DP/NF level B, freestanding NF level B/subacute and pediatric subacute, DP/NF level B/subacute and pediatric subacute, transitional inpatient care, ICF/DDs, ICF/DD-Hs, and ICF/DD-Ns,...statewide.
(c) Rural swing-beds...statewide.

J. Special Treatment Program (STP)

For eligible Medi-Cal patients 65 years or older who receive services in an Institution for Mental Disease the STP patch rate will apply. This is a flat add-on rate determined to be the additional cost for facilities to perform these services. STP does not constitute a separate level of care.

II. COST REPORTING

A. All long term-care facilities participating in the Medi-Cal Program shall maintain, according to generally accepted accounting principles, the uniform accounting systems adopted by the State and shall submit cost reports in the manner approved by the State.

1. Cost Reports are due to the State no later than 120 days after the close of each facility's fiscal year (150 days for facilities that are distinct parts of a hospital), in accordance with Medicare and Medi-Cal cost reporting

requirements.

2. Each facility shall retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and shall make such records available upon request to authorized state or federal representatives.

3. All cost reports received by the State shall be maintained for a period of not less than five years following the date of submission of reports, in accordance with 42 CFR 433.32.

4. Cost reports for freestanding facilities shall be included in the rate study even though they may contain more or less than 12 months and/or more than one report, as long as the fiscal periods all end within the time frame specified for the universe being studied. Only cost reports accepted by the Office of Statewide Health Planning and Development (OSHPD) shall be included in the rate study.

5. For DP/NFs and subacute providers, only cost reports formally accepted by the Department with 12 or more months of DP/NF or subacute costs shall be used in the rate study to determine the median facility rate. For purposes of the median determination, only DP/NFs with Medi-Cal patient days accounting for 20 percent or more of their total patient days shall be included.

6. The State reserves the right to exclude any cost report or portion thereof that it deems to be inaccurate, incomplete or unrepresentative.

7. Freestanding STP facilities are excluded from the determination of freestanding NF rates due to their different staffing requirements and the complexity of their reporting costs by level of care and services. The cost reports for these facilities often comingle the data related to NF, Short-Doyle and special county programs.

8. NF Level A rates shall be established on the basis of costs reported by facilities that only provided that level of care during the cost report period.

9. The universe of facilities used to establish the prospective freestanding rates shall be provided by OSHPD on hard copy and tapes. In the case that an error

or oversight is discovered or brought to the State's attention, which would create an inequity, the Department would adjust rates in the following year to compensate providers for the error. Such an adjustment would normally be in the form of an add-on. (See paragraph IV.C, below.)

10. Where identified, facilities that have switched their level of care (e.g., ICF/DD to NF Level B) will not be used to establish rates if their cost report does not reflect their current status.

11. Where identified, facilities that have terminated from the program will be excluded from the rate studies.

12. When ICF/DD-H and N providers erroneously report calendar days instead of patient days on their cost reports, the State will contact the provider for the correct information to be used in the rate study.

B. The Department shall determine reasonable allowable costs based on Medicare reimbursement principles as specified in 42 Code of Federal Regulations (CFR) Part 413. The exceptions to this provision are:

1. The Deficit Reduction Act of 1984 (DEFRA) requires the Department to recognize depreciation only once for reimbursement purposes when a change of ownership has occurred after July 18, 1984. Since the Department reimburses long term care providers using a prospective rate methodology, the Department shall use the net book value approach in lieu of recapturing depreciation to ensure that depreciation is recognized only once for reimbursement purposes. The net book value approach is defined as follows:

   Net book value means that when a change of ownership occurs after July 18, 1984, the asset sold shall have a depreciable basis to the new owner that is the lesser of the: acquisition cost of the new owner; or historical cost of the owner of record as of July 18, 1984, less accumulated depreciation to the date of sale (or in the case of an asset not in existence as of July 18, 1984, the acquisition cost less accumulated depreciation to the date of sale of the first owner of record after July 18, 1984).

2. For developmentally disabled and psychiatric patients in state owned facilities, appropriate personal clothing in lieu of institutional gowns or pajamas are an allowable cost.

3. For purposes of determining reasonable compensation of facility administrators, pursuant to Chapter 9 of the CMS Provider Reimbursement Manual (HIM 15) – reproduced in full at Paragraph 5577 of the CCH Medicare and Medicaid Guide, the State shall conduct its own survey. Based on the data collected from such surveys, the State shall develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those facilities.

   For purposes of this section, "facilities" are defined as: acute care, long term care (skilled nursing, intermediate care, intermediate care for the developmentally disabled, intermediate care for the developmentally disabled habilitative and nursing), Federally Qualified Health Centers, and Rural Health Clinics.

4. (a) Allowable costs shall not include provider expenditures to assist, promote, or deter union organizing to the extent such expenditures are paid by the provider with State funds. Definitions applicable to this paragraph 4 are set forth below in subparagraphs (b) and (c).

   (b) "Assist, promote, or deter union organizing" means any attempt by the provider to influence the decision of its employees in California, or the California employees of its subcontractors, regarding either of the following:

      (i) Whether to support or oppose a labor organization that represents or seeks to represent employees.

      (ii) Whether to become a member of any labor organization.

   (c) "State funds" means California State Treasury funds or California State special or trust funds received by the provider on account of the provider's participation in a California state program. If State funds and other funds are commingled, any expenditures to assist, promote, or deter union organizing shall be allocated between State funds and other funds on a pro rata basis.

   (d) Any costs, including legal and consulting fees and salaries of supervisors and employees, incurred for research for, or preparation, planning, or coordination of, or carrying out, an activity to assist, promote, or deter union organizing shall be treated as paid or incurred for that activity.

(e) To the extent the costs are not for expenditures to assist, promote, or deter union organizing, reasonable costs incurred are allowable for activities, such as:

(i) Addressing a grievance or negotiating or administering a collective bargaining agreement.

(ii) Allowing a labor organization or its representatives access to the provider's facilities or property.

(iii) Performing an activity required by federal or state law or by a collective bargaining agreement.

(iv) Negotiating, entering into, or carrying out a voluntary recognition agreement with a labor organization.

III. AUDITS

A. Except for DP/NFs, subacute, pediatric subacute, transitional inpatient care units, NF-As, ICF/DDs and state-operated facilities, a minimum of 15 percent of cost reports will be field audited by the Department each year. Facilities identified for audit shall be selected on a random sample basis, except where the entire universe of a class is selected for audit. Field audits may be restricted to facilities that have a complete year of reporting. The sample size for each shall be sufficiently large to reasonably expect, with 90 percent confidence, that it will produce a sample audit ratio which varies from the estimated class population audit ratio by not more than two percent. Other facilities may be audited as necessary to ensure program integrity. The results of federal audits, where reported to the State, may also be applied in determining the audit adjustment for the ongoing rate study.

B. The labor data reported by providers shall be audited. In the event that facilities are inconsistently reporting their labor costs in the OSHPD data, the Department will adjust the data utilized to develop the labor index so that the correct amount will be reflected. If the labor data used in developing the labor index is adjusted, the State Plan will be amended to provide the specific methodology for such adjustments.

C. Reports of audits shall be retained by the State for a period of not less than five years, in accordance with 42 CFR 433.32.

D. Providers will have the right to appeal findings which result in an adjustment to program reimbursement or reimbursement rates. Specific appeal procedures are contained in Section 14171 of the Welfare and

Institutions Code, and Article 1.5 (Provider Audit Appeals) of Title 22, California Code of Regulations. See Appendix 2.

E. When facilities being audited have more than one cost report with an end date in the audit year, the last report will be the one audited, except in those cases where a facility-specific audit adjustment will be applied or actual audited costs are used. In these cases, all cost reports with an end date in the audit year will be audited.

F. All state-operated facilities will be subject to annual audits.

G. Cost reports for nursing facilities that are distinct parts of acute care hospitals may be audited annually.

H. All subacute and pediatric subacute providers will be subject to annual audits.

I. All transitional inpatient care units may be subject to annual audits.

IV. PRIMARY REIMBURSEMENT RATE METHODOLOGY

Reimbursement rates shall be reviewed by the Department at least annually. Prospective rates for each class shall be developed on the basis of cost reports submitted by facilities. The following method shall be used to determine rates of reimbursement for a class of facilities when cost reports are available:

A. Audit Adjustment.

1. An audit adjustment shall be determined for each of the following classes:

   (a) NF level B field audited facilities with 1-59 beds.
   (b) NF level A field audited facilities with no bedsize category
   (c) NF level B field audited facilities with 60+ beds.
   (d) ICF/DD field audited facilities with 1-59 beds.
   (e) ICF/DD field audited facilities with 60+ beds.
   (f) ICF/DD-H field audited facilities with combined bedsizes.
   (g) ICF/DD-N field audited facilities with combined bedsizes.

2. Except for DP/NFs and subacute providers, where the audit sample exceeds 80 percent of the universe in a class, the audit adjustment will be applied on a facility-specific basis except that the: (1) class average will be used for unaudited facilities and (2) actual audited costs will be used when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study.

3. For DP/NFs and subacute providers, actual audited costs will be used to determine the facility's prospective rate when the fiscal period of the field audit agrees with the fiscal period of the cost report used in the study. If the field audit of the cost report used in the study is not available by July 1, then an interim rate shall be established by applying the field audit adjustment of the NF level Bs with 60+ beds to the cost report. If a facility has an interim reimbursement rate, when the audit report that matches the cost report is issued or the cost report is deemed true and correct under W&I Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to the beginning of the rate year to reflect these costs, not to exceed the maximum rate as set forth in Section IV.E. Interest shall accrue and be payable on any underpayments or overpayments resulting from such adjustment. Medicare standards and principles of cost reimbursement shall be applied when auditing DP/NFs (see 42 CFR Part 413).

4. As a result of the appeal process mentioned in III.D., some audit findings may be revised. Except for DP/NFs and subacute, the audit adjustment for the current year shall incorporate any revisions resulting from a decision on an audit appeal. The Department shall consider only the findings of audit appeal reports that are issued more than 180 days prior to the beginning of the new rate year.

   For DP/NFs or subacute providers, excluding pediatric subacute, that obtain an audit appeal decision that the facility-specific audit adjustment on which a DP/NF or subacute rate is based inaccurately reflects the facility's projected costs, the facility shall be entitled to seek a retroactive adjustment in their prospective reimbursement rate, not to exceed the maximum DP/NF or subacute rate, as set forth under Section IV (E)(1), (10) and (11).

5. Audited costs will be modified by a factor reflecting share-of-cost overpayments in the case of class audit adjustments.

6. The results of federal audits, when reported to the state, may be applied in determining audit adjustments.

B. Adjustment for facilities which provide a different type of service from the remainder of the class.

Additional amounts, where appropriate, shall be added to the payment rates of individual facilities in a class to reimburse the costs of meeting

requirements of state or federal laws or regulations including the costs of special programs.

C. Change in service provided since cost report period.

Adjustments to reported costs of facilities will be made to reflect changes in state or federal laws and regulations which would impact upon such costs. These adjustments will be reflected as an "add-on" to the rates for these costs and, where appropriate, an "add on" may be used to reflect other extraordinary costs experienced by intermediate care facilities for the developmentally disabled (including habilitative and nursing facilities for the developmentally disabled). Add ons for extraordinary costs shall not be considered for other categories of long term care providers. To the extent not prohibited by federal law or regulations, "add-ons" to the rate may continue until such time as those costs are included in cost reports used to set rates under this state plan.

For example, state or federal mandates may include such costs as changes to the minimum wage or increases in nurse staffing requirements. An example of other extraordinary costs might include unexpected increases in workers compensation costs or other costs which would impact facilities ability to continue to provide patient care.

A brief description of all add-ons included in the current year's rate study will be provided to HCFA by December 31st of the rate year, as a part of Supplement 1.

D. Updates.

Updates to reported costs will reflect economic conditions of the industry. The following economic indicators will be considered where the Department has not developed other indicators of cost:

1. California Consumer Price Index, as determined by the State Department of Finance.
2. An index developed from the most recent historical data in the long term care industry as reported to OSHPD by providers.

The update factors used by the Department shall be applied to all classes from the midpoint of each facility's fiscal period to the midpoint of the State's rate year in which the rates are effective.

E. Cost-of-Living Update

Adjusted costs for each facility are updated from the midpoint of the facility's report period through the midpoint of the State's Medi-Cal rate year

Adjusted costs are divided into categories and treated as follows:

1. Fixed or Capital-Related Costs - These costs represent depreciation, leases and rentals, interest, leasehold improvements, and other amortization. No update is applied.

2. Property Taxes - These costs, where identified, are updated at a rate of 2 percent annually, converted to 0.1652 percent per month. Some facilities do not report property taxes---either because they are nonprofit and exempt from such tax or because they have a lease or rental agreement that includes those costs.

3. Labor Costs - A ratio of salary, wage, and benefits (SWB) costs to the total costs of each facility is used to determine the amount of the labor cost component to be updated. The ratio is determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report, and adding costs that represent all wage-related benefits, including vacation and sick leave.

   The labor costs for ICF/DD-Hs and ICF/DD-Ns are facility-specific, obtained directly from each cost report in the study. Labor costs for each facility are updated from the midpoint of its cost reporting period to the midpoint of the State's rate year.

4. All Other Costs - These costs are the total costs less fixed or capital-related costs, property taxes, and labor costs. The update for this category utilizes the California Consumer Price Index (CCPI) for "All-Urban Consumers" and figures projected by the State Department of Finance.

F. The reimbursement rate per patient day shall be set at the median of projected costs for the class, as determined above, except that:

1. NF-B services, excluding subacute and pediatric subacute, which are provided in distinct parts of acute care hospitals, shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate.

2. NF-A services provided in distinct parts of acute care hospitals shall be reimbursed at the applicable NF-A rate for freestanding facilities in the same geographical area location.

3. Rural hospitals are identified each year by OSHPD. For those rural hospitals with Medi-Cal distinct part nursing facility days, their rates, as determined for the DP/NF-B level of care, are arrayed and the median rate is applied to all rural swing bed days. Facilities that report no Medi-Cal days, have an interim rate, or

submit only a partial year cost report are excluded from the swing bed rate calculation.

4. NF services provided in a facility which is licensed together with an acute care hospital under a single consolidated license, yet fails to meet the definition of a DP/NF, shall be reimbursed at the applicable rate for freestanding facilities.

5. As long as there is a projected net increase in the California Consumer Price Index during the State's fiscal year previous to the new rate year, no prospective rate of reimbursement shall be decreased solely because the class median projected cost is less than the existing rate of reimbursement. In the event the existing prospective class median is adopted as the maximum reimbursement rate for DP/NF-Bs and subacute units providers with projected costs below the existing class median shall be reimbursed their projected costs as determined in the most recent rate study.

   In the event there are components in the previous rate study that increased the reimbursement rate to compensate for time periods prior to the effective date of the rates, the rates shall be adjusted (for purposes of determining the existing rate) to reflect the actual per diem cost without the additional compensation. As an example, assume that the per diem cost of a new mandate was $.10. The new mandate was effective June 1, 1997, but the rates were not implemented until August 1, 1997. The rates would include an add-on of $.117 ($.10 times 14 months, divided by 12 months) to compensate 14 months add-on over a 12 month rate period.

6. If a DP, formerly licensed as a freestanding facility, has costs less than the freestanding median rate for their group, their rate will not be reduced to less than the median solely because of the change to distinct part licensure.

7. DPs in areas where there are excess freestanding beds may accept patients at the area's highest NF-B rate to assure greater access to Medi-Cal patients and to provide a savings to the program.

8. State operated facilities shall be reimbursed their costs as reflected in their cost reports, in accordance with the provisions of this plan, using individual audit data for adjustments. These costs are not to be included in the calculation of the class median rate for all other DP/NF level Bs.

9. ICF/DDs (except state operated facilities), ICF/DD-H and ICF/DD-N facilities will be reimbursed at the 65th percentile, instead of the median, in recognition of the fact that they serve a disproportionate share of low income patients with special needs.

10. Subacute services which are provided in both distinct parts of acute care hospitals and freestanding NFs shall be reimbursed at the lesser of costs as projected by the Department or the prospective class median rate, broken down by ventilator and non-ventilator and DP or freestanding NF.

11. The subacute rate includes additional ancillary costs. Where available, the facility's projected cost is based on the audited ancillary cost data. In the event that audited ancillary costs are not available, the facility's projected cost is based on the median of the projected subacute ancillary costs of the facilities in the study that have audited ancillary costs.

12. For purposes of setting the DP/NF or subacute prospective class median rate, the Department shall use the facility's interim projected reimbursement rate when their audit report is not issued as of July 1st.

13. (a) For the rate year 2002-03, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2002-03 rate year, had its subacute prospective reimbursement rate for 2002-03 set at its 2001-02 rate. The facility's 2002-03 subacute prospective reimbursement rate was no more than the 2002-03 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

(b) For the rate year 2003-04, a facility experiencing a reduction in costs, which would result in a reduced subacute reimbursement rate for the 2003-04 rate year, had its subacute prospective reimbursement rate for 2003-04 set at its 2002-03 rate. The facility's 2003-04 subacute prospective reimbursement rate was no more than the 2003-04 prospective class median rate determined under subparagraph 12 or the facility's Medicare upper payment limit, whichever is lower. This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

(c) For the rate year 2005-06, and each rate year thereafter, a DP/NF subacute facility that experiences a reduction in costs in the previous rate year, which would result in a reduced reimbursement rate for the current rate year, will have its prospective reimbursement rate for the current rate year established at the reimbursement rate for the previous rate year. For example, if a DP/NF subacute facility's 2006-07 prospective reimbursement rate was less than the DP/NF subacute's 2005-06 prospective reimbursement rate, the DP/NF subacute's reimbursement rate for the 2006-07 rate year will be established at its 2005-06 prospective reimbursement rate This subparagraph shall not apply to facilities with an interim rate established pursuant to Section IV.H of this Attachment.

14. Any facility that has been a NF-A 100+ bedsize facility will no longer have its reimbursement rate adjusted at the same percentage increase as other NF-level As. Its reimbursement rate will be based on the applicable methodology described in this Section IV paragraph F.

15. (a) Nursing facilities and other specified facilities as identified in Section 14110.65 of the Welfare and Institutions Code, will be eligible to request and receive a supplemental rate adjustment when the facility meets specific requirements.

(b) In order to qualify for the rate adjustment, the facility must have a verifiable written collective bargaining agreement or other legally binding, written commitment to increase non-managerial, non-administrative. and non-contract salaries, wages and/or benefits that complies with Section 14110.65 of the Welfare and Institutions Code and regulations adopted pursuant thereto.

(c) Except as provided in subparagraph (d) below, the rate adjustment will be equal to the Medi-Cal portion (based on the proportion of Medi-Cal paid days) of the total amount of any increase in salaries, wages and benefits provided in the enforceable written agreement referenced in subparagraph (b). This amount will be reduced by an increase, if any, provided to that facility during that rate year in the standardized rate methodology for labor related costs (see Section LE of this state plan) attributable to the employees covered by the commitment. A rate adjustment made to a particular facility pursuant to this subparagraph 15 will only be paid for the period of the non-expired, enforceable, written agreement. The Department will terminate the rate adjustment for a specific facility if it finds the binding written commitment has expired and does not otherwise remain enforceable.

(d) A rate adjustment under this subparagraph 15 will be no more than the greater of 8 percent of that portion of the facility's per diem labor costs, prior to the particular rate year (August 1st through July 31st), attributable to employees covered by the written commitment, or 8 percent of the per diem labor costs of the peer group to which the facility belongs, multiplied by the percentage of the facility's per diem labor costs attributable to employees covered by the written commitment.

(e) The payment of the rate adjustment will be subject to certification of the availability of funds by the State Department of Finance by May 15 of each year and subject to appropriation of such funds in the State's Budget Act

(f) This subparagraph 15 will become effective as of the first day of the month following the date that this provision is approved by the Centers for Medicare and Medicaid Services.

16. (a) Hospice care rates apply to four basic levels of care: Routine Home Care, Continuous Home Care, Inpatient Respite Care, and General Inpatient Care. Each year after the end of the Federal fiscal year (September 30), the Centers for Medicare & Medicaid Services provides the Department of Health Services with the new Medicare rates and the wage indices for the various groupings of California counties. Each Medicare rate for the services referenced above consists of a wage and non-wage component. The wage component of each Medicare rate is multiplied by the wage index for each county grouping and the result is added to the non-wage component to arrive at the reimbursement rate for hospice care services rendered within the particular county grouping. These rates are effective from October 1 through September 30 of each year.

(b) Effective January 3, 2004, in addition to the reimbursement for the services referenced in (a) above, payment to facilities for room and board services shall be made at 95 percent of the Medi-Cal facility rate where the patient resides, if the facility is classified as one of the following: Nursing Facility Level B, Nursing Facility Level A, Intermediate Care Facility – Developmentally Disabled, Intermediate Care Facility – Developmentally Disabled, Habilitative, Intermediate Care Facility – Developmentally Disabled, Nursing.

G. Notwithstanding paragraphs A through E of this Section, in the five situations described below, DP/NF-Bs will receive an interim per diem rate established by the Department. The interim rate will be based on the DP/NF-B's estimate of its total patient days and costs, including the patient days and costs associated with the additional beds that are added. The interim rate established by the Department will not exceed the applicable DP/NF-B median rate for the particular rate year. This provision applies to the following situations:

1. A general acute care hospital (GACH) without a DP/NF-B acquires a previously licensed freestanding NF-B and converts it to newly approved DP/NF-B.
2. A GACH with a DP/NF-B merges with another GACH with a DP/NF-B and consolidates all beds under one existing license.
3. A GACH with a DP/NF-B consolidates a freestanding NF-B into one existing license.
4. Any instance, which results in the creation of a Composite DP/NF-B, as defined in 42 Code of Federal Regulations section 483.5(c) which refers to a facility with one license, one provider agreement, and one provider number.
5. A GACH forms a newly licensed DP/NF-B.

The interim per diem rate and supplementation under Section VIII will be effective upon the date the Department issues a consolidated license or adds the additional beds to the hospital's current license. When DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-B's final

2. A GACH with a DP/NF-B merges with another GACH with a DP/NF-B and consolidates all beds under one existing license.

3. A GACH with a DP/NF-B consolidates a freestanding NF-B into one existing license.

4. Any instance, which results in the creation of a Composite DP/NF-B, as defined in 42 Code of Federal Regulations section 483.5(c) which refers to a facility with one license, one provider agreement, and one provider number.

Newly licensed DP/NF-Bs without historical costs of providing NF-B services shall receive an interim reimbursement rate. This interim rate shall be based on the DP/NF-B's projection of their total patient days and costs, as approved by the Department. When actual DP/NF-B audit report data becomes available, interim rates will be retroactively adjusted to the DP/NF-Bs final prospective rate. Final DP/NF-B rates may be less than the interim rate, in which case the Department shall recover any overpayment.

H. DP/NF subacute providers that do not have historical costs shall receive an interim reimbursement rate. This interim rate shall be based on the facility's projection of their total patient days and costs, as approved by the Department. When twelve or more months of actual DP/NF subacute audit report data becomes available, interim rates will be retroactively adjusted to the facility's final prospective rate. Final rates may be less than the interim rate, in which case the Department shall recover any overpayment. Only DP/NF subacute providers participating in the program as of June 1st will be included in the rate study.

I Notwithstanding Paragraphs A. through G. of this Section, San Mateo County Hospital shall receive an interim reimbursement rate for the skilled nursing facility located at 1100 Trousdale Drive in Burlingame, California. The interim rate will be effective on August 1, 2003 and will be equal to the hospital DP/NF rates of its existing DP/NF skilled nursing facility located at 222 West 39th Avenue in San Mateo, California. The interim rate will apply through July 31, 2006.

J. In accordance with Section 14105.06 of the Welfare and Institutions Code and notwithstanding paragraphs A through F of this Section, all Medi-Cal long-term care facility rates that went into effect August 1, 2003, will remain unchanged through July 31, 2005, and be in effect for the period August 1, 2003, through July 31, 2005. This provision applies to all long-term care facility types (except those operated by the State), including the following:

1. Freestanding nursing facilities licensed as either of the following:

(a) An intermediate care facility pursuant to subdivision (d) of Section 1250 of the Health and Safety Code.

(b) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code.

2. A skilled nursing facility that is a distinct part of a general acute care hospital as defined in Section 72041 of Title 22 of the California Code of Regulations.
3. A subacute care program, as described in Section 14132.25 or subacute care unit, as described in Sections 51215.5 and 51215.8 of Title 22 of the California Code of Regulations.
4. An adult day health care center.

V. DETERMINATION OF RATES FOR NEW OR REVISED PROGRAMS

A. When the State adopts a new service or significantly revises an existing service, the rate of reimbursement shall be based upon comparable and appropriate cost information which is available. Comparable rate and cost data shall be selected and combined in such a manner that the rate is reasonably expected to approximate median audited facility costs, had accurate cost reports been available for the particular class of facility. Such factors as mandated staffing levels and salary levels in comparable facilities shall be taken into account. This method of rate-setting shall ordinarily be relied upon to set rates only until such time as accurate cost reports which are representative of ongoing operations become available.

B. When it is determined that cost report data from a class of facilities is not reliable for rate-setting purposes due to inaccuracies or reporting errors, a random sample of such facilities shall be selected for audit and the resulting audited costs shall be used for the rate study. After five years from the end of the fiscal year in which a facility begins participating in a program for Medi-Cal reimbursement, the reimbursement rate methodology will either revert to the provisions described in Section I through IV of Attachment 4.19-D or be subject to new provisions as described in a State Plan amendment.

VI. DP/NF SERVICES SUPPLEMENTAL REIMBURSEMENT PROGRAM

This program provides supplemental reimbursement for a DP/NF of a general acute care hospital or an acute psychiatric care hospital, which meets specified requirements and provides a large proportion of nursing facility services to Medi-Cal beneficiaries.

Supplemental reimbursement is available for the costs associated with the construction, renovation, expansion, remodel, or replacement of an eligible facility, and would be in addition to the rate of payment the facility receives for nursing facility services under the current DP/NF reimbursement methodology.

A. Definition of an Eligible Project

1. Projects eligible for supplemental reimbursement under this program will include any new capital projects for which final plans have been submitted to the appropriate review agency after January 1, 2000, and before July 1, 2001, or as permitted by subsequent legislation that changes the final plan submission date.

2. "Capital project" means the construction, expansion, replacement, remodel, or renovation of an eligible facility, including buildings and fixed equipment. A "capital project" does not include furnishings or items of equipment that are not fixed equipment.

3. Capital projects receiving funding under this program will include the upgrade or construction of buildings and equipment only to a level required by the most current accepted medical practice standards, including projects designed to correct Joint Commission on Accreditation of Hospitals and Health Systems, fire and life safety, seismic, or other federal and state related regulatory standards.

B. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity had all of the following additional characteristics during the entire 1998 calendar year:

1. Provided services to Medi-Cal beneficiaries;
2. Was a DP/NF of an acute care hospital providing nursing facility care;

3. Had not less than 300 licensed nursing facility beds;
4. Had an average nursing facility Medi-Cal patient census of not less than 80 percent of the total nursing facility patient days; and
5. Was owned by a county, or city and county.

C. Supplemental Reimbursement Methodology

Supplemental reimbursement provided by this program will be distributed under a payment methodology based on nursing facility services provided to Medi-Cal patients at the eligible facility. An eligible facility's supplemental reimbursement for a capital project qualifying for this program will be calculated and paid as follows:

1. For any fiscal year the facility is eligible to receive supplemental reimbursement, the facility will report to the Department the amount of debt service on the revenue bonds or other financing instruments issued to finance the capital project. This amount represents the gross total amount to be considered for supplemental reimbursement. The gross total amount will be reduced by all other funds received by an eligible county or city and county for the purpose of construction/renovation of an eligible project.

2. Only those projects, or portions thereof, that are available and accessible to Medi-Cal beneficiaries will be considered for supplemental reimbursement, and such supplemental reimbursement will only be made for capital projects, or for that portion of capital projects, which provide nursing facility services and qualifies for reimbursement according to applicable Medicare reimbursement principles.

   Capital project expenditures for an eligible facility are those expenditures which, under generally accepted accounting principles, are not properly chargeable as expenses of operation and maintenance and are related to the acquisition, construction, renovation, improvement, modernization, expansion, or replacement of a plant, buildings, and equipment with respect to which the expenditure is made, including, but not limited to the following, if included in revenue bond debt service: (1) studies, surveys, designs, plans, working drawings, and specifications bid preparation, inspection, and material testing; (2) site preparation, including demolishing or razing structures, hazardous waste removal, and grading and paving; and (3) permit and license fees.

3. For each fiscal year in which an eligible facility requests reimbursement, the Department will establish the ratio of nursing facility Medi-Cal days of care provided by the eligible facility to total nursing facility patient days of care provided by the eligible facility. The ratio will be established using the most current Medi-Cal data obtained from audits performed by the Department. This ratio will be applied to the corresponding fiscal year of debt service on the revenue bonds or other financing instruments used to finance the capital project.

4. The amount of debt service submitted to the Federal Health Care Financing Administration for the purpose of claiming reimbursement for each fiscal year will equal the amount determined annually in paragraphs 1 and 2, multiplied by the percentage figure determined in paragraph 3.

For example:

- Eligible Debt Service (paragraphs 1 and 2) $1,000,000
- Annual Ratio (paragraph 3) $\frac{75}{100}$ (Total nursing facility Medi-Cal days) (Total nursing facility patient days) $= .75$

$1,000,000 x .75 = $750,000

The resulting net amount (i. e. $750,000) will be claimed at the applicable federal Medicaid assistance percentage for each fiscal year it is submitted.

D. Facility Reporting Requirements

1. An eligible facility must submit documentation to the Department regarding debt service on revenue bonds or other financing instruments used for financing the capital project. This documentation includes, but is not limited to, a copy of the initial financing instrument that has funded an eligible capital project and any refinancing.

2. To meet the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, the county, or city and county, for any eligible facility, is required to certify (in the manner specified by the Department) that the

claimed expenditures for the capital project are eligible for federal financial participation.

3. In order to fully disclose reimbursement amounts to which the eligible facility may be entitled, the county, or city and county is required to keep, maintain, and have readily retrievable, records as specified by the Department. Such records include, but are not limited to, construction and debt service costs.

4. Prior to receiving supplemental reimbursement an eligible hospital must submit to the Department a copy of the certificate of occupancy for the capital project.

5. Prior to paying any supplemental reimbursement, the Department will require the county, or city and county, to disclose all public and private funds it receives for the purpose of financing the capital project.

6. Any and all funds expended pursuant to this program are subject to review by the Department. The Department will review, on a semiannual basis, the special account where all payments received by an eligible facility are placed and used exclusively for the debt service on an eligible project to verify that funds are used exclusively for the payment of appropriate expenses related to the eligible capital project.

E. Standards for Supplemental Reimbursement

1. The Department will require that any county, or city and county, receiving supplemental reimbursement under this program enter into a written interagency agreement with the Department for the purpose of implementing this program.

2. Supplemental reimbursement paid under this program must not duplicate any reimbursement received by an eligible facility for construction costs that would otherwise be eligible for reimbursement for nursing facility services under the DP/NF reimbursement methodology specified in this Attachment.

3. The total Medi-Cal reimbursement received by a facility eligible under this program will not result in a reduction of the rate of payment the facility

receives for nursing facility services under the most current DP/NF reimbursement methodology.

4. The supplemental reimbursement provided by this program will not commence prior to the date the hospital submits to the Department a copy of the certificate of occupancy for the capital project.

5. All payments received by an eligible facility must be placed in a special account; the funds in the special account will be used exclusively for the payment of expenses related to the eligible capital project.

6. Supplemental reimbursement will be equal to the amount of federal financial participation received for the claims submitted by the Department for debt service expenditures allowable under federal law.

7. In no instance will the total amount of supplemental reimbursement received under this program combined with that received from all other sources dedicated exclusively to debt service, exceed 100 percent of the debt service for the capital project over the life of the loan, revenue bond, or other financing mechanism.

8. A facility qualifying for and receiving supplemental reimbursement pursuant to this program will continue to receive reimbursement: (i) until the qualifying loan, revenue bond, or other financing mechanism is paid off; and (ii) as long as the facility's eligible capital project continues to provide nursing facility services and is available and accessible to Medi-Cal patients.

9. The state share of the debt service amount submitted to the Federal Health Care Financing Administration for purposes of supplemental reimbursement will be: (i) paid with only county, or only city and county funds; and (ii) certified to the state as specififed in paragraph D. 2. above.

10. Total Medicaid reimbursement provided to an eligible facility will not exceed applicable federal upper payment limits.

VII. PUBLIC CONSIDERATION

A. A public comment period is provided, during which a public hearing may be requested by interested parties. During this period, the evidentiary base and a report of the study methodology and findings are available to the public.

1. Interested parties will be notified of the time and place of the hearing (if scheduled), and the availability of proposed rates and methodologies by direct mail and public advertising in accordance with state and federal law.
2. Comments, recommendations, and supporting data will be received during the public comment period and considered by the Department before certifying compliance with the state Administrative Procedures Act.
3. As part of the final regulation package, the Department will respond to all comments received during the public comment period concerning the proposed changes.

VIII. PUBLIC HOSPITAL DP/NF ADDITIONAL REIMBURSEMENT

This program provides additional reimbursement for a DP/NF of a general acute care hospital that is owned or operated by a city, county, city and county, or health care district, which meets specified requirements and provides nursing facility services to Medi-Cal beneficiaries.

Additional reimbursement under this program is available only for the federal share of costs that are in excess of the rate of payment the facility receives for nursing facility services under the current DP/NF reimbursement methodology and any other source of Medi-Cal reimbursement for DP/NF services.

A. Definition of an Eligible Facility

A facility is determined eligible only if the submitting entity continuously has all of the following additional characteristics during the Department's rate year beginning August 1, 2001, and subsequent rate years:

1. Provides services to Medi-Cal beneficiaries.

2. Is a DP/NF of an acute care hospital providing nursing facility care. For purposes of this section, "acute care hospital" means the facilities described at subdivision (a) or (b), or both, of Section 1250 of the Health and Safety Code.

3. Is owned or operated by a city, county, city and county, and/or health care district organized pursuant to Chapter 1 of Division 23 (commencing with Section 32000) of the Health and Safety Code.

Owners of eligible facilities must provide certification to the state that the amount claimed by them is eligible for federal financial participation.

B. Additional Reimbursement Methodology

Additional reimbursement provided by this program to an eligible nursing facility is intended to allow federal financial participation for certified public expenditures.

1. As described in paragraph A, the expenditures certified by the local agency to the state shall represent the payment

eligible for federal financial participation. Allowable certified public expenditures shall determine the amount of federal financial participation.

2. In no instance shall the amount certified pursuant to paragraph C.1 , when combined with the amount received from all other sources of reimbursement from the Medi-Cal program, exceed 100 percent of the projected costs (as determined pursuant to Sections I through V of this Attachment 4.19-D) for DP/NF services at each facility.

3. Costs associated with the provision of subacute services pursuant Section 14132.25 of the Welfare and Institutions Code will not be certified for reimbursement pursuant to this section.

4. The additional Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on skilled nursing services provided to Medi-Cal patients at the eligible facility. The provider shall report to the Department, on a quarterly basis, the amount of the eligible costs that are the lesser of actual costs or the Department's projected costs for that facility. In no case shall total annual reimbursement under this section exceed the Department's projected costs.

C. Facility Reporting Requirements

The governmental entity reporting on behalf of any eligible facility must do all of the following:

1. Certify, in conformity with the requirements of Section 433.51 of Title 42 of the Code of Federal Regulations, that the claimed expenditures for DP/NF services are eligible for federal financial participation.

2. Provide evidence supporting the certification as specified by the Department.

3. Submit data as specified by the Department to determine the appropriate amounts to claim as expenditures qualifying for federal financial participation.

4. Keep, maintain and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible facility is entitled, and any other records required by the Centers for Medicare and Medicaid Services.

D. Standards for Additional Reimbursement

1. The Department may require that any city, county, city and county, or health care district receiving additional reimbursement under this program enter into a written interagency agreement with the Department for the purposes of implementing this program.

2. Additional reimbursement paid under this program must not be greater than the difference between total projected Medi-Cal costs and the amount paid under the existing DP/NF reimbursement methodology specified in Sections I through V of this state plan.

3. The total Medi-Cal reimbursement received by a facility eligible under this program will in no instance exceed 100 percent of the projected costs (as determined pursuant to Sections I through V of this state plan) for DP/NF services at each facility.

E. Department's Responsibilities

1. The Department will submit claims for federal financial participation for the expenditures for services that are allowable expenditures under federal law.

2. The Department will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for federal financial participation will include only those expenditures that are allowable under federal law.

3. The state share of the additional reimbursement under this program will be equal to the amount of the federal financial participation of eligible expenditures paid by city, county, city and county and/or health care district funds and certified to the state as specified in Section C.1 above.

4. Total Medicaid reimbursement provided to an eligible facility will not exceed applicable federal upper payment limits.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

LONG TERM CARE (LTC) CLASSES TO BE USED FOR RATE-SETTING PURPOSES

PATIENT ACUITY LEVELS	*ORGANIZATION TYPE*	*No. of Beds*	*Geographical Location*	*Reimbursement Basis*
NF LEVEL B	-Distinct part NF	All	Statewide	*
(EXCEPT SUBACUTE,	-Freestanding NF	1-59	Los Angeles Co.	Median
PEDIATRIC SUBACUTE,		1-59	Bay Area**	Median
and TRANSITIONAL		1-59	All Other Counties	Median
INPATIENT CARE		60+	Los Angeles Co.	Median
		60+	Bay Area**	Median
		60+	All Other Counties	Median
SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	*
	-Freestanding NF	All	Statewide	*
NON-VENTILATOR	-Distinct part NF	All	Statewide	*
DEPENDENT	-Freestanding NF	All	Statewide	*
PEDIATRIC SUBACUTE:				
VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NON-VENTILATOR DEPENDENT	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NSITIONAL INPATIENT CARE:				
IABILITATIVE	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
MEDICAL	-Distinct part NF	All	Statewide	Model
	-Freestanding NF	All	Statewide	Model
NF LEVEL A	-All	1-99	Los Angeles Co.	Median
		1-99	Bay Area**	Median
		1-99	All Other Counties	Median
		100+	Statewide	***
ICF/DD	-All	1-59	Statewide	65th percentile
		60+	Statewide	65th percentile
ICF/DD-Hs and Ns	-All	4-6	Statewide	65th percentile
		7-15	Statewide	65th percentile
RURAL SWING-BED NF LEVEL B SERVICES	-Rural acute hospitals	All	Statewide	Median

* DP/NF level Bs and Subacute providers are reimbursed at either the lesser of costs as projected by the Department or the prospective median rate of the LTC class.

** Bay area is defined as San Francisco, San Mateo, Marin, Napa, Alameda, Santa Clara, Contra Costa, and Sonoma counties.

*** Current rate increased by the same percentage rate as received by other NF level As.

STUDY TO DETERMINE SUBACUTE COST-BASED REIMBURSEMENT

REPORT NO. 01-95-05

Long Term Care Reimbursement Section
Rate Development Branch
Medi-Cal Policy Division
Department of Health Services
August 1995

TN 95-017
Supersedes
TN _____

Approval Date 10/1/98

Effective Date August 1, 1995

STUDY TO DETERMINE SUBACUTE COST-BASED REIMBURSEMENT

INTRODUCTION

The California Department of Health Services (DHS) is changing the rate setting methodology for Medi-Cal subacute program services provided in long term care (LTC) nursing facilities - level B (NF-B), and hospital-based nursing facilities that are a distinct part of the hospital (DP/NF) from a model to a cost-based methodology.

The State's approved reimbursement methodology for LTC services calls for a cost-based system.

The cost-based subacute rate setting methodology will not affect the pediatric subacute program rate setting methodology.

BACKGROUND

The Medi-Cal subacute program has been in existence since 1985. The subacute all-inclusive reimbursement rate methodology in effect since 1988 has been based on a model as provided for in the State Plan, as adequate historical cost information was not available until this past year.

Starting with the 1993 calendar year, there are cost data available to establish a cost-based subacute reimbursement rate. The costs of the subacute facilities that rendered subacute services in the 1993 calendar year have been audited by DHS during the State's 1994-95 fiscal year.

The subacute modeled rates were broken down into three categories: labor, skilled nursing facility costs and other costs. The new methodology, using audited data, is consistent with other LTC rate setting methodologies of applying economic indicators to actual costs to develop a prospective rate.

DETAIL OF RECOMMENDED MEDI-CAL SUBACUTE RATES

The following represent the recommended Medi-Cal maximum per diem rates for the subacute program. Facilities with projected subacute costs lower than these maximum rates will receive their projected costs as determined by DHS.

FACILITY TYPE	PATIENT TYPE	DAILY RATE
DP/NF	VENT	$423.67
	NON-VENT	$401.08
FS/NF	VENT	$267.84
	NON-VENT	$245.26

GENERAL ASSUMPTIONS

1. The subacute reimbursement rates are peer grouped by licensure category and ventilator dependency.

2. There are distinct rates for subacute units within freestanding (FS) NF-Bs and DP/NF-Bs.

3. There are distinct rates for subacute units based on the ventilator dependency of the subacute patient: one rate for ventilator dependency and a different rate for non-ventilator dependency.

4. Included within the subacute per diem rate are all services, equipment and supplies necessary for patient care pursuant to Title 22, California Code of Regulations (CCR), Section 51511, except 51511 (a).

5. The subacute program's all-inclusive per diem reimbursement rates are the lesser of the facility's costs as projected by the Department or the prospective class median rate.

6. The audited data are from fiscal periods ended January 1, 1993 through December 31, 1993. The data will be updated to the midpoint of the State's rate year in the same manner as other LTC reimbursement methodologies.

7. Only audit reports for facilities that provided subacute care to Medi-Cal patients for 12 months will be used to establish the prospective class median rate.

8. Only facilities that provide subacute care services to Medi-Cal patients during the rate year will be used to establish the prospective class median rate.

9. For facilities whose applicable cost report audits were not issued by July 1, 1995, the Department will establish an interim projected rate based on the facility's cost report with a fiscal period ending January 1, 1993 through December 31, 1993 adjusted by the audit disallowance that is derived from the class audit adjustment for the category of freestanding nursing facilities with 60 plus beds.

10. The all-inclusive rate includes ancillary costs. These costs will continue to be modeled due to lack of adequate historical data in this area.

11. Ventilator dependent days were determined by audit to be 40 percent of total patient days. There were 29,121 ventilator dependent patient days out of 73,624 total patient days in subacute units with this information available. Note: the table below reflects total audited subacute patient days.

12. The subacute modeled rates, weighted for ventilator/non-ventilator are:

1993/1994 WEIGHTED DAILY SUBACUTE RATES				
	DP/NF		FS/NF	
	VENT	NON-VENT	VENT	NON-VENT
TOTAL AUDITED SUBACUTE DAYS	181,770		58,621	
SUBACUTE PATIENT DAYS	72,708 (40%)	109,062 (60%)	23,448 (40%)	35,173 (60%)
1993/94 RATES	$392.22	$370.50	$270.49	$248.80
PROJECTED PAYMENT (days X rates)	$28,517,532	$40,407,471	$6,342,558	$8,750,943
PROJECTED PAYMENT	$68,925,003		$15,093,501	
WEIGHTED RATE	$379.19 ($68,925,003 ÷ 181,770)		$257.48 (15,093,501 ÷ 58,621)	

13. As provided in the State Plan, cost reports that were inaccurate, incomplete, or unrepresentative were excluded from this study.

LABOR

Labor costs are updated by a labor index developed by the Department as specified in Rate Study 01-95-01.

The direct patient care labor cost is available from the cost report. The indirect labor costs are not available from the cost report or the audit report. The total labor percentage was calculated using the subacute rate setting model. The Department's historical labor percentage in nursing facilities is 67 percent. The total of 67 percent of the NF-B costs from the model combined with the direct labor portion of the model will be compared to the weighted modeled rate to calculate a labor percentage. This percentage will be used to determine the labor portion of the actual audited costs. The labor percentage for DP/NF subacute units is 54.79 percent and the labor percentage for freestanding subacute units is 47.84 percent as per the following table.

DETERMINATION OF SUBACUTE LABOR PERCENTAGE		
	DP/NF	FS/NF
MODELED INDIRECT SNF COST	$143.63	$41.89
INDIRECT LABOR @ 67%	$96.23	$28.07
MODELED DIRECT LABOR	$111.51	$95.11
MODELED TOTAL LABOR	$207.74	$123.18
WEIGHTED RATE	$379.19	$257.48
LABOR PERCENTAGE OF WEIGHTED RATE	54.79%	47.84%

FIXED COSTS

Fixed costs are not updated. Direct fixed costs used in this rate study are obtained from the audit report and are identified as capital related costs in the audit report.

Indirect fixed costs are not available for the DP/NF-B facilities. The audit reports do not contain details of these amounts. It is anticipated that this information will be included in future audit reports and the information will be available for future rate studies.

Indirect fixed costs are available for the FS/NF-B facilities. The information is available and will be used in determining the FS/NF-B subacute reimbursement rates. The fixed cost amount will be calculated using the same methodology as for the freestanding nursing homes. The subacute percentage of total plant operations cost is used to determine the subacute portion of the fixed costs.

ALL OTHER COSTS

All costs other than the fixed and the labor costs make up this cost category. All other costs are updated by the California Consumer Price Index (CCPI).

ADD-ONS

Valdivia

There is no add-on related to the Valdivia settlement included in this subacute rate study. The terms of the Valdivia settlement did not include the subacute program. The Valdivia settlement provided nursing facilities more money for additional staffing. However, the subacute program already requires staffing at a higher level than nursing care.

Assembly Bill 3477

This add-on is for CNA background checks. The subacute program utilizes CNAs, and therefore this item affects the subacute program. There will be an add-on for Assembly Bill 3477, Chapter 1246, Statutes of 1994, in the amount of $0.014 per patient day (PPD).

SUBACUTE PROGRAM ANCILLARY COSTS

Subacute ancillary costs are determined to be $30.49 PPD.

Assumptions:

1. Intensive acute rehabilitation therapy, which contains occupational therapy, speech therapy, physical therapy, etc., in an acute facility is 3 hours per day for 6-7 days per week.
2. Rehabilitation therapy is less intense in nursing facilities and is rarely more than 5 days per week. Therapy in nursing facilities is usually ¾ hour time duration per session. This rate study will use a 5 day per week therapy schedule for subacute patients.
3. Subacute patients receive ¾ hour per day of some type of therapy for 5 days per week. This calculates to 3¾ hour of therapy per week.
4. Medi-Cal subacute reimbursement is a 7 days per week per diem. The seven day per week reimbursement calculates to be .5357 therapy hour/day.

SUBACUTE CARE ANCILLARY COST				
	PHYSICAL THERAPY	OCCUPATIONAL THERAPY	OTHER THERAPY	TOTAL
1992 SALARY PER HR	$18.74 *	$18.62 *	$15.08 **	$52.44
LABOR UPDATE @ 1.085408	$20.34	$20.21	$16.37	$56.92
WEEKLY COST 3¾ HR PER WEEK	$76.28	$75.79	$61.39	$213.45
DAILY THERAPY REIMBURSEMENT	$10.90 ***	$10.82 ***	$8.77 ***	$30.49 ***

* From California Occupational Guide Wage Supplement, Wages by County for Selected Occupations, August 1993.

** From OSHPD Aggregate Long-Term Care Facility Financial Data with Report Periods Ending December 31,1991 - December 30,1992.

*** Daily reimbursement based on payment for seven days per week.

RATE SETTING METHODOLOGY

The audited costs for all of the applicable facilities are accumulated and the routine portion of the subacute costs of the facility is used in this rate study.

The applicable audited routine costs for subacute services are updated by the various factors (labor & CCPI) to determine the projected weighted daily routine cost. The costs are updated from the midpoint of the audited year to the midpoint of the State's rate year.

The projected weighted daily routine cost is then broken down into ventilator and non-ventilator dependent projected routine subacute costs using the facility's total patient days. Ventilator dependent days are estimated to be 40 percent of total days.

The only differential in the routine subacute cost PPD is the equipment cost of the ventilator. The equipment cost of the ventilator, updated from the model, is $22.58 PPD. When the cost of the ventilator is removed from the projected weighted daily routine cost, the remainder is the non-ventilator cost PPD. The ventilator cost PPD is the non-ventilator cost PPD plus the equipment cost of the ventilator.

Ancillary costs and all applicable add-ons are added to the ventilator and non-ventilator routine subacute costs for the all-inclusive subacute rates.

The all-inclusive subacute rates are arrayed, and the median rate is determined. Facilities whose projected costs are lower than the median rate are reimbursed at their projected costs. Facilities whose projected costs are at or above the median are reimbursed at the median rate.

An example of the rate methodology follows:

RATE STUDY EXAMPLE
ASSUMPTIONS

FREESTANDING NURSING FACILITY	
Fiscal Period Beginning	07/01/92
Fiscal Period Ending	06/30/93
Total Days in the Report Period	365
Licensed Nursing Facility Beds	50
Contracted Subacute Beds	20
PATIENT DAYS	
Total Facility Nursing Facility Patient Days	18,000
Subacute Patient Days	7,000
Ventilator Dependent Patient Days (est.)	40%
COSTS	
Total Capital Related Cost	$ 120,000

Total Subacute Unit Routine Expenses	$1,500,000
Reported Routine Subacute Cost PPD ($1,500,000 ÷ 7,000)	$ 214.29
Ancillary Cost PPD	$ 30.49
Ventilator Equipment Cost PPD	$ 22.58
License Fee per Bed...Revised	$ 66.90
License Fee per Bed...Prior	$ 54.07

VARIABLES

Midpoint of report (1/1/93) to midpoint of rate year (1/31/96) in months	37
Salaries, Wages, & Benefits as an Average Percentage of Total Cost	0.4784
Fixed Cost Update	1.00000
Salaries, Wages, & Benefits Update	1.055075
All Other Costs Update	1.049225
Audit Adjustment	1.00000

OTHER

Add-on for AB3477 (Background Check)	0.014

DETERMINATION OF SUBACUTE WEIGHTED ROUTINE COST PPD

	CAPITAL RELATED	LABOR	ALL OTHER	TOTAL	COST PPD (7,000 DAYS)
REPORTED ROUTINE COST	$120,000	$717,600	$622,878	$1,500,000	$214.29
UPDATE FACTOR	1.0000	1.055075	1.049225	N/A	N/A
UPDATED ROUTINE COST	$120,000	$757,122	$653,539	$1,530,661	$218.67

DETERMINATION OF ALL-INCLUSIVE COST PPD			
	VENT/NON-VENT WEIGHTED	NON-VENT DEPENDENT 60%	VENT DEPENDENT 40%
REPORTED ROUTINE COST PPD	$214.29	N/A	N/A
UPDATED ROUTINE COST PPD	$218.67	N/A	N/A
UPDATED ROUTINE COST PPD	N/A	$209.63 *	$232.21 **
AB3477 ADD-ON	N/A	$0.014	$0.014
ANCILLARY COST ADD-ON	N/A	$30.49	$30.49
ALL-INCLUSIVE COST PPD	N/A	$240.13	$262.71

* Non-Ventilator Routine Cost PPD Calculation:
Total Subacute Ventilator Equipment Cost:
40 percent of 7,000 subacute days = 2,800 subacute vent days
2,800 x $22.58 (ventilator equipment cost) = $63,224
Non-Ventilator Routine Cost PPD Calculation:
$1,530,661 - $63,224 = $1,467,437
$1,467,437 ÷ 7,000 = $209.63

** Ventilator Routine Cost PPD Calculation:
$209.63 + $22.58 = $232.21

STUDY TO DETERMINE RATES FOR
TRANSITIONAL INPATIENT CARE

REPORT NO. 01-95-06
Rate Year 1995-1996

This study establishes a model rate for the Transitional Inpatient Care (TC) program which was mandated by the Budget Act of 1995. TC means the level of care needed by an individual who has suffered an illness, injury, or exacerbation of a disease, and whose medical condition has clinically stabilized so that daily physician services, and the immediate availability of technically complex diagnostic and invasive procedures usually available only in the acute care hospital, are not medically necessary, and when the physician assuming the responsibility of treatment rnanagement of the patient in transitional care has developed a definitive and time-limited course of treatment. There are two groups of TC patients, medical and rehabilitation. Some patients may require a combination of both services.

Lacking actual cost data for this level of care, a model was developed based on the maximum rate established in 1995/96 for nursing facilities that are distinct parts of acute care hospitals (DP/NFs) and 4estirnates of costs for additional requirements for TC providers. The recommended reimbursement rate for transitional care is an average of the estimated cost to provide TC rehabilitative care and TC medical care.

No component was built into these rates for hemodialysis, physician services, customized DME, plasmapheresis, prescription medications, radiology and laboratory services, decubitus care equipment and medical supplies as provided in **the list established by the Department of Health Services**, except for

hypodermoclysis and IV solution administration sets which are included in the rate. These items and services may be billed separately for either medical or rehabilitative patients.

The following is an explanation of each component of the TC rate, describing the assumptions used to develop the estimates for each component:

BASE COST

The maximum reimbursement rate to provide care to patients in DP/NFs was used as a base to build the TC rate. Total DP/NF direct care hours for nursing along with appropriate salaries were derived from data shown in the Office of Statewide Health Planning and Development's (OSHPD) publication "Aggregate Long Term Care Facility Data, Report Periods Ending December 31, 1992 to December 30, 1993". The salaries were updated using factors from the 1995/96 long term care rate study and benefits were added. The salaries and benefits component was deducted to estimate basic DP/NF cost, including overhead, to provide care to TC patients. TC specific salaries and other costs were subsequently added to form the new rate.

NURSE MANAGER WAGES

A nurse manager component was estimated using OSHPD data. It is assumed that the nurse manager will manage a 25-bed unit, including private subacute patients, Medicare patients and TC patients. For purposes of these calculations, an 85 percent occupancy factor which is based on the 1995/96 hospital distinct part nursing facility occupancy rates was assumed.

DIRECT NURSING WAGES

OSHPD data was also used to calculate the cost of direct nursing care for the TC unit, using assumptions of 5.0 hours per patient day including 60 percent certified nurse assistant (CNA) hours for rehabilitative patients, 50 percent CNA hours for medical patients and a minimum of 24 hours of Registered Nurse coverage for licensed nursing requirements. For every 12 patients, an additional 8 hour shift of RN cost was added. The calculations for direct nursing wages assumes that the TC unit is within a 25-bed Medicare unit, and includes an 85 percent occupancy adjustment, as referred to above.

SUPPLIES

The cost of supplies were developed from a combination of data from supplier catalogs, Title 22, California Code of Regulations, Section 51521, Medicare allowable costs and Medi-Cal paid

claims data. TC therapy supplies were estimated based on discussions with staff from industry organizations as the average cost to stock a 10-bed unit. The amount and types of other supplies priced in this spreadsheet were based on assumptions provided by staff of the Medi-Cal Benefits Branch.

THERAPY

This is the estimated cost to provide therapy services to TC patients. The hourly rates for therapists was determined using California state employee pay scales for the various professional classifications. The average wage for the highest range in each classification, plus benefits , was used for the calculations. No other statewide data specific to therapy costs were available on which to base estimates. For rehabilitative patients, it was assumed that patients requiring therapy would receive 2 hours per day, 5 days a week. Medical patients who required therapy were assumed to receive 3/4 of an hour therapy, 5 days per week. Respiratory therapy, which was added at the end of the calculation, was assumed to include 15 minutes treatment 4 times per day and an additional 15 minutes per day evaluation, for each patient requiring such therapy.

INTERDISCIPLINARY TEAM

It is assumed that an interdisciplinary team composed of the nurse manager, therapists and physicians is required to evaluate all patients in the TC unit. It is also assumed that rehabilitative patients will each require 3 hours per week to evaluate while each medical patient will need 2 hours per week evaluation. The time required of each of the professional classifications was an assumption developed by the Medi-Cal Policy Division's Benefits Branch staff.

THERAPY EQUIPMENT

Because of the diversity in the type, quantity and quality of equipment used in therapy units, it was estimated with the concurrence of industry staff that the average start up cost for equipment for a new therapy unit would be approximately $100,000. This cost was amortized over a 10-year-life. The cost per patient day was computed by assuming that TC patients, private subacute patients and Medicare patients would all have access to the equipment. In order to develop an estimate of the cost for medical patients who require less therapy, the rate was based upon a ratio of the cost of therapy professional fees for medical patients to fees for rehabilitative patients.

METHODS AND STANDARDS FOR ESTABLISHING FACILITY-SPECIFIC REIMBURSEMENT RATES FOR FREESTANDING SKILLED NURSING FACILITIES LEVEL-B AND SUBACUTE CARE UNITS OF FREESTANDING SKILLED NURSING FACILITIES

I. Introduction

A. This document, labeled Supplement 4 to Attachment 4.19-D, describes the overall reimbursement rate methodology for skilled nursing facility services provided to Medi-Cal recipients by: (1) freestanding skilled nursing facilities level-B (FS/NF-B), both publicly and privately operated, and (2) subacute care units of FS/NF-Bs as defined in California Code of Regulations, title 22, section 51124.5.

B. This Supplement is submitted by the single State Medicaid (Medi-Cal) Agency, the State of California Department of Health Services (hereinafter "Department"). This Supplement is necessary to describe changes to the FS/NF-B reimbursement rate methodology adopted by the 2004 State Legislature in Assembly Bill (AB) 1629, signed into law on September 29, 2004, as Chapter 875 of the Statutes of 2004.

C. AB 1629 establishes the Medi-Cal Long-Term Care Reimbursement Act, which mandates a facility-specific rate-setting methodology effective on August 1, 2005, and which will cease to be operative on and after July 31, 2008. This statute requires the Department to develop and implement a Medi-Cal cost-based facility-specific reimbursement rate methodology for Medi-Cal participating FS/NF-Bs, including FS/NF-Bs with subacute care beds.

D. The cost-based reimbursement rate methodology is intended to reflect the costs and staffing levels associated with the quality of care for residents in FS/NF-Bs. This methodology will be effective August 1, 2005, and will be implemented the first day of the month following federal approval. A retroactive increase in reimbursement rates to August 1, 2005, to FS/NF-Bs will be provided in the event that federal approval occurs after the effective date of the methodology.

E. The reimbursement rates established will be based on methods and standards described in Section V of this Supplement.

F. Provisions of this legislation require that the facility-specific reimbursement rates for rate years 2005/06 and 2006/07 will not be less than the rates developed based upon the methodology in effect as of July 31, 2005, as described in Attachment 4.19-D, Pages 1 through 22 of the State Plan, plus projected proportional costs for new state or federal mandates for the applicable rate years.

II. General Provisions

A. Within the provisions of this Supplement, the following abbreviation will apply: FS/NF-B meaning freestanding level-B nursing facility.

B. Reimbursement to FS/NF-Bs (excluding those with FS/NF-B subacute beds) will be for routine per diem services, exclusive of ancillary services. The reimbursement rate for these ancillary services are reviewed and audited by the Department and are reimbursed separately.

C. The routine service per diem reimbursement rate will be consistent with Medicare Reimbursement Principles as specified in Title 42, Code of Federal Regulations, Part 413. Aggregate Medi-Cal payments may not exceed the aggregate payments that the state would pay for the same or similar services under the Medicare Prospective Payment System.

D. The FS/NF-B routine service per diem payment includes all equipment, supplies and services necessary to provide appropriate nursing care to long-term care residents, except those items listed as separately payable, as described in the California Code of Regulations, title 22, section 51511(c), or personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shaves or shampoos performed by the facility and periodic hair cuts performed as part of resident care), and television rental.

E. For subacute care units of FS/NF-Bs the per diem payment includes all services, equipment and supplies necessary for the administration of the treatment procedures for residents determined to need subacute care services. Items included in the reimbursement rate are specified in the California Code of Regulations, title 22, section 51511.5(d).

F. Notwithstanding any other provisions of this State Plan, the per diem payment will be limited to the usual charges made to the general public, as described in the California Code of Regulations, title 22, section 51501.

G. All long-term care providers must be licensed and certified to participate in the Medi-Cal program and must meet the requirements of the California Code of Regulations, title 22, section 51200. In order to assure that reimbursement rates take into account the cost of compliance with statutory requirements, FS/NF-Bs will be reimbursed according to this Supplement based on the following resident acuity levels:

1. Freestanding NF-B residents;
2. Freestanding subacute ventilator-dependent residents;
3. Freestanding subacute non-ventilator-dependent residents.

H. FS/NF-B subacute care facilities provide medically necessary services of varying degrees of higher intensity care, as provided in the California Code of Regulations, title 22, section 51124.5.

III. Cost Reporting

A. All long-term care FS/NF-Bs participating in the Medi-Cal Program will maintain, according to generally accepted accounting principles, the uniform accounting systems as described in California Code of Regulations, title 22, section 51511.2 and will submit cost reports in the manner approved by the state.

B. Cost reports are due to the state no later than 120 days after the close of each facility's fiscal year, in accordance with Medi-Cal cost reporting requirements.

C. Each FS/NF-B will retain its supporting financial and statistical records for a period of not less than three years following the date of submission of its cost report and will make such records available upon request to authorized state or federal representatives, as described in Welfare and Institutions Code section 14124.1.

D. All cost reports will be prepared according to the Office of Statewide Health Planning and Development's (OSHPD) Reporting Requirements and Instructions. These cost reports will be maintained by the state for a period of not less than five years following the date of electronic submission of reports, in accordance with Title 42, Code of Federal Regulations, section 433.32.

E. The reimbursement rate methodology for FS/NF-Bs may include more or less than twelve months and/or more than one cost report, as long as the fiscal periods all end within the timeframe specified for rate-setting. Only cost reports accepted by the OSHPD will be included in the calculation of the facility-specific reimbursement rates, except as specified in Section VIII of this Supplement.

F. For FS/NF-Bs providing subacute care services, only cost reports with twelve or more months of subacute costs which have been formally accepted by the state will be used in the rate study to determine the facility-specific reimbursement rate.

G. Supplemental schedules may be used to augment and/or update cost reports and other source data used to develop facility-specific rates. Supplemental schedules will be subject to audit or review prior to use in the facility-specific rate-setting process.

H. The Department reserves the right to exclude any cost report or supplemental schedule or portion thereof that it deems inaccurate, incomplete or unrepresentative.

I. FS/NF-Bs that no longer participate in the Medi-Cal program will be excluded from the rate-setting process.

J. For purposes of calculating reasonable compensation of facility administrators, the Department will adhere to the standards established under Chapter 9 of the Centers for Medicare & Medicaid Services Provider Reimbursement Manual (HIM 15), reproduced in full in Volume 2 at Paragraph 5577 of the Commerce Clearing House Medicare and Medicaid Guide. The Department will conduct its own compensation survey for calculating reasonable compensation for facility administrators. Based on the data collected from such surveys, the state will develop compensation range tables for the purpose of evaluating facility administrator compensation during audits of those FS/NF-Bs, and adjust the costs accordingly.

IV. Audits and Audit Adjustments

A. The Department will conduct financial audits of FS/NF-Bs participating in the Medi-Cal program a minimum of once every three years. These audits may be full-scope field audits, limited scope reviews, or desk reviews. Limited scope or desk reviews will be conducted at intervening periods, as necessary. All subacute care units of FS/NF-Bs will be subject to audit or review on an annual basis.

B. The Department will adjust or reclassify reported cost and statistical information submitted by the FS/NF-Bs for the purposes of calculating facility-specific Medi-Cal rates consistent with applicable requirements of this Supplement and as required by Title 42, Code of Federal Regulations, Part 413.

C. Audited or reviewed cost data and/or prospective audit adjustments will be used and/or applied to develop facility-specific reimbursement rates.

1. On an annual basis, the Department will use FS/NF-B cost reports, including supplemental reports as required by the Department, and the results of any state or federal audits to determine if there is any difference between the reported costs used to calculate a FS/NF-B's reimbursement rate and the FS/NF-B's audited expenditures in the rate year.

2. If the Department determines that there is a difference between reported costs used to calculate a FS/NF-B's reimbursement rate and the audited facility expenditures, the Department will adjust the FS/NF-B's

reimbursement rate prospectively over the intervening year(s) between audits. The amount a cost category is adjusted will be determined by an error factor that reflects a ratio of the difference between the reported cost and the audited expenditures for each cost category, consistent with the methodology specified in this Supplement.

D. In the event that the FS/NF-B's labor costs are incorrectly reported on facility cost reports or supplemental schedules, the Department will prospectively adjust the facility's reimbursement rate, in the same manner as described in Section IV.C.2. of this Supplement. Those adjustments received after computation of the annual labor study will be excluded from that study.

E. Compliance by each FS/NF-B with state laws and regulations regarding staffing levels will be documented annually, either through supplemental reports or through the annual licensing inspection process specified in Health and Safety Code section 1422.

F. Overpayments to any FS/NF-B will be recovered in a manner consistent with applicable recovery procedures and requirements of state and federal laws and regulations. Overpayment recovery regulations are described in the California Code of Regulations, title 22, section 51047. Overpayments referred to in this Section do not include those situations described above in Paragraphs IV.C.2. or IV.D.

G. Providers have the right to appeal audit or examination findings that result in an adjustment to Medi-Cal reimbursement rates. Specific appeal procedures are contained in Welfare and Institutions Code, section 14171, and in Division 3, Subdivision 1, Chapter 3, Article 1.5 (Provider Audit Appeals) of the California Code of Regulations, title 22, sections 51016 through 51048.

H. For FS/NF-Bs that obtain an audit appeal decision that results in revision of the facility's allowable costs used to calculate a facility's reimbursement rate, the Department will make a retroactive adjustment in the facility-specific reimbursement rate.

V. Methods and Standards for Establishing FS/NF-B Reimbursement Rates

A. Effective August 1, 2005, a FS/NF-B's actual reimbursement rate (per diem payment) is the amount the Department will reimburse to a FS/NF-B for services rendered to an eligible resident for one resident day. The per diem payment is calculated prospectively on a facility-specific basis using facility-specific data from the FS/NF-B's most recent cost report period (audited or adjusted), supplemental schedules, and other data determined necessary by the Department.

B. The prospective per diem payment for each FS/NF-B is computed on a per resident day basis. The per diem payment is comprised of five major cost categories:

1. labor costs
2. indirect care non-labor costs
3. administrative costs
4. capital costs
5. direct pass-through costs.

Payment for FS/NF-Bs will be based on facility-specific cost-based reimbursement rates consisting of the five major cost categories, and determined as described in the following Section V.C. of this Supplement.

C. Cost Categories. The facility-specific cost-based per diem payment for FS/NF-Bs is based on the sum of the projected costs of the five major cost categories, each subject to ceilings described in this Section. Costs within a specific cost category may not be shifted to any other cost category. In addition, per diem payments will be subject to overall limitations described in Section VI of this Supplement.

1. The labor cost category is comprised of a direct resident care labor cost component, an indirect care labor cost component, and a labor-driven operating allocation cost component. These components are comprised of more specific elements described below:

a. Direct resident care labor costs include salaries, wages, and benefits related to routine nursing services personnel, defined as nursing, social services, and activities personnel. Direct resident care labor costs include labor expenditures associated with a FS/NF-B's permanent direct care employees, as well as expenditures associated with temporary agency staffing. These costs are limited to the 90th percentile of each FS/NF-B's respective peer-group, as described in Section VII of this Supplement.

i. For the rate year beginning August 1, 2005, and for subsequent rate years, the direct resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal direct

resident care labor cost per diems. FS/NF-B's will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

ii. An inflation index, based on the Department's labor study, developed from the most recently available industry-specific historical wage data as reported to OSHPD by providers will be applied to the FS/NF-B's allowable direct resident care labor per diem costs. Each facility's direct resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

b. Indirect care labor costs include all labor costs related to staff supporting the delivery of resident care including housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance costs. These costs are limited to the 90th percentile of each facility's respective peer-group, as described in Section VII of this Supplement.

i. In-service education activities are defined as education conducted within the FS/NF-B for facility nursing personnel. Salaries, wages and payroll-related benefits of time spent in such classes by those instructing and administering the programs will be included as in-service education labor costs. If instructors do not work full-time in the in-service education program, only the cost of the portion of time they spend working in the in-service education program is allowable. In-service education does not include the cost of time spent by nursing personnel as students in such classes or costs of orientation for new employees. The costs of nursing in-service education supplies and outside lecturers will be reflected in the in-service education non-labor costs of the indirect care non-labor cost category.

ii. For the rate year beginning August 1, 2005, and for subsequent rate years, the indirect resident care labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the facility's most recently available cost report, as adjusted for audit findings. Each facility's per diem payment will be limited to a ceiling amount, identified as the 90th percentile of each facility's peer-grouped allowable Medi-Cal indirect

resident care labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

iii. An inflation index, based on the Department's labor study, developed from the most recently available industry-specific historical wage data as reported to OSHPD by providers will be applied to the FS/NF-B's allowable indirect resident care labor per diem costs. Each facility's indirect resident care labor costs will be inflated from the mid-point of the cost reporting period or supplemental schedule reporting period to the mid-point of the rate year.

c. Labor-driven operating allocation includes an amount equal to eight percent of direct and indirect resident care labor costs, less expenditures for agency staffing, such as nurse registry and temporary staffing agency costs. The labor-driven operating allocation may be used to cover allowable Medi-Cal expenditures incurred by a FS/NF-B to care for Medi-Cal residents. In no instance will the operating allocation exceed five percent of the facility's total Medi-Cal reimbursement rate.

2. Indirect care non-labor costs include the non-labor costs related to services supporting the delivery of resident care, including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education and plant operations and maintenance costs. These costs are limited to the 75th percentile of each facility's respective peer-group, as described in Section VII of this Supplement.

a. For the rate year beginning August 1, 2005, and for subsequent rate years, the indirect care non-labor per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report, as adjusted for audit findings. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 75th percentile of each FS/NF-B's peer-grouped allowable Medi-Cal indirect care non-labor cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-B's allowable indirect care non-labor per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

3. Administrative costs include allowable administrative and general expenses of operating the facility, including a FS/NF-B's allocated expenditures related to allowable home office costs. The administrative cost category will include allowable property insurance costs, and exclude expenditures associated with caregiver training, liability insurance, facility license fees, and medical records.

   a. For the rate year beginning August 1, 2005, and for subsequent rate years, the administrative per diem payment will be calculated from the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report or supplemental schedule, as adjusted for audit findings. For purposes of establishing reimbursement ceilings, each FS/NF-B will be peer-grouped as described in Section VII of this Supplement. Each FS/NF-B's per diem payment will be limited to a ceiling amount, identified as the 50th percentile of the allowable Medi-Cal administrative cost per diem. FS/NF-Bs will be reimbursed the lower of their actual cost per diem or the ceiling per diem amount.

   b. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to the FS/NF-B's allowable administrative per diem costs to inflate costs from the mid-point of the cost reporting period to the mid-point of the rate year.

4. Capital costs. For the rate year beginning August 1, 2005, and for subsequent rate years, a Fair Rental Value System (FRVS) will be used to reimburse FS/NF-B's property (capital) costs. Under the FRVS, the Department reimburses a facility based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent or lease payments. The FRVS establishes a facility's value based on the age of the facility. For rate years subsequent to 2005/06, additions and renovations (subject to a minimum per-bed limit) will be recognized by lowering the age of the facility. The facility's value will not be affected by sale or change of ownership. Capital costs, limited as specified below in Section V.C.4.e. of this Supplement, are derived from the FRVS parameters as follows:

   a. The initial age of each facility is determined as of the mid-point of the 2005/06 rate year, using each facility's original license date, year of construction, initial loan documentation, or similar documentation. For the 2005/06 rate year, all FS/NF-Bs with an original license date of February 1, 1976, or prior, will have five

years subtracted from their facility age to compensate for any improvements, renovations or modifications that have occurred in the past. The age of each facility will be adjusted every rate year to make the facility one year older, up to a maximum age of 34 years.

b. For the 2006/07 and 2007/08 rate years, costs incurred for major capital improvements, modifications or renovations equal to or greater than $500 per bed on a total licensed-bed basis will be converted into an equivalent number of new beds, effectively lowering the age of the facility on a proportional basis. If a facility adds or replaces beds, these new beds will be averaged in with the age of the original beds, and the weighted average age of all beds will represent the facility's age. If a facility performs a major renovation or replacement project (defined as a project with capitalized cost equal to or greater than $500 per bed, on a total bed basis), the cost of the renovation project will be converted to an equivalent number of new beds. The equivalent number of new beds would then be used to determine the weighted average age of all beds for the facility.

c. The FRVS per diem calculation, subject to the limitations identified in Section V.C.4.e. of this Supplement, is calculated as follows:

i. An estimated building value will be determined based on a standard facility size of 400 square feet per bed, each facility's licensed beds, and the R.S. Means Building Construction Cost Data, adjusted by the location index for each locale in the State of California. The estimated building value will be trended forward annually to the mid-point of the rate year using the percentage change in the R.S. Means Construction Cost index.

ii. An estimate of equipment value will be added to the estimated building value in the amount of $4,000 per bed.

iii. The greater of the estimated building and equipment value or the fully depreciated building and equipment value will be determined for each facility (hereinafter, the "current facility value"). The fully depreciated building and equipment value is based on a 1.8 percent annual depreciation rate for a full 34 years.

iv. An estimate of land value will be added to the current facility value based on ten percent of the estimated building value as calculated in Section V.4.C.c.i. of this Supplement.

v. A facility's fair rental value is calculated by multiplying the facility's current value plus the estimated land value, times a rental factor. The rental factor will be based on the average 20-year U.S. Treasury Bond yield for the calendar year preceding the rate year plus a two percent risk premium, subject to a floor of seven percent and a ceiling of ten percent.

vi. The facility's fair rental value is divided by the greater of actual resident days for the cost reporting period, or occupancy-adjusted resident days, based on the statewide average occupancy rate. Days from partial year cost reports will be annualized in the FRVS per diem payment calculation.

d. Continued explanation and examples of the FRVS per diem calculations follow:

Example of FRVS Per Diem Calculation

Example Assumptions

Building License Date = 2/1/1976
Actual Age on 2/1/2006 (mid-point of 2005/06 rate year) = 30 years
Effective Age for FRVS = 25 years (subtract 5 years for improvements)
Rental Factor = 7 percent
Construction Cost = $123 per square foot
Occupancy = 90% = 30,715 resident days
Licensed Beds = 99
Facility Location = San Diego = 1.061 location index

Base Value Computation

Estimated Building Value (99 beds x 400 square feet x $123 x 1.061)	$ 5,167,919
Add: Equipment Value at $4,000 per bed	$ 396,000
Gross Value	$ 5,563,919
Depreciation (1.8% x 25 years)	$ 2,503,764
Net Value (undepreciated current facility value)	$ 3,060,155
Add: Land Value at 10% of Undepreciated Building Value	$ 516,792
Total Base Value	**$ 3,576,947**

FRVS Per Diem Calculation

Fair Rental Value (rental factor x total base value)	$ 250,386
FRVS per diem (Fair Rental Value + occupancy adjusted resident days)	**$ 8.15**

Example of FRVS Per Diem Calculation With Improvement Modification

Example Assumptions

Original Building Assumptions Remain Static	
Cost of Remodel	$ 500,000
Remodel Cost Per Bed ($500,000 ÷ 99 beds)	$ 5,051
Base Value Per New Bed Prior to Improvement Modification (gross value ÷ 99 beds)	$ 56,201

Modified Facility Age Calculation

Equivalent Number New Beds (cost of remodel ÷ base value/bed before improvement)	8.9

Weighted Average Age

Prior to Improvement – 99 Beds x 25 years	2,475
Resulting from Improvement – 8.9 Beds x 0 years	0
Total = 107.9 Beds	2,475
Weighted Average Age = 2,475/107.9	**22.9 Years**

Modified Base Value Computation

Gross Value (Building and Equipment)	$ 5,563,919
Adjusted Depreciation = 1.8% x 22.9 years x gross value	$ 2,293,447
Modified Net Value	$ 3,270,472
Add: Land Value	$ 516,792
Modified Total Base Value	**$ 3,787,264**

Modified FRVS Per Diem Calculation

FRVS Per Diem (rental factor x modified base value)/(total resident days)	**$ 8.63**

e. The capital costs based on FRVS will be limited as follows:

i. For the 2005/06 rate year, the capital cost category for all FS/NF-Bs in the aggregate will not exceed the Department's estimate of FS/NF-B's capital reimbursement for the 2004/05 rate year, based on the methodology in effect as of July 31, 2005.

ii. For the 2006/07 and 2007/08 rate years, the maximum annual increase for the capital cost category for all FS/NF-Bs in the aggregate will not exceed eight percent of the prior rate year's FRVS aggregate payment.

iii. If the total capital cost category for all FS/NF-Bs in the aggregate for the 2005/06 rate year exceeds the value of the capital cost category for all FS/NF-Bs in the aggregate for the 2004/05 rate year, the Department will reduce the capital cost category for each and every FS/NF-B in equal proportion.

iv. If the capital cost category for all FS/NF-Bs in the aggregate for the 2006/07 or 2007/08 rate year exceeds eight percent of the prior rate year's cost category, the Department will reduce the capital FRVS cost category for each and every FS/NF-B in equal proportion.

5. Direct pass-through costs are comprised of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, liability insurance costs, the Medi-Cal portion of the skilled nursing facility quality assurance fee, and new state and federal mandates for the applicable rate year.

a. For the rate year beginning August 1, 2005, and for subsequent rate years, the Medi-Cal proportional share of the pass-through per diem costs will be calculated as the FS/NF-B's actual allowable Medi-Cal cost as reported on the FS/NF-B's most recently available cost report and/or supplemental schedule(s), as adjusted for audit findings.

b. Caregiver training costs are defined as a formal program of education that is organized to train students to enter a caregiver occupational specialty. Until the Medi-Cal cost report is revised to specifically identify these costs, FS/NF-Bs will be required to complete an annual supplemental report detailing these

expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

c. The Medicare reimbursement principles consistent with Title 42, Code of Federal Regulations, Part 413 will be used to determine reasonable allowable pass-through costs for professional liability insurance. FS/NF-Bs will be required to complete an annual supplemental report detailing these expenditures. These supplemental reports may be audited or reviewed prior to use in rate-setting.

d. The California Consumer Price Index for All-Urban Consumers, as determined by the State Department of Finance, will be applied to update caregiver training costs and liability insurance pass-through costs from the mid-point of the cost report period or supplemental report period to the mid-point of the rate year.

e. Property tax pass-through costs will be updated at a rate of two percent annually from the mid-point of the cost report period to the mid-point of the rate year.

f. Facility-license fee pass-through costs and the Medi-Cal portion of the skilled nursing facility quality assurance fee will be applied on a prospective basis for each rate year, and will not require an inflation adjustment.

D. For the 2005/06 and 2006/07 rate years, the facility-specific Medi-Cal reimbursement rate calculated under the methodology set forth in Section V of this Supplement will not be less than the Medi-Cal reimbursement rate that the FS/NF-B would have received under the rate methodology in effect as of July 31, 2005, plus Medi-Cal's projected proportional costs for new state or federal mandates for rate years 2005/06 and 2006/07, respectively.

E. Pursuant to AB 1629, the details, definitions and formulas may be set forth in regulations and provider bulletins or similar instructions.

F. The Department will establish reimbursement rates pursuant to AB 1629 on the basis of facility cost data reported in the Integrated Long-Term Care Disclosure and Medi-Cal Cost Report required by Health and Safety Code section 128730 for the most recent reporting period available and cost data reported in other facility financial disclosure reports, supplemental reports, or surveys required by the Department.

G. The percentiles in labor costs, indirect care non-labor costs, and administrative costs will be based on annualized costs divided by total resident days and computed on a geographic peer-group basis.

VI. Limitations on the Medi-Cal Facility-Specific Reimbursement Rate Calculation

In addition to limitations described in Section V.C.4.e. of this Supplement (FRVS reimbursement limitations), the aggregate facility-specific Medi-Cal payments calculated in accordance with the methodology set forth in Section V of this Supplement will be limited by the following:

A. For the 2005/06 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed eight percent of the weighted average reimbursement rate for the 2004/05 rate year, as adjusted for the change in the cost to the FS/NF-B to comply with the skilled nursing facility quality assurance fee for the 2005/06 rate year, plus the total projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

B. For the 2006/07 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed five percent of the weighted average Medi-Cal rate for the 2005/06 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

C. For the 2007/08 rate year, the maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medi-Cal rate for the 2006/07 rate year, as adjusted for the projected FS/NF-B Medi-Cal cost of complying with new state or federal mandates.

D. To the extent that the prospective facility-specific reimbursement rates are projected to exceed the adjusted limits calculated pursuant to VI.A,. VI.B. and VI.C. of this Supplement, the Department will adjust the increase to each FS/NF-B's projected reimbursement rate for the applicable rate year by an equal percentage.

VII. Peer-Grouping

The percentile caps for FS/NF-B facility labor, indirect care non-labor, and administrative costs will be computed on a geographic peer-grouped basis. The median per diem direct resident care labor cost for each individual county will be subjected to a statistical clustering algorithm, based on commercially available statistical software. The statistical analysis of county costs will result in a defined and finite number of peer groups. A list of counties and their respective peer groups, along with a more detailed

explanation of the peer-grouping methodology is available on-line at: http://www.dhs.ca.gov/mcs/mcpd/RDB/LTCSDU/default.htm, or by contacting the Department at:

California Department of Health Services
Medi-Cal Policy Division/Long-Care System Development Unit
MS 4612
P.O. Box 997417
Sacramento, CA 95899-7417

Phone: (916) 552-9600

VIII. Determination of FS/NF-B Rates for State-Owned Facilities, Newly Certified Providers or Changes of Ownership

A. State-owned and operated skilled nursing facilities will receive a prospective payment rate based on the peer-group weighted average Medi-Cal reimbursement rate.

B. New FS/NF-Bs with no cost history in a newly constructed facility or an existing facility newly certified to participate in the Medi-Cal program will receive an interim reimbursement rate based on the peer-grouped weighted average Medi-Cal reimbursement rate. Once the FS/NF-B has submitted six months of cost and/or supplemental data, its facility-specific rate will be calculated according to the methodology set forth in this Supplement. The difference between the FS/NF-B's interim per diem payment rate and the facility-specific per diem payment rate calculated based on Section V of this Supplement will be determined upon audit or review of the cost report and/or supplemental report. The Department will adjust the difference in reimbursement rate on a prospective basis, consistent with the methodology described in Section IV.C.2 of this Supplement.

C. Changes of ownership or changes of the licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. In instances where the previous provider participated in the Medi-Cal program, the Department will reimburse the new owner or operator the per diem payment rate of the previous provider until the new owner or operator has submitted six or more months of cost and/or supplemental data. If, upon audit or review, the per diem payment rate calculated for the new owner or operator is less than the per diem payment rate of the previous owner or operator, the Department will prospectively adjust the new owner's or operator's per diem payment rate as calculated in this Supplement.

§ 14170.5. Special claims review period

(a) No provider's claims for reimbursement under this chapter shall be subject to any special claims review procedure for a period in excess of nine months unless the department shows cause why the provider's claims for reimbursement should continue to be subject to special claims review procedures.

(b) The department shall provide notice to a provider of its reasons for determining that the provider shall be subject to extended special claims review.

(Added by Stats.1987, c. 608, § 1.)

§ 14171. Findings of audit or examination; administrative appeal processes for tentative or final settlements; informal conferences; time limitations; final decision; interest

(a) The director shall establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination made pursuant to Sections 10722 and 14170.

(b) Different administrative appeal processes may be established by the director for grievances or complaints arising from the determinations of a tentative or final settlement based on audit or examination findings made by or on behalf of the department pursuant to Sections 10722 and 14170, except that consistent with existing practice, no administrative appeal shall be available for tentative settlement of cost reports.

(c) The administrative appeal process established by the director for final settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations shall include the procedural requirements of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The impartial hearing shall be conducted by an administrative law judge appointed by the director. The director may subcontract with the Office of Administrative Hearings to conduct hearings on cases involving complicated issues of fact or law, or to reduce the backlog of cases.

(d) The administrative appeal process established by the director for tentative settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations shall be an informal process which, however, guarantees a provider the right to present any grievance or complaint to the department in writing. Any subsequent hearings shall be conducted in an informal manner and shall be held at the discretion of the department.

(e) The time limitations in subdivisions (f) and (g) for the impartial hearing and the final decisions are mandatory. If the department fails to conduct the hearing or to adopt a final decision thereon within the time limitations provided in subdivisions (f) and (g), the amount of any overpayment which is

ultimately determined by the department to be due shall be reduced by 10 percent for each 30-day period, or portion thereof, that the hearing or the decision, or both, are delayed beyond the time limitations provided in subdivisions (f) and (g). However, the time period shall be extended by either of the following:

(1) Delay caused by a provider.

(2) Extensions of time granted a provider at its sole request or at the joint request of the provider and the department.

(f)(1) Notwithstanding subdivision (c), the administrative appeal process established by the director shall commence with an informal conference with the provider, a representative of the department, and the administrative law judge. The informal conference shall be conducted no later than 90 days after the filing of a timely and specific statement of disputed issues by the provider. The administrative law judge, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. The review conducted at this informal level shall be completed no later than 180 days after the filing of a timely and specific statement of disputed issues by the provider.

(2) Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (c). The impartial hearing shall be conducted no later than 300 days after the filing of a timely and specific statement of disputed issues by the provider. For noninstitutional providers, a proposed decision shall be prepared and transmitted to the director and the parties within 60 days after the closure of the record of the impartial hearing. For institutional providers, a proposed decision shall be prepared and transmitted to the director and the parties within 180 days after the closure of the record of the impartial hearing.

(3) Subject to subdivision (g), a final decision in a noninstitutional provider appeal shall be adopted within 180 days after the closure of the record of the impartial hearing, and a final decision in an institutional provider appeal shall be adopted within 300 days after the closure of the record of the impartial hearing.

(g) In the event the director intends to modify a proposed decision, on or before the 180th day following the closure of the record of the hearing for noninstitutional providers or the 300th day following the closure of the record of the hearing for institutional providers, the director shall provide written notice of his or her intention to the parties and shall afford the parties an opportunity to present oral and written argument. Following this notice, on or before the 240th day following the closure of the record of the hearing for noninstitutional providers or the 420th day following closure of the record of the hearing for institutional providers, or within that additional time period as is granted pursuant to the sole request of a provider or at the joint request of the provider and the department, the director shall issue a modified decision.

(h) In the event recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of a disallowed payment shall be entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, commencing on the date the appeal is formally accepted by the department or the date payment is received by the department, whichever is later.

(i) Commencing 60 days after issuance of the first statement of account status or demand for repayment resulting from an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund during the month the first statement of account status or demand for repayment was issued shall be assessed against any unrecovered overpayment due to the department.

(j) The final decision of the director shall be reviewable in accordance with Section 1094.5 of the Code of Civil Procedure within six months of the issuance of the director's final decision.

(Added by Stats.1977, c. 1046, p. 3172, § 6. Amended by Stats.1978, c. 429, § 248.2, eff. July 17, 1978, operative July 1, 1978; Stats.1979, c. 373, § 388; Stats.1981, c. 102, p. 747, § 130, eff. June 28, 1981; Stats.1981, c. 1163, p. 4661, § 18, eff. Oct. 2, 1981; Stats.1982, c. 842, p. 3174, § 2; Stats.1983, c. 900, § 1; Stats.1985, c. 1333, § 4; Stats.1986, c. 562, § 2; Stats.1987, c. 56, § 188; Stats.1988, c. 1079, § 1.)

Historical and Statutory Notes

The 1978 amendment deleted former subd. (b) which had read:

"(b) The director shall contract with the Department of Benefit Payments to conduct hearings or other proceedings and to prepare proposed decisions for adoption by the director pursuant to such regulations."; it relettered the remaining subdivisions; in subd. (b) [now subd. (c)], in the first sentence, it substituted "department" for "Department of Benefit Payments" and in the second and third sentences substituted "director" for "Director of Benefit Payments"; and in subd. (c), formerly (d) [now subd. (f)], references to former subd. (c) were corrected to refer to subd. (b).

The 1979 amendment, in subd. (a), substituted "10722" for "14102"; and in subd. (b) [now subd. (c)] first sentence, it substituted "10722 and 14170" for "14102 and 14105."

The 1981 amendment by c. 102, § 130, added subd. (d) [now subd. (h)], relating to interest rates applicable to the recovery of a disallowed payment, and subd. (e) [now subd. (i)], relating to the interest rate to be assessed against unrecovered overpayments; and, redesignated the subdivisions accordingly.

Application of provisions of Stats.1981, c. 102 which are in conflict with federal statutes or regulations, see Historical and Statutory Notes under § 10020.

The 1981 amendment by c. 1163, § 18, in subd. (d), [now subd. (h)], inserted "whichever is later" to the end of the provisions relating to interest rates on recovery of disallowed payments and rewrote subd. (e) [now subd. (i)], which previously read:

"Commencing 60 days after issuance of the first statement of accountability or demand for repayment resulting from an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate equal to the rate received on investments in the Pooled Money Investment Fund shall be assessed against any unrecovered overpayment due to the department."

The 1982 amendment substituted "monthly average" for "rate" preceding "received on investments" in subd. (d) [now subd. (h)].

The 1983 amendment in subd. (c) [now subd. (f)] in the first sentence inserted "for institutional providers" following "by the director"; inserted subd. (d); and redesignated former subds. (d), (e), and (f) as subds. (e), (f), and (g) respectively.

The 1985 amendment rewrote subd. (a); inserted subd. (b); relettered former subd. (b) as subd. (c); rewrote the first sentence of subd. (c) which had read:

"The administrative appeal process established by the director shall guarantee a provider the right to present any grievances or com-

plaints arising from the findings of an audit or examination made by or on behalf of the department pursuant to Sections 10722 and 14170 at an impartial hearing which shall include the procedural requirements of Chapter 5 (commencing with Section 11500), Part 1, Division 3, Title 2 of the Government Code."; inserted a new subd. (d); and relettered former subds. (c) through (g) to be subds. (e) through (i).

The 1986 amendment substituted "administrative law judge" for "hearing officer" throughout the section; inserted subd. (e) relating to mandatory time limitations; relettered the remaining subdivisions; increased the numbers of days within which appeals occur in subd. (g); and made nonsubstantive changes.

The 1987 amendment substituted, in subds. (h) and (i), "Surplus Money Investment Fund" for "Pooled Money Investment Fund"; and made non-substantive changes to maintain the codes.

The 1988 amendment, in subds. (c) and (d) substituted "Code of Regulations" for "Administrative Code"; and rewrote subds. (e) to (g) which had read:

"(e) The time limitations in subdivision (g) for the impartial hearing and the final decisions are mandatory. If the department fails to conduct the hearing within 360 days or to adopt a final decision thereon within 180 days of the hearing, the amount of any overpayment which is ultimately determined by the department to be due shall be reduced by 10 percent for each 30-day period that either the hearing or the decision, or both, are delayed beyond 360 days or the additional 180 days provided in subdivision (g). However, the time period shall be extended by either of the following:

"(1) Delay caused by a noninstitutional provider.

"(2) Extensions of time granted a noninstitutional provider at its sole request or at the joint request of the provider and the department.

"(f) Notwithstanding subdivision (c), the administrative appeal process established by the director for institutional providers at final settlements shall commence with an informal conference with the provider, a representative of the department and the hearing officer. The hearing officer, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (c).

"(g) Notwithstanding subdivision (c), the administrative appeal process established by the director for noninstitutional providers shall commence with an informal conference with the provider, a representative of the department, and the hearing officer. The informal conference shall be conducted no later than 90 days after the filing of a timely and specific statement of disputed issues by the noninstitutional provider. The administrative law judge, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. The review conducted at this informal level shall be completed no later than 180 days after the filing of a timely and specific statement of disputed issues by the noninstitutional provider. Nothing in this subdivision shall prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (c). For noninstitutional providers, the impartial hearing shall be conducted no later than 360 days after the issuance of the first statement of account status or demand for payment to the noninstitutional provider. A proposed decision shall be prepared within 60 days after the impartial hearing is concluded, and a final decision shall be adopted within 180 days of the hearing."

Cross References

Office of administrative hearings, see Government Code § 11370 et seq.
Review of administrative orders or decisions, see Code of Civil Procedure § 1094.5.

Code of Regulations References

Provider audit appeals, see 22 Cal. Code of Regs. 51016 et seq.

Library References

Social Security and Public Welfare ⇐241.105.
WESTLAW Topic No. 356A.

C.J.S. Social Security and Public Welfare § 135.

(d) After following this procedure, a provider who is not satisfied with the decision by the designated county department may seek appropriate judicial remedies in compliance with Section 14104.5 of the Welfare and Institutions Code, no later than one year after receiving notice of the decision.

NOTE: Authority cited: Section 14132.95, Welfare and Institutions Code; Section 8, Chapter 939, Statutes of 1992; Section 3, Chapter 7, Statutes of 1993. Reference: Section 14132.95, Welfare and Institutions Code; Section 1396d(a)(7) of Title 42 of the United States Code; Article 7 (commencing with Section 12300) of Part 3 of Division 9 of the Welfare and Institutions Code; Section 440.170(f) of Title 42 of the Code of Federal Regulations.

HISTORY

1. New section filed 4-14-93 as an emergency; operative 4-14-93. Submitted to OAL for printing only pursuant to section 8, AB 1773 (Chapter 939, Statutes of 1992) (Register 93, No. 16).

Article 1.5. Provider Audit Appeals

§ 51016. Definitions.

(a) The following definitions shall be used throughout this article unless otherwise noted.

(1) Audits or Examination Report. "Audit or examination report" means a document that presents the final audit or examination findings and is formally issued to the provider by the Department upon the completion of the audit or examination.

(2) Completed Audit or Examination. "Completed audit or examination" means an audit or examination for which an audit or examination report has been issued.

(3) "Date of mailing" means the date postmarked on the envelope if postage was prepaid and the envelope was properly addressed.

(4) Demand for Repayment. "Demand for repayment" means a written notice issued to the provider by the Department that identifies the amount of the overpayment, determined by an audit or examination, that must be repaid. The notice may be made through the issuance of a statement of accountability, statement of account status, letter, or any combination of the foregoing.

(5) Duplicate. "Duplicate" means a counterpart or facsimile copy of the original produced by the same impression or from the same matrix as the original or by some technique of accurate reproduction.

(6) "Exit conference" means an informal meeting, between the provider and those Department representatives responsible for the audit or examination, at which the preliminary findings of the audit or examination are discussed.

(7) Formal Hearing. "Formal hearing" means an administrative hearing conducted by a hearing officer pursuant to Section 14171(b), Welfare and Institutions Code, and the provisions of this article.

(8) Hearing Auditor. "Hearing auditor" means an individual designated to conduct the informal level of review.

(9) Hearing Officer. "Hearing officer" means a hearing officer appointed by the Director pursuant to Section 14171(b), Welfare and Institutions Code.

(10) Informal Conference. "Informal conference" means a proceeding conducted in person or by telephone, for the purpose of scheduling the informal level of review and formal hearing; exchanging documents; and resolving other preliminary matters.

(11) Informal Level of Review. "Informal level of review" means an informal hearing for institutional providers and a pretrial conference for non-institutional providers, held by a hearing officer or hearing auditor prior to a formal hearing to clarify or resolve facts and issues in dispute.

(12) Party. "Party" means the provider, the Department, and any person, other than a hearing officer, allowed to appear in the proceedings.

(13) Institutional Provider. "Institutional provider" means any of the following:

(A) Any individual, entity or organization of a type required to be licensed pursuant to either Chapter 1 (commencing with Section 1200) or Chapter 2 (commencing with Section 1250) of Division 2, Health and Safety Code, or exempt from licensure pursuant to Section 1206(b) through (l) Health and Safety Code, or Section 1254 Health and Safety Code which provides services or supplies under the Medi-Cal program, and is subject to audit by the Department.

(B) Any individual, entity, or organization of a type required to file a cost report or cost information with the Department.

(14) Non-institutional Provider. "Non-institutional provider" means any individual, entity, or organization other than those defined in subsection (13) who provides services or supplies under the Medi-Cal program, and who is subject to audit by the Department.

(15) File. "File" means delivery of a pleading or other paper to, and its date stamping by, the Office of Administrative Hearings and Appeals, Office of Legal Services, Department of Health Services.

(16) Serve. "Serve" means the delivery of a pleading or other paper on a party in the manner provided by Government Code Section 11505(c).

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Sections 14171 and 14172.5, Welfare and Institutions Code.

HISTORY

1. Repealer of Section 51016 and new Article 1.5 (Sections 51016–51043) filed 3-2-76; designated effective 4-1-76 (Register 76, No. 10). For prior history, see Register 72, No. 11, and Register 75, No. 23.
2. Repealer of Article 1.5 (Sections 51016–51043) and new Article 1.5 (Sections 51016–51047) filed 5-8-80; effective thirtieth day thereafter (Register 80, No. 19).
3. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).
4. Amendment filed 9-17-85; effective thirtieth day thereafter (Register 85, No. 38).

§ 51017. Provider Audit Hearing.

A provider may request a hearing under the provisions of this article to examine any disputed audit or examination finding which results in an adjustment to Medi-Cal program reimbursement or reimbursement rates by submitting a Statement of Disputed Issues to the Department in accordance with Section 51022.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Amendment filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51018. Home Office—Chain Organization Related Entities.

The home office of a chain organization has no separate right to an individual hearing under this article. Where a provider in a chain organization disputes an audit or examination finding concerning the allocation of home office costs, other related entity costs or any other matter affecting all or some of the providers in the chain organization, all providers in the chain organization that are affected by the issue in dispute shall be made parties to the proceedings for the purpose of resolution of that issue only, in accordance with Section 51030.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51019. Amended Cost Reports.

(a) An amended cost report may be submitted by a provider and accepted by the Department for the fiscal period or periods for which proceedings are pending under this article.

(b) The hearing officer may suspend the proceedings until identification of any additional disputes that may result from an amended report filed by a provider.

(c) Additional issues which are raised by accepted cost report amendments may be included in the proceedings at the request of the provider in accordance with Section 51022.

(d) The hearing officer may dismiss the proceeding without prejudice to the right to request a subsequent hearing under this article when the hearing officer deems this course to be appropriate.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

TN 95-017
Supersedes
TN 72-12

Approval Date 10/1/98

Effective Date August 1, 1995

§ 51020. Amended Audit Report.

(a) An amended audit report may be issued by or on behalf of the Department for the fiscal period or periods for which proceedings are pending under this article.

(b) The hearing officer may suspend the proceedings until identification of any additional disputes that may result from an amended audit report.

(c) Additional issues in dispute which are raised by the amended audit report may be included in the proceedings at the request of the provider in accordance with Section 51022.

[The next page is 397.]

(d) The hearing officer may dismiss the proceeding without prejudice to the right to request a subsequent hearing under this article when the hearing officer deems this course to be appropriate.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51021. Exit Conference and Audit Report.

(a) The provider shall be afforded a reasonable opportunity to participate in an exit conference after the conclusion of any field audit or examination of records or reports of a provider, by or on behalf of the Department, and prior to the issuance of the Audit Report. The purpose of the exit conference is to:

(1) Inform the provider of the audit or examination findings and the supporting reasons and evidence.

(2) Inform the provider of the specific instances in which no records were found to substantiate claims billed to the program which was the subject of the audit or examination.

(3) Allow the provider an opportunity to present relevant information concerning the audit or examination findings.

(b) The provider must make available to the Department any records which were identified as unavailable for review or missing within 15 calendar days of the exit conference to be included in the Audit Report.

(c) Where the audit or examination involves the records or reports of a provider of pharmaceutical services:

(1) The auditor or reviewer shall identify missing prescriptions by beneficiary name, beneficiary number, prescription number and date of service to the provider at the exit conference.

(2) The audit worksheets relating to exceptions taken shall be furnished to the provider subsequent to the submission of missing prescriptions pursuant to subsection (b), in the event that a request for repayment of an overpayment is made.

(d) An audit or examination findings issued by or on behalf of the Department shall include the following:

(1) A complete copy of the audit report which identifies all items to which exception has been taken, the monetary value of each and the reason for the exception, including citation to the appropriate statutory or regulatory authority.

(2) Notice of the provider's right to a hearing pursuant to the provisions of this article. A copy of the provisions of this article shall accompany such notice.

NOTE: Authority cited: Sections 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 14170 and 14171, Welfare and Institutions Code.

History

1. Editorial correction of NOTE filed 12-14-84 (Register 84, No. 50).

§ 51022. Request for Hearing.

(a) An Institutional provider may request a hearing for any disputed audit or examination finding as follows:

(1) A written request shall be filed with the Department within 60 calendar days of the receipt of the written notice of the audit or examination findings.

(2) This request may be amended at any time during the 60 calendar day period.

(b) A Non-institutional provider may request a hearing on any disputed audit or examination finding as follows:

(1) A written request shall be filed with the Department within 30 calendar days of the receipt of the audit or examination finding.

(2) This request may be amended at any time during the 30 calendar day period.

(c) All late requests by either Institutional or Non-institutional providers shall be denied and the audit or examination findings deemed final unless the provider establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.

(d) The request shall be known as "Statement of Disputed Issues." It shall be in writing, signed by the provider or the authorized agent, and shall state the address of the provider and of the agent, if any agent has been designated. A provider or the agent shall specify the name and address of the individual authorized on behalf of the provider to receive any and all documents, including the final decision of the Director, relating to proceedings conducted pursuant to this article. The Statement of Disputed Issues need not be formal, but it shall be specific as to each issue as are in dispute, setting forth the provider's contentions as to those issues and the estimated amount each issue involves. The information specified in subsection (e) shall also be included. If the hearing officer determines that a Statement of Disputed Issues fails to state the specific grounds upon which objection to the specific item is based, the provider or the agent shall be notified that it does not comply with the requirement of this regulation, and the reasons therefor.

(1) An Institutional provider shall be granted 30 calendar days after the date of the mailing of the notice of deficiency to the provider within which to file an amended Statement of Disputed Issues.

(2) A Non-institutional provider shall be granted 15 calendar days after the date of mailing of the notice of deficiency within which to file an amended Statement of Disputed Issues.

(3) If within the time permitted in (1) or (2) above, the Institutional or Non-institutional provider, respectively, or the agent fails to amend its appeal as notified, the appeal as to those issues shall be rejected.

(e) The request shall also specify whether the provider does or does not wish that an informal level of review among the parties be held, together with the reasons therefor. Either party may request, or the hearing officer may order, that a telephone conference call be initiated among the parties for discussion of the advisability of conducting an informal level of review. The hearing officer shall decide whether an informal level of review would be appropriate and notify the parties of this decision in writing.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).
2. Editorial correction of Authority cite (Register 95, No. 45).

§ 51023. Informal Level of Review.

(a) If the hearing officer determines that an informal level of review is appropriate, it shall be ordered and scheduled as soon as reasonably possible. The hearing officer, or a hearing auditor designated by the hearing officer, shall preside at this informal level of review.

(b) Written notice of the time and place of informal level of review shall be mailed to each party at least 30 calendar days before the date of the informal level of review. This period may be shortened with the consent of the parties. Any party may waive notice. This notice may be combined with the notice of formal hearing.

(c) Efforts shall be made to resolve the facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. Matters in dispute, raised in the provider's Statement of Disputed Issues pursuant to Section 51022, which are not discussed or raised at the informal level of review shall not be deemed waived.

(d) The proceedings at the informal level of review shall be electronically recorded unless the parties agree otherwise.

(e) The results of the informal level of review shall be:

(1) Served on the parties, within a reasonable time, in the form of a written Report of Findings or Pretrial Order.

(2) For Institutional providers, the report of findings shall be considered as final unless the provider submits written request for a formal hearing in accordance with Section 51024.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).
2. Amendment of subsection (e)(2) filed 7-13-95; effective thirtieth day thereafter (Register 95, No. 29).

§ 51024. Request for Formal Hearing.

(a) The form and content of the request shall be as specified in Section 51022(d).

TN 95-017
Supersedes
TN 92-12

Approval Date 10/1/98

Effective Date August 1, 1995

this paragraph shall apply only to those overpayments determined by audit reports issued after April 6, 1976 and before June 28, 1981. In all other cases, interest shall be paid in accordance with the provisions of Sections 14171(e) and 14172.5, Welfare and Institutions Code.

(f) As used in this section, "Statement of Account Status" also includes statement of accountability or demand for repayment.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Sections 14171, 14171.5 and 14172.5, Welfare and Institutions Code.

HISTORY

1. Amendment filed 9-15-82 as an emergency; effective upon filing (Register 82, No. 38). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 1-13-83.
2. Certificate of Compliance transmitted to OAL 1-13-83 and filed 2-16-83 (Register 83, No. 8).
3. Editorial correction of NOTE filed 12-13-84 (Register 84, No. 50).
4. Amendment filed 9-17-85; effective thirtieth day thereafter (Register 85, No. 38).
5. Editorial correction of subsection (f) (Register 95, No. 45).

§ 51048. Administrative Review of Performance Under Selective Provider Contracts.

(a) As an alternative to judicial review pursuant to Welfare and Institutions Code Section 14087.27(a), administrative review of disputes between a contracting hospital and the state relating to performance under the Selective Provider Contracting Program shall be heard by an independent hearing examiner appointed by the Director of the Department of Health Services.

(b) The independent hearing examiner shall conduct an administrative hearing and render a proposed decision to be adopted by the Director pursuant to the applicable procedural requirements of Article 1.5, Provider Audit Appeals (Sections 51016-51047) with the following exceptions:

(1) There shall be no exit conference or informal hearings.

(2) All references to a hearing officer shall apply to the independent hearing examiner appointed by the Director pursuant to Welfare and Institutions Code Section 14087.27.

NOTE: Authority cited: Sections 14124.5 and 14082, Welfare and Institutions Code; Section 57, Chapter 328, Statutes of 1982; and Chapter 1594, Statutes of 1982. Reference: Section 14087.27, Welfare and Institutions Code.

HISTORY

1. New section filed 10-8-82 as an emergency; effective upon filing (Register 82, No. 41). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 3-5-83.
2. Certificate of Compliance transmitted to OAL 12-31-82 and withdrawn 1-28-83 (Register 83, No. 12).
3. New section refiled 1-28-83 as an emergency; effective upon filing (Register 83, No. 12). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 5-28-83.
4. Certificate of Compliance transmitted to OAL 5-26-83 and filed 6-30-83 (Register 83, No. 27).
5. Editorial correction of subsection (b) (Register 95, No. 45).

Article 1.6. Skilled Nursing Facility and Intermediate Care Facility Certification Appeals Procedure

§ 51048.1. Limitations.

(a) A skilled nursing and/or intermediate care facility Medi-Cal provider may, in accordance with the regulations contained in Sections 51048.2 through 51048.8, appeal the decision of the Department that a facility is not qualified to participate in the Medi-Cal program.

(b) The Department in rendering its determination shall set forth the pertinent facts and conclusions upon which the determination is made, and shall notify the provider of its right to appeal under subdivision (a).

(c) The effective date of a determination rendered under this article is as follows:

(1) A determination not to renew a certification is effective on the date the existing certification actually expires.

(2) A determination to deny a certification is effective upon the receipt of the determination by the provider, except if the provider files a request for reconsideration under Section 51048.3, the determination shall be effective upon receipt of the reconsidered determination by the provider.

(d) These appeal processes are only available to Medi-Cal providers of skilled nursing facilities who do not participate in the Medicare program. Providers who participate in both Medi-Cal and Medicare may appeal certification decisions to the Department of Health and Human Services in accordance with 42 CFR, 405.1501 et seq. A final decision rendered pursuant to 42 CFR 405.1501 et seq. is binding for purposes of Medi-Cal participation.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

HISTORY

1. New Article 1.6 (Sections 51048.1-51048.8) filed 7-31-85; effective thirtieth day thereafter (Register 85, No. 31).

§ 51048.2. Right to a Reconsideration.

(a) A skilled nursing and/or intermediate care facility provider who disagrees with a determination that the skilled nursing or intermediate care facility does not qualify as a provider of services in the Medi-Cal program may, in accordance with Section 51048.3, request that the Department reconsider that decision.

(b) The reconsideration of a nonrenewal of an existing provider agreement shall be completed prior to the end of the certification period.

(c) The reconsideration of a denial of an initial application for certification shall be made within 30 days of the receipt of the request for a reconsideration.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

HISTORY

1. Editorial correction of subsection (a) (Register 95, No. 45).

§ 51048.3. Request for Reconsideration.

(a) If a provider or authorized representative of the provider requests a reconsideration, the request shall be filed within 15 days after the date of receipt of notice of the determination that the provider does not qualify as a Medi-Cal provider. The request shall be filed with the Director of the Department of Health Services or the designee authorized to accept such requests.

(b) A request for reconsideration shall:

(1) Be in writing.

(2) State the reasons upon which the provider disagrees with the determination.

(3) Include relevant evidence.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

§ 51048.4. Reconsidered Determination.

(a) The Department shall review each request for reconsideration that is filed in accordance with Section 51048.2. The Department shall reconsider the determination and the reasons on which it was based. The Department shall issue, within 30 days of the receipt of the request, a reconsidered determination affirming, revising, in whole or in part, or reversing the determination.

(b) The reconsidered determination shall be based upon the evidence considered in making the original determination and any other evidence submitted by the provider and verified by the Department.

(c) The written reconsidered determination shall be mailed to the provider or his authorized representative. The reconsidered determination shall:

(1) Contain the reason or reasons for affirming, revising or reversing the determination.

(2) Inform the provider of the right to a full evidentiary hearing.

NOTE: Authority cited: Sections 10725 and 14124.5, Welfare and Institutions Code. Reference: Section 14100.1, Welfare and Institutions Code.

§ 51048.5. Right to Full Evidentiary Hearing.

(a) A skilled nursing facility or intermediate care facility provider which disagrees with the Department's reconsidered determination that the skilled nursing facility or intermediate care facility does not qualify as a provider of services in the Medi-Cal program may, by complying with Section 51048.6 request a full evidentiary hearing on the provider

(b) A party may request the disqualification of a hearing officer by filing an affidavit stating in detail the grounds upon which it is claimed that a fair and impartial hearing cannot be given or that the hearing officer has an interest in the proceeding. The hearing officer shall immediately present the affidavit to the Chief Counsel of the Department who shall:

(1) Investigate the allegations and advise the complaining party in writing of the decision granting or denying the request to disqualify the hearing officer. A copy of the decision shall be mailed to the other parties. Or

(2) Reassign the case to another hearing officer without investigation.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment of subsection (b)(1) filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51044. Decision.

(a) The hearing officer shall take the matter under submission at the conclusion of the hearing. A proposed decision, in a form that may be adopted as the decision of the Director, shall be submitted to the Director as soon as practical. A copy of the proposed decision, upon submission to the Director, shall be:

(1) Filed by the Department as a public record.

(2) Served by the Department on each party in the case and each party's representative.

(b) The Director may:

(1) Adopt the proposed decision without reading or hearing the record.

(2) Reject the proposed decision and have a decision prepared based upon the documentary and electronically recorded record, with or without taking additional evidence. The Director shall decide no case provided for in this paragraph without affording the parties the opportunity to present either oral or written argument.

(3) Refer the matter to the hearing officer to take additional evidence. If the case is so assigned, the hearing officer shall prepare a proposed decision as provided in subsection (a), upon the additional evidence and the documentary and electronically recorded record of the prior hearing. A copy of such proposed decision shall be furnished to each party and each party's representative as prescribed in subsection (a).

(c) The decision shall be final upon adoption by the Director. Copies of the decision of the Director shall be mailed by certified mail to the designated representative of the provider.

(d) A dismissal may be issued if a provider fails to appear at a formal hearing. A copy of such dismissal shall be mailed to each party together with a statement of the provider's right to reopen the hearing.

(e) The Director may vacate any dismissal if the provider makes application in writing, within ten calendar days after personal service or receipt of such dismissal, showing good cause for failure to appear at the hearing. Lack of good cause shall be inferred if a continuance of the formal hearing is not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(f) If a party to a formal hearing other than the provider fails to appear at a hearing and the hearing officer issues a decision on the merits adverse to that party's interests, the decision shall be accompanied by a statement of the party's right to make application to vacate the decision. The application may be in writing and shall be made within ten calendar days after personal service or mailing of the decision. Upon a showing of good cause for failure to appear at the hearing, the Director may issue an order to vacate the decision and the matter may be set for further hearing. Lack of good cause will be inferred when a continuance of the hearing was not requested promptly upon discovery of the reasons for failure to appear at the hearing.

(g) The parties shall be given written notice of an order granting or denying any application to vacate a decision.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51045. Reconsideration.

(a) The Department may order a reconsideration of all or part of the case on its own motion or on petition of any party. The power to order a reconsideration shall expire 30 calendar days after delivery or mailing of a decision to the provider. The Department may grant a stay of expiration of its power to order reconsideration:

(1) for up to 30 days for the purpose of enabling a party to file a petition for reconsideration; or

(2) for up to 10 days when needed solely for the purpose of considering a petition filed prior to expiration of its power to order reconsideration.

The petition of a party shall be deemed denied if the Department takes no action within the time allowed for ordering reconsideration.

(b) The case may be:

(1) Reconsidered by the Department on all the pertinent parts of the records and such additional evidence and arguments as may be permitted.

(2) Assigned to a hearing officer for further written or oral hearing.

(c) The decision for a reconsideration assigned to a hearing officer shall be subject to the procedure provided in section 51044.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Change without regulatory effect amending subsection (a) filed 10-4-90 pursuant to section 100, title 1, California Code of Regulations (Register, No. 45).

§ 51046. Judicial Review.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51047. Recovery of Overpayments.

(a) When it is established upon audit that an overpayment has been made to a provider, the Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment. The demand for repayment or Statement of Accountability shall be issued no later than 60 days after the issuance of the audit or examination report establishing such overpayment. When a noninstitutional provider has filed a request for hearing pursuant to Section 51022 of this Article, liquidation of the disputed overpayments shall be deferred until the appeal is rejected or a final administrative decision is rendered. The overpayment shall be recovered by any of the following methods:

(1) Lump sum payment by the provider.

(2) Offset against current payments due to the provider.

(3) A repayment agreement executed between the provider and the Department.

(4) Any other method of recovery available to and deemed appropriate by the Director.

(b) An offset against current payments shall continue until one of the following occurs:

(1) The overpayment is recovered.

(2) The Department enters into an agreement with the provider for repayment of overpayment.

(3) The Department determines, as a result of proceedings under this article, that there is no overpayment.

(c) The provider shall pay interest at the rate of seven percent per annum on any unrecovered overpayment in all cases where the statement of account status was issued before June 28, 1981. In all other cases, the provider shall pay interest as provided by Welfare and Institutions Code Section 14171(f).

(d) Nothing in this section shall prohibit a provider from repaying all or a part of the disputed overpayment without prejudice to his right to a hearing under this article.

(e) Any recovered overpayment that is subsequently determined to have been erroneously collected shall be promptly refunded to the provider, together with interest computed at the legal rate of seven percent per annum from the date of such liquidation or 60 days after issuance of the audit or examination findings, whichever is later. The provisions of

(2) Hearsay evidence shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions.

(3) The rules of privilege shall be effective to the same extent that they are now or hereafter may be recognized in civil actions and irrelevant and unduly repetitious evidence shall be excluded.

(f) The following additional exception to the "best evidence" rule (Evidence Code Section 1500) applies:

(1) A duplicate is admissible to the same extent as an original unless:

(A) A genuine question is raised as to the authenticity of the original or the duplicate.

(B) It would be unfair to admit the duplicate in lieu of the original.

(g) A hearing officer may question any party or witness and may admit any relevant and material evidence.

(h) The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts ad safeguard the rights of the parties. Prior to taking evidence, the hearing officer shall set forth the order in which evidence will be received.

(i) The Department shall present its audit findings and evidence first at the hearing. The Department has the burden of proof of demonstrating, by a preponderance of the evidence, that the audit findings were correctly made. Once the Department has presented such a prima facie case, the burden of proof shifts to the provider to demonstrate, by a preponderance of the evidence, that the provider's position regarding disputed issues is correct.

(j) The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

(k) The hearing shall be conducted in the English language. The proponent of any testimony to be offered by a witness who does not speak the English language proficiently shall provide an interpreter, approved by ting officer, proficient in the English language and the language the witness will testify, to serve as interpreter during the hearing. st of the interpreter shall be paid by the party providing the interpreter.

NOTE Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51038. Official Notice.

(a) The hearing officer shall take official notice of those matters which must be judicially noticed by a court under Section 451 of the Evidence Code. The hearing officer may take official notice of those matters set forth in Section 452 of the Evidence Code.

(b) Parties present at the formal hearing shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto.

(c) Each party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing officer.

NOTE Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51039. Continued or Further Hearings.

(a) A hearing officer may continue a formal hearing to another time or place if deemed advisable or upon request and a showing of good cause.

(1) Written notice of the time and place of the continued formal hearing, except as provided herein, shall be in accordance with this article.

(2) Oral notice of the time and place of the continued formal hearing may be given to each party present at the formal hearing. Such oral notice shall be confirmed in writing by the hearing officer subsequent to the formal hearing.

(b) The hearing officer may order a further formal hearing prior to the decision, if the hearing officer deems advisable or on a showing of good cause. Notice shall be given in accordance with Section 51025.

NOTE Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51040. Evidence.

(a) In Non-institutional provider cases, notwithstanding any other provision of these regulations, and unless otherwise ordered by the assigned Administrative Law Judge, the parties shall:

(1) Not less than ten (10) calendar days prior to the pretrial conference, file a list of all documents and other items to be offered into evidence at the formal hearing, except for impeachment or rebuttal, with a brief statement following each document describing its substance or purpose and the identity of the sponsoring witness.

(2) Not less than seven (7) calendar days prior to the date on which the formal hearing is scheduled to commence, exchange copies of all documents and other items to be offered into evidence at the formal hearing other than for impeachment or rebuttal. Each proposed exhibit shall be premarked for identification.

(3) Prior to the commencement of the formal hearing, any party proposing to object to the receipt in evidence of any proposed exhibit shall advise the opposing party of such objection. The parties shall confer with respect to any objections in advance of the formal hearing and attempt to resolve them. Failure to comply with the requirements of (1) or (2) above shall constitute a ground for objection to the introduction of undisclosed documents and other items, into evidence other than for impeachment or rebuttal.

(b) In all cases, the hearing officer, in order to obtain additional evidence necessary for the proper determination of the case, may:

(1) Continue the formal hearing and hold the record open for either party to produce additional evidence.

(2) Close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any material submitted after the close of the formal hearing shall be made available to both parties and each party shall have the opportunity for rebuttal.

(3) Order a further formal hearing if the nature of the additional evidence or the refutation thereof makes a further hearing desirable.

NOTE Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).

§ 51041. Representation at a Formal Hearing.

(a) A hearing officer or hearing auditor may refuse to allow any person to represent a party in any hearing when the person:

(1) Engages in unethical, disruptive or contemptuous conduct.

(2) Intentionally fails to comply with the proper instructions or orders of the hearing officer or hearing auditor or the provisions of this article.

(b) This section shall not be construed to limit the right of a party or its representative to make evidentiary and procedural objections and state the reasons therefor.

NOTE Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment of subsection (a) filed 7-15-85; effective thereth day thereafter (Register 85, No. 29).

§ 51042. Oral Argument and Briefs.

(a) The hearing officer shall grant oral and may grant written argument at the request of any party made prior to the close of the formal hearing. The parties shall be advised as to the time and manner within which written argument is to be filed.

(b) The hearing officer may require any party to submit written memoranda pertaining to any or all issues raised in the formal hearing.

NOTE Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51043. Disqualification of Hearing Officer.

(a) A hearing officer shall voluntarily withdraw from any proceedings in which the hearing officer:

(1) Cannot give a fair or impartial hearing.

(2) Has an interest

(b) A party shall have the same rights as are accorded a party under the provisions of Section 11507.7 of the Government Code in the event that a request for discovery pursuant to this section has not been granted. In the event an order to show cause is issued, a copy shall be filed with each party.

(c) The provisions of this article provide the exclusive right to and method of discovery as to any proceeding governed by this article.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment of subsection (a) filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51033. Subpoenas and Witnesses.

(a) The hearing officer shall issue subpoenas and subpoenas duces tecum before the formal hearing, for attendance or production of documents at the formal hearing, as necessary or at the request of any party. The hearing officer may also issue subpoenas and subpoenas duces tecum after the formal hearing has commenced. Compliance with the provisions of Section 1985, California Code of Civil Procedure, shall be a condition precedent to the issuance of a subpoena duces tecum.

(b) The process issued pursuant to subsection (a) shall be extended to all parts of the State and shall be served in accordance with the provisions of Sections 1987 and 1988, California Code of Civil Procedure. No witness shall be obliged to attend at a place out of the county in which he resides unless the distance be less than 150 miles from his place of residence except that the hearing officer, upon affidavit of any party showing that the testimony of such witness is material and necessary, may endorse on the subpoena an order requiring the attendance of such witness.

(c) All witnesses appearing pursuant to subpoena, other than the parties or officers or employees of the State or any political subdivision thereof, shall receive fees and all witnesses appearing pursuant to subpoena, except the parties, shall receive mileage in the same amount and under the same circumstances as prescribed by law for witnesses in civil actions in a superior court.

(d) Witnesses appearing pursuant to subpoena, except the parties, who attend formal hearings at points so far removed from their residences as to prohibit return thereto from day to day shall be entitled, in addition to fees and mileage, to a per diem compensation of $3.00 for expenses of subsistence for each day of actual attendance and for each day necessarily occupied in traveling to and from the hearing. Fees, mileage and expenses of subsistence shall be paid by the party at whose request the witness is subpoenaed.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51034. Depositions.

(a) On verified petition of any party, the hearing officer may order that the testimony of any material witness residing within or without the State be taken by deposition in the manner prescribed by law for depositions in civil actions. The petition shall set forth:

(1) The nature of the pending proceeding.

(2) The name and address of the witness whose testimony is desired.

(3) A showing of the materiality of his testimony.

(4) A showing that the witness will be unable or cannot be compelled to attend.

(5) A request for an order requiring the witness to appear and testify before an officer named in the petition for that purpose.

(b) The hearing officer's order for taking of testimony by deposition from a witness residing out-of-State shall be supported by a court order. The court order shall be obtained by filing a petition in the Superior Court of Sacramento County, in accordance with Section 11189, Government Code.

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51036. Affidavits.

(a) Any party may mail or deliver to the opposing party, at least ten calendar days prior to a formal hearing or a continued hearing, a copy of any affidavit to be introduced in evidence, together with a notice as provided in subsection (b). Unless the opposing party, within seven days after such mailing or delivery, mails or delivers to the proponent a request to cross-examine an affiant, the right to cross-examine such affiant is waived and the affidavit, if introduced in evidence, shall be given the same effect as if the affiant had testified orally. If an opportunity to cross-examine an affiant is not offered after request therefor is made as herein provided, the affidavit may be introduced in evidence, but shall be given only the same effect as other hearsay evidence.

(b) The notice referred to in subsection (a) shall be substantially in the following form:

NOTICE

The accompanying affidavit of (here insert name of affiant) will be introduced as evidence at the formal hearing in (here insert title of proceeding). (Here insert name of affiant) will not be called to testify orally and you will not be entitled to question him unless you notify (here insert name of proponent or his attorney) at (here insert address) that you wish to cross-examine him. To be effective your request must be mailed or delivered to (here insert name of proponent or his attorney) on or before (here insert a date seven days after the day of mailing or delivering the affidavit to the opposing party).

NOTE: Authority cited: Sections 14105, 14124.5, and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51036. Preparation for Formal Hearing.

A party appearing at a formal hearing shall have necessary evidence and witnesses present and be ready to proceed. Each party shall make available sufficient copies, as indicated by the hearing officer, of any documents to be introduced in evidence. The hearing officer, if necessary and following reasonable notice, may require any or all parties to submit a written statement of contentions and reasons, together with any requested documents. Each party submitting written statements and documents shall also provide a copy to all other parties.

NOTE: Authority cited: Sections 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

History

1. Amendment filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).
2. Editorial correction of Authority cite (Register 95, No. 45).

§ 51037. Conduct of Formal Hearing.

(a) Testimony shall be taken only on oath, affirmation or penalty of perjury.

(b) The proceedings at the formal hearing shall be electronically recorded.

(c) Each party shall have the right to:

(1) Call and examine parties and witnesses.

(2) Introduce exhibits.

(3) Question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination.

(4) Impeach any witness regardless of which party first called the witness to testify.

(5) Rebut the evidence against him.

(d) The provider shall not be called to testify during presentation of the Department's prima facie case pursuant to subsection (i). A provider who thereafter fails to testify, in the provider's behalf, may be called and examined by the Department as if under examination.

(e) The formal hearing need not be conducted according to technical rules relating to evidence and witnesses.

(f) Relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions.

TN 95-017
Supersedes
TN 92-13

Approval Date 10/1/98

Effective Date August 1, 1995

(b) An institutional provider shall have 30 calendar days following the receipt of the written Report of Findings within which to file a request for formal hearing with the Director. The request shall be deemed filed on the date mailed to the Department. The audit findings, as amended by the Report of Findings, shall be considered final and deemed dispositive of all issues raised in the Statement of Disputed Issues filed pursuant to Section 51022 at the end of this period unless good cause for late filing is found.

(c) A request for formal hearing filed after the time permitted in subsection (b) shall be rejected unless the provider establishes in writing good cause for late filing within 15 calendar days of being notified of the untimeliness of its request.

(d) A formal hearing shall routinely be scheduled in each case involving a Non-institutional provider. No separate request for formal hearing shall be required.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Amendment filed 10-11-84; effective upon filing pursuant to Government Code Section 11346.2(d) (Register 84, No. 41).

§ 51025. Notice of Formal Hearing.

Written notice of the time and place of formal hearing shall be mailed to each party at least 30 calendar days before the date of hearing. This period may be shortened with the consent of the parties. Any party may waive notice.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

§ 51026. Department Mailings.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

...ber filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51027. Time and Place of Informal Level of Review and Formal Hearing.

(a) The hearing officer shall determine the time and place of an informal level of review or formal hearing. The informal level of review or formal hearing shall be held at one of the following locations.

(1) In the County of:

(A) San Francisco if the provider resides within the First Appellate District.

(B) Los Angeles if the provider resides within the Second or Fourth Appellate District.

(C) Sacramento if the provider resides within the Third or Fifth Appellate District.

(b) Notwithstanding subdivision (a), the hearing officer may select:

(1) A different place nearer the place where the provider resides.

(2) Any place within the State agreeable to the parties.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Amendment filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51028. Merger of Successive Requests for Hearings.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51029. Consolidation of Proceedings.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51030. Hearing Officer's Authority.

(a) The hearing officer may, on his/her own motion or the motion of any party, as the hearing officer deems appropriate:

(1) Consolidate for hearing or decision any number of issues or appeals when the facts and circumstances are similar and no substantial right of any party will be prejudiced.

(2) Join other parties, grant continuances and hold additional formal hearings as necessary to dispose of all issues.

(3) Hear any issue before any other issue in the proceeding where it is found that the decision on that issue could abate further proceedings.

(4) Prepare a proposed decision on any separately heard issue for the Director's signature and postpone hearing on any remaining issues until a final decision has been issued by the Director.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer and new section filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51031. Severance of Issues.

NOTE: Authority cited: Sections 14105, 14124.5 and 14171, Welfare and Institutions Code. Reference: Section 14171, Welfare and Institutions Code.

HISTORY

1. Repealer filed 7-15-85; effective thirtieth day thereafter (Register 85, No. 29).

§ 51032. Discovery.

(a) After the acceptance of the Statement of Disputed Issues, a party, upon written request made to another party, prior to the hearing and within thirty (30) calendar days after receipt of the Notice of Acceptance of the Statement of Disputed Issues or within fifteen (15) calendar days after the receipt of the Notice of Acceptance of an amended Statement of Disputed Issues or issuance of a Report of Findings, is entitled to:

(1) Obtain the names and addresses of witnesses to the extent known to the other party, including, but not limited to, those intended to be called to testify at the informal hearing or formal hearing.

(2) Inspect and make a copy of any of the following in the possession or custody or under the control of the other party:

(A) Statements pertaining to the subject matter of the proceeding made by any party to another party or person.

(B) Statements of witnesses then proposed to be called by the party and of other persons having personal knowledge of the acts, omissions or events which are the basis for disputed audit or examination findings, not included in subdivision (2)(A).

(C) All writings, including but not limited to audit work papers, patient ledgers, medical records and invoices or things which the party then proposes to offer into evidence.

(D) Other writing or thing which is relevant and which would be admissible in evidence.

(E) Investigative reports made for or on behalf of the Department or other party pertaining to the subject matter of the proceeding, to the extent that such reports:

(1) Contain the names and addresses of witnesses or of persons having personal knowledge of the acts, omissions or events which are the basis for the disputed audit or examination findings.

(2) Reflect matters perceived by the investigator in the course of his investigation.

(3) Contain or include by attachment any statement or writing described in subsections (2)(A) through (2)(D) inclusive, or summary thereof.

(4) For the purpose of this section, "statements" includes written statements by the person, signed or otherwise authenticated by the person, stenographic, mechanical, electrical or other recordings, or transcripts thereof, or oral statements by the person and written reports or summaries of such oral statements.

(5) Nothing in this section shall authorize the inspection or copying of any writing or thing which is privileged from disclosure by law or otherwise made confidential or protected as the attorney's work product.

(6) Any denial of discovery by a party shall be in writing and shall be accompanied by a written statement describing the specific reasons for denial as to each item of discovery denied. Such a denial shall be mailed within 30 calendar days from the date of filing the request for discovery.

TN 95-017
Supersedes
TN 92-12

Approval Date 10/1/98

Effective Date August 1, 1995

(f) The development of alternative standards for beneficiary eligibility and copayment under Medi-Cal.

(g) The development of a method of response to temporary deficits in the Medi-Cal program that will both control expenditures and, to the extent possible, preserve the availability to beneficiaries of essential health services.
(Added by Stats.1983, c. 960, § 7.)

Article 5.3

AUDIT, APPEAL, AND RECOVERY OF OVERPAYMENTS

Section

Article 5.3 was added by Stats.1977, c. 1046, p. 3172, § 6.

Operative effect

Chapter to remain operative during times federal aid available, see § 14020.

Code of Regulations References

Health care services, provider audit appeals, see 22 Cal. Code of Regs. 51016 et seq.

§ 14170. Audits; controls; cost reports; corrections; payroll records; maintenance

Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by the department. The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. Cost reports and other data submitted by providers to a state agency for the purpose of determining reasonable costs for services or establishing

rates of payment shall be considered true and correct unless audited or reviewed by the department within 18 months after July 1, 1969, the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later. Moreover the cost reports and other data for cost reporting periods beginning on January 1, 1972, and thereafter shall be considered true and correct unless audited or reviewed within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later.

Nothing in this section shall be construed to limit the correction of cost reports or rates of payment when inaccuracies are determined to be the result of intent to defraud, or when a delay in the completion of an audit is the result of willful acts by the provider or inability to reach agreement on the terms of final settlement.

Notwithstanding any other provision of law, nursing facilities and all categories of intermediate care facilities for the developmentally disabled which have received and are receiving funds for salary increases pursuant to Sections 14110.6 and 14110.7 shall maintain payroll and personnel records for examination by auditors from the department and the Labor Commissioner beginning March 1985 until the records have been audited, or until December 31, 1992, whichever occurs first.

(Added by Stats.1977, c. 1046, p. 3172, § 6. Amended by Stats.1978, c. 429, § 248.1, eff. July 17, 1978, operative July 1, 1978; Stats.1981, c. 1129, p. 4408, § 1; Stats.1985, c. 787, § 1, eff. Sept. 19, 1985; Stats.1989, c. 731, § 23; Stats.1990, c. 1329 (S.B.1524), § 32, eff. Sept. 26, 1990.)

Historical and Statutory Notes

Section 2 of Stats.1978, c. 19, p. 80, amended by Stats.1981, c. 1129, p. 4410, § 2, and § 2.5 of Stats.1978, c. 19, added by Stats.1981, c. 1129, p. 4412, § 3, and amended by Stats.1985, c. 787, § 2, provide:

"Sec. 2. (a) The Legislature hereby finds and declares that a high rate of turnover among staff in intermediate care facilities and skilled nursing facilities diminishes the quality of care rendered to patients in those facilities. The Legislature further finds that the turnover among employees of those facilities is substantially attributable to the fact that the wages paid those employees are generally lower than the wages paid employees of other health care institutions in similar job classifications. It is the intent of the Legislature that Medi-Cal reimbursement rates for skilled nursing facilities and intermediate care facilities, to the extent feasible, be set at levels sufficient to allow those employees to be paid at wages which are sufficient to reduce turnover among such employees, in order to improve the level and quality of patient care.

"(b) The Legislature further finds that the rates for wages contained in this act were developed with recognition of the costs of increased wages and related benefits. It is the intent of the Legislature that the funds resulting from the Medi-Cal rate increases provided in this section be used for wage increases and for costs of normal benefit increases related to the wage and salary increases.

"(c) Notwithstanding any other provision of law, the State Director of Health Services shall establish and implement regulations effective March 1, 1978, that establish a payment rate for intermediate care facilities and skilled nursing facilities as defined in Section 1250 of the Health and Safety Code, which is sufficient to provide an increase of two dollars and twenty-eight cents ($2.28) per patient-day with respect to skilled nursing facilities and one dollar and eighty-four cents ($1.84) per patient-day with respect to intermediate care facilities, for wages and benefits of nonadministrative employees. The increase required by this section shall be in addition to any future mandatory increases required by federal or state law. The rate shall provide funding for the portion of additional costs necessary to implement the wage and benefit increase required by this

section attributable to Medi-Cal patients. The portion of those additional costs shall be the same as the ratio of Medi-Cal patients to the total patients in the facility.

"(d) Each skilled nursing facility or intermediate care facility shall certify that funds received pursuant to this section for the period commencing March 1, 1978, to and including June 30, 1978, are expended for employee wages and benefits, except if the entry level wages of the lowest paid nonadministrative employee of a skilled nursing facility or an intermediate care facility exceeds three dollars and ninety-seven cents ($3.97) per hour on the effective date of this section, the funds received pursuant to regulations adopted pursuant to this section shall be used to ensure the continued delivery of quality care in that facility. The base, from which employee wages and benefits are increased pursuant to this section, shall be the facility payroll for the month of December, 1977, but including only nonovertime hours worked by covered employees, plus any amount received pursuant to Section 1439.7 of the Health and Safety Code. For purposes of determining the amount of Medi-Cal funds to be distributed for employee wages and benefits, the total Medi-Cal patient-days recorded by the facility in the month of December, 1977, shall be multiplied by the amount per patient-day specified in subdivision (c) of this section.

"(e) The director shall inspect relevant payroll and personnel records of skilled nursing facilities and intermediate care facilities which are reimbursed for Medi-Cal patients under the rate of reimbursement established pursuant to subdivision (c) of this section to insure that the wage and benefit increases provided for have been implemented.

"(f) Any facility which is paid under the rate provided for in which the director finds has not made the wage and benefit increases provided for shall be liable to the employees for the amount of funds paid to the facility based upon the wage and benefit requirements provided for by this section but not distributed to employees for wages and benefits. The facility shall make payment of the outstanding amounts to the state for appropriate distribution, plus an amount equal to 10 percent of the funds not so distributed, to be retained by the state as a penalty.

"(g) On or before July 1, 1978, and annually thereafter, each skilled nursing facility or intermediate care facility shall certify to, and in the manner prescribed by, the director, all of the following:

"(1) All nonadministrative employees of the facility employed less than three months receive at least an entry level wage amounting to the prevailing federal minimum wage rate plus 50 percent of the average hourly wage increase established pursuant to this section for that facility during the period March through June, 1978.

"(2) All nonadministrative employees of the facility employed three months or more receive at least the prevailing federal minimum wage rate plus the average hourly wage increase established pursuant to this section for that facility during the period March through June, 1978; provided, however, that no employee then employed shall receive a wage less than that which that person received pursuant to this section for the period March through June, 1978, after July 1, 1978.

"(3) Any wage increase required pursuant to subdivision (a) of Section 1338 of the Health and Safety Code is in addition to any minimum wages provided in this subdivision.

"Sec. 2.5. (a) The Labor Commissioner is hereby authorized to audit payroll and personnel records of skilled nursing facilities and intermediate care facilities for the purposes of ensuring compliance with the wage levels provided for in this chapter.

"(b) The Labor Commissioner is hereby authorized to recover from the skilled nursing facility or the intermediate care facility any wages less than the minimum provided for in this chapter. The recovered funds shall be provided to the employees who were underpaid.

"(c) The Labor Commissioner may recover any funds not used for increases in wages pursuant to Sections 14110.6 and 14110.7 of the Welfare and Institutions Code. The recovered funds shall be provided to the employees who were underpaid. All penalties collected pursuant to these sections shall be forwarded to the Controller for deposit in the General Fund.

"(d) The Labor Commissioner is hereby authorized to impose any other penalties within his or her powers against any skilled nursing facility or intermediate care facility that is in violation of the wage requirements of this chapter. The amount of any penalties already paid to the State Department of Health Services pursuant to this chapter shall be deducted from the amount of any unpaid penalties imposed by the Labor Commissioner pursuant to this chapter. The amount of any penalties already paid to the Labor Commissioner pursuant to this chapter shall be deducted from the amount of any unpaid penalties imposed by the State Department of Health Services pursuant to this chapter.

"Any evidence of failure to pay wage ... as provided for by this chapter shall be provided to the Labor Commissioner."

Amendment of this section by § 1.5 of Stats. 1981, c. 1129, p. 4409, failed to become operative under the provisions of § 4 of that Act.

Code of Regulations References

Requirements for electronic claims submission, see 22 Cal. Code of Regs. 51502.1.

Library References

Social Security and Public Welfare ⇐241.65. WESTLAW Topic No. 356A.

C.J.S. Social Security and Public Welfare §§ 137, 138.

Notes of Decisions

Limitation of actions 1

1. Limitation of actions

Even if Medi-Cal services provider was entitled to avoid exhaustion of administrative remedies and proceeded directly to trial court on its appeal of 1972 audit adjustment, it did not do so within the applicable statute of limitations and its claim was barred for that reason. Pacific Coast Medical Enterprises v. Department of Benefit Payments (1983) 189 Cal.Rptr. 558, 140 C.A.3d 197.

§ 14170.1. Underpayments for pharmaceutical services; credit against overpayments

(a) Prior to the issuance to a provider of pharmaceutical services of any demand for payment pursuant to an audit or examination conducted under Sections 10722 and 14170, the amount of any underpayment to the provider for validly submitted claims or for valid claims which have inadvertently not been submitted and which arose during the audit period shall be determined and credited toward the amount of any overpayment due to the department. This section shall apply to all audits and examinations conducted under ...tions 10722 and 14170 relative to amounts paid during the audit period for services provided to Medi-Cal beneficiaries. No audit may be reopened to provide for underpayments in which a final decision has been reached pursuant to Section 14171 or in which a certificate has been filed pursuant to Section 14172.

(b) When a provider of pharmaceutical services asserts that a claim has been underpaid for purposes of receiving a credit against overpayments, as authorized by this section, the provider shall submit to the department information and documentation sufficient to resolve any dispute as to whether such claim was in fact underpaid.

(c) For purposes of this section, the term "underpayments" shall include errors made by the pharmacist and errors made by the fiscal intermediary in determining payments for claims submitted within the billing time limits specified in Section 14115.

(Added by Stats.1983, c. 1146, § 1. Amended by Stats.1986, c. 562, § 1.)

Library References

Social Security and Public Welfare ⇐241.110. WESTLAW Topic No. 356A.

C.J.S. Social Security and Public Welfare § 136.

**TRANSITIONAL INPATIENT CARE (TC)
HFPA TRIGGERING**

FACILITY	*NO TC CONTRACTOR HFPA IS NOT TRIGGERED*	*TC CONTRACT AWARDED HFPA TRIGGERED TC BEDS UNAVAILABLE**	*TC CONTRACT AWARDED HFPA TRIGGERED TC BEDS AVAILABLE*
Hospital with TC contract	Not Applicable	[redacted]	[redacted] May transfer patient
Hospital without TC contract	Retain patient at Hospital Inpatient Services Reimbursement**	[redacted]	No TC Authorization****

*Transitional inpatient care beds may not be available because all the beds in the transitional inpatient care units are occupied, or facilities may not accept the patient due to level of care or staffing considerations.

**The hospital inpatient services reimbursement for contracted hospitals as provided in Article 2.7 of the Welfare and Institutions Code shall be the rate specified in the hospital contract. The hospital inpatient services reimbursement for non-contract hospitals is set forth in Article 7.5 of Title 22 California Code of Regulations. Reimbursement at this level will be made if the hospital is not in an area triggered as provided in subsection (b)(3).

***Acute administrative day process applies as specified in the Manual of Criteria for Medi-Cal authorization.

****Transitional inpatient care days will not be authorized in this circumstance.

(1) The hospital referral area for transitional inpatient care placement shall not impose additional commute from the general acute care hospital location of more than 15 miles, which shall be defined as 30 minutes at 30 miles per hour, for the person designated as the patient's primary visitor.

(2) The Department and general acute care hospitals shall maintain a list of all health facilities which have contracted to provide transitional inpatient care. General acute care hospitals shall receive written notification from the Department of changes to that list. Upon request, a list of current health facilities contracted to provide transitional inpatient care shall be available from the Department. The certified nursing facilities included on this list shall be contacted before any other certified nursing facility in placement attempts for any appropriate Medi-Cal patient.

(3) The Department will reimburse general acute care hospitals for transitional inpatient care services, provided in licensed acute care hospital beds, at the hospital inpatient services reimbursement rate until there is a contracted transitional inpatient care provider within the general acute care hospital's Health Facility Planning Area (HFPA) as developed by the Office of Statewide Health Planning and Development pursuant to Health and Safety Code Sections 127000 et seq. If a general acute care hospital is within 15 miles (which shall be defined as 30 minutes at 30 miles per hour) of a health facility in a neighboring HFPA that contracts to provide transitional inpatient care, the hospital will be considered within the contracted health facility's HFPA and subject to the provisions of transitional inpatient care reimbursement. The HFPA shall be triggered for transitional inpatient care when a provider is awarded a contract to provide transitional inpatient care. The HFPA shall be triggered for transitional rehabilitation care when a provider is awarded a contract to provide transitional rehabilitation care. The word "triggered" means that there is a contracted transitional inpatient care provider in the HFPA, and general acute care hospitals within that HFPA, or neighboring HFPA, as specified, will receive the transitional inpatient care reimbursement of [redacted] for the care rendered to qualified patients if:

(A) The general acute care hospital maintains a transitional inpatient care contract with the Department; or

(B) The general acute care hospital does not have a transitional inpatient care contract with the Department but makes daily attempts and documents daily attempts to place the qualified transitional inpatient care patient in a transitional inpatient care unit.

(4) For general acute care hospitals that contract for the provision of transitional inpatient care services provided in licensed general acute care hospital beds, the Department will reimburse the transitional inpatient care per diem of [redacted] when the general acute care hospital's HFPA is designated a trigger area.

(5) General acute care hospitals in that HFPA will be provided notice that the transitional inpatient care reimbursement rate will be paid to the general acute care hospital for a transitional inpatient care patient.

(c) In specified HFPAs, the reimbursement to health facilities for transitional medical care and transitional rehabilitation care provided to Medi-Cal patients shall be based on a negotiated contract. "Negotiated contract" means an executed contract resulting from negotiations, competitive bidding or any other method the Department deems appropriate as permitted by Sections 14087.3 and 14132.22(o) of the Welfare and Institutions Code.

(1) The contracting process used for a negotiated contract shall include, but not be limited to, the following steps:

(A) The Department will first determine the Medi-Cal patients' transitional inpatient care needs within the HFPA. Projections of transitional inpatient care service for patients within the HFPA will then be established. The projected transitional inpatient care service needs within the HFPA will be met by negotiating contracts for sufficient bed capacity.

(B) Health facilities as specified in Section 14132.22 of the Welfare and Institutions Code in an HFPA selected by the Department will be notified of the opportunity to negotiate a contract for the provision of transitional inpatient care services to Medi-Cal patients.

(C) Health facilities which indicate an interest in negotiating a contract for the provision of transitional inpatient care will be asked to present their proposal to the Department.

(D) The Department will contract with only the number of providers necessary to assure sufficient bed capacity and accessibility of transitional inpatient care services within the HFPA to Medi-Cal patients. Transitional inpatient care capacity projected to be needed in an HFPA may be contracted for in a neighboring HFPA.

(E) All affected health facilities in each HFPA will be notified when projected needs have been met in accordance with paragraphs (A) and (D). Affected hospitals will be designated as contracting for transitional inpatient care or non-contracting for transitional inpatient care and will be notified of facilities contracting to meet the projected transitional inpatient care needs within the HFPA.

(F) Once designation has occurred in accordance with paragraph (E), the Department is exempt from the provisions of paragraphs (B) and (C).

(2) Hospitals, without a negotiated contract for transitional inpatient care, shall receive the administrative day reimbursement of [redacted] for the provision of transitional inpatient care to Medi-Cal patients as long

as placement attempts to facilities with a transitional inpatient care contract are documented.

(d) Payment under subsection (a) and (b) shall only be made for services authorized pursuant to conditions set forth in Section 51335.1 for a patient determined to need transitional inpatient care services.

(e) Each provider of transitional inpatient care services shall furnish equipment, drugs, supplies, and services necessary to provide transitional level services except as provided in subsection (d). Such equipment, drugs, supplies, and services are, at a minimum, those which are required by law, including those required by federal Medicaid regulations and state licensing regulations.

(f) Not included in the per diem reimbursement and to be billed separately by the provider thereof, subject to the utilization controls and limitations of Medi–Cal regulations covering such services and supplies, are:

(1) Allied health services, except occupational therapy, physical therapy, speech therapy and respiratory therapy

(2) Blood, plasma, and substitutes

(3) Dental services

(4) DME as specified in Section 51321(g), except suction pumps, IV poles, oxygen and oxygen therapy equipment, excluding ventilators

(5) Decubitus care equipment

(6) Traction equipment and accessories

(7) Hemodialysis

(8) Insulin

(9) Laboratory services

(10) Legend drugs

(11) MacLaren or Pogon Buggy

(12) Medical supplies as specified in Section 59998, except hypodermoclysis sets and intravenous solutions administration sets

(13) Osteogenesis stimulator device

(14) Physician services

(15) Plasmapheresis

(16) Prescribed prosthetic and orthotic devices for exclusive use of patient

(17) Reagent testing sets

(18) X–rays

(g) Not included in the transitional inpatient care per diem reimbursement rate nor in the Medi–Cal schedules of benefits are personal items such as cosmetics, tobacco products and accessories, dry cleaning, beauty shop services (other than shave or shampoos performed by the facility staff as part of patient care and periodic hair trims) and television rental.

(h) Payment for leave of absence for the transitional rehabilitation patient authorized in accordance with Section 51335.1(p) shall be made pursuant to Section 51535.

(i) Payment for bedhold authorized in accordance with Section 51335.1(q) shall be made pursuant to Section 51535.1.

(j) Reimbursement to physicians for all medically necessary care provided to transitional inpatient care patients shall be commensurate with those visits to non–transitional acute care patients in general acute care hospitals.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Sections 127000 et seq, Health and Safety Code; and Sections 14105.981 and 14132.22, Welfare and Institutions Code.

HISTORY

1. New section filed 4–1–96 as an emergency; operative 4–1–96 (Register 96, No. 14). A Certificate of Compliance must be transmitted to OAL by 9–30–96 pursuant to Welfare and Institutions Code section 14132.22 or emergency language will be repealed by operation of law on the following day.
2. Editorial correction of subsection (b), table, subsection (f), and HISTORY 1 (Register 96, No. 35).
3. New section refiled 9–28–96 as an emergency; operative 9–30–96 (Register 96, No. 35). A Certificate of Compliance must be transmitted to OAL by 1–28–97 or emergency language will be repealed by operation of law on the following day.
4. Certificate of Compliance as to 9–28–96 order, including amendment of section, transmitted to OAL 1–22–97 and filed 3–10–97 (Register 97, No. 11).

§ 51511.5. Nursing Facility Services—Subacute Care Reimbursement.

(a) The all–inclusive per diem rates of reimbursement for subacute services as defined in Section 51335.5(a) shall be the lesser of the facility's costs as projected by the Department or the prospective class median rates of:

Type of Licensure	*Type of Patient*	*Rate of Reimbursement*
Hospital–based	Ventilator dependent	[redacted]
Freestanding	Ventilator dependent	[redacted]
Hospital–based	Nonventilator dependent	[redacted]
Freestanding	Nonventilator dependent	[redacted]

(b) Payments to nursing facilities with subacute care units for patients on bedhold receiving acute services shall be in accordance with section 51535.1(d).

(c) The provisions of section 51511 shall apply to subacute care units except for section 51511(a). Section 51511(c) shall apply to subacute providers with the exception of items included within the subacute rate pursuant to section 51511.5(d).

(d) Included within the subacute care per diem rate are all services, equipment and supplies necessary for the administration of the treatment procedures listed in the patient care criteria including but not limited to:

(1) Oxygen and all equipment necessary for administration including positive pressure apparatus.

(2) Ventilators, including calibration and maintenance.

(3) Feeding pumps and equipment necessary for tube feedings, including formula.

(4) Speech therapy.

(5) Occupational therapy.

(6) Physical therapy.

(7) Equipment and supplies necessary for the care of a tracheostomy.

(8) Lab, X–ray and transportation services.

(9) Equipment and supplies for continuous IV therapy.

(10) Equipment and supplies necessary for debridement, packing and medicated irrigation with or without whirlpool treatment.

(e) For purposes of this section, the rate year is August 1, 1996 through July 31, 1997.

(f) The facility's projected cost shall be based on the audit report findings of cost reports with fiscal periods ending January 1, 1994 through December 31, 1994. In the event that a facility's audit report findings do not include subacute ancillary costs, the facility's projected ancillary cost will be based on the median of the subacute ancillary costs of facilities that had audited ancillary cost.

(g) If the audit of a cost report is not issued by July 1, 1996, the Department shall establish an interim projected reimbursement rate based on the cost report with a fiscal period ending January 1, 1994 through December 31, 1994, adjusted by an audit disallowance factor of .96414.

(h) The Department will use the facility's interim projected reimbursement rate in the computation of the prospective class median rate. In addition, facilities that did not provide subacute care services to Medi–Cal patients during the cost report period and/or facilities with less than a full year's reported cost shall not be used to establish the prospective class median rate.

(i) If the facility has an interim reimbursement rate as specified in (g), when the audit report is issued or when the cost report is deemed true and correct under Welfare and Institutions Code Section 14170(a)(1), the Department shall adjust the facility's projected reimbursement rate retroactively to August 1, 1996 to reflect the cost determined pursuant to such audit, or to reflect the cost in the cost report in the event that cost report is deemed true and correct.

(j) Interest will accrue from August 1, 1996 and be payable on any such underpayment or overpayment at a rate equal to the monthly average received on investment in the Surplus Money Investment Fund (as refer-

enced in the Welfare & Institutions Code Section 14171) during the month the audit report is issued.

(k) If a provider appeals an audit adjustment pursuant to Welfare & Institutions Code Section 14171, and there is a final determination that the audit findings inaccurately reflect the audited facility's projected costs, the provider shall be entitled to seek a retroactive adjustment in its reimbursement rate but the resulting reimbursement rate shall not exceed the prospective median rate as provided in subdivision (a).

(l) Payment under subsection (a) shall only be made for services authorized pursuant to conditions set forth in Section 51355.5 for patients determined to need subacute care services.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 1996, Chapter 162, Items 4260-101-0001 and 4260-101-0890.

HISTORY

1. Certificate of Compliance as to 10-27-88 order including amendment of subsection (d) transmitted to OAL 2-24-89 and filed 3-27-89 (Register 89, No. 13). For prior history, see Register 89, No. 1.
2. Amendment filed 8-7-89 as an emergency; operative 8-7-89 (Register 89, No. 32). A Certificate of Compliance must be transmitted to OAL within 120 days or emergency language will be repealed on 12-5-89.
3. Certificate of Compliance transmitted to OAL 12-1-89 and filed 1-2-90 (Register 90, No. 2).
4. Amendment filed 12-10-90 as an emergency; operative 12-10-90 (Register 91, No. 6). A Certificate of Compliance must be transmitted to OAL by 4-9-91 or emergency language will be repealed by operation of law on the following day.
5. Amendment of subsection (a) and heading filed as an emergency 3-14-91; operative 3-14-91 (Register 91, No. 14). A Certificate of Compliance must be transmitted to OAL by 7-12-91 or emergency language will be repealed by operation of law on the following day.
6. Certificate of Compliance as to 12-10-90 order transmitted to OAL 4-8-91 and filed 5-8-91 (Register 91, No. 24).
7. Amendment of subsection (c) and repealer of subsections (e) and (f) filed 5-21-91 as an emergency pursuant to Statutes of 1990, chapter 456, section 36, p. 1658-1659; operative 5-22-91 (Register 91, No. 27). A Certificate of Compliance must be transmitted to OAL by 9-19-91 or emergency language will be repealed by operation of law on the following day.
8. Certificate of Compliance as to 3-14-91 order transmitted to OAL 7-11-91 and filed 8-9-91 (Register 91, No. 50).
9. Amendment of subsection (a) and NOTE filed 8-12-91 as an emergency; operative 8-12-91 (Register 92, No. 6). A Certificate of Compliance must be transmitted to OAL 12-10-91 or emergency language will be repealed by operation of law on the following day.
10. Certificate of Compliance as to 8-12-91 order transmitted to OAL 12-9-91 and filed 1-2-92 (Register 92, No. 18).
11. Amendment of subsection (c) refiled 1-23-92 as an emergency; operative 1-17-92 (Register 92, No. 25). A Certificate of Compliance must be transmitted to OAL 5-22-92 or emergency language will be repealed by operation of law on the following day.
12. Certificate of Compliance as to 1-23-92 order transmitted to OAL 5-22-92 and filed 7-6-92 (Register 92, No. 28).
13. Amendment of subsection (a) and NOTE filed 12-3-92 as an emergency; operative 12-3-92 (Register 92, No. 49). A Certificate of Compliance must be transmitted to OAL 4-2-93 or emergency language will be repealed by operation of law on the following day.
14. Certificate of Compliance as to 12-3-92 order transmitted to OAL 4-2-93 and filed 5-14-93 (Register 93, No. 20).
15. Amendment of subsection (a) and NOTE filed 8-24-93 as an emergency; operative 8-24-93 (Register 93, No. 35). A Certificate of Compliance must be transmitted to OAL by 12-22-93 or emergency language will be repealed by operation of law on the following day.
16. Amendment of subsection (a) and NOTE refiled 12-20-93 as an emergency; operative 12-20-93 (Register 93, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-21-94 or emergency language will be repealed by operation of law on the following day.
17. Certificate of Compliance as to 12-20-93 order transmitted to OAL 3-22-94 and filed 4-28-94 (Register 94, No. 17).
18. Amendment of subsection (a), new subsections (e)-(f) and amendment of NOTE filed 10-16-95 as an emergency; operative 10-16-95 (Register 95, No. 42). A Certificate of Compliance must be transmitted to OAL by 2-13-96 or emergency language will be repealed by operation of law on the following day.
19. Editorial correction of HISTORY 18 (Register 96, No. 6).
20. Amendment of subsection (a), new subsections (e)-(f) and amendment of NOTE refiled 2-5-96 as an emergency; operative 2-5-96 (Register 96, No. 6). A Certificate of Compliance must be transmitted to OAL by 6-6-96 or emergency language will be repealed by operation of law on the following day.
21. Certificate of Compliance as to 2-5-96 order transmitted to OAL 6-4-96 and filed 7-12-96 (Register 96, No. 28).
22. Amendment of subsections (a), (e)-(g) and (i)-(j) and NOTE filed 9-19-96 as an emergency; operative 9-19-96 (Register 96, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-17-97 or emergency language will be repealed by operation of law on the following day.
23. Certificate of Compliance as to 9-19-96 order transmitted to OAL 1-17-97 and filed 3-3-97 (Register 97, No. 10).

§ 51511.6. Nursing Facility Services — Pediatric Subacute Care Reimbursement.

(a) The per diem rates of reimbursement for pediatric subacute services as defined in Section 51335.6(a) shall be as follows:

Licensure	*Type of Patient*	*Effective Until "7/1/97" for Alameda, Contra Costa Marin, San Francisco, San Mateo, Santa Clara Counties*	*Effective Until "7/1/97" for All Other Counties*	*Effective on 7/1/97 Statewide*
Hospital Based	Ventilator Dependent	[redacted]		
Hospital Based	Non Ventilator Dependent	[redacted]		
Free standing	Ventilator Dependent	[redacted]		
Free standing	Non-Ventilator Dependent	[redacted]		

(b) The per diem rate of reimbursement for supplemental rehabilitation therapy services shall b[redacted] This rate shall include payment for physical therapy, occupational therapy and speech therapy services provided in accordance with Section 51215.10(i) through (m).

(c) The per diem rate of reimbursement for ventilator weaning services shall be [redacted] This rate shall include respiratory care practitioner and nursing care services provided in accordance with Section 51215.11.

(d) Payment to nursing facilities with pediatric subacute units for patients on bedhold receiving acute services shall be in accordance with Section 51535.1(d).

(e) The provisions of Section 51511 shall apply to pediatric subacute units except for Section 51511(a). Section 51511(c) shall apply to pediatric subacute units except as provided for in 51511.6(f).

(d) The pediatric subacute per diem rate includes the following:

(1) Equipment and supplies necessary for continuous intravenous therapy;

(2) Oxygen and all equipment necessary for administration including positive pressure apparatus;

(3) Ventilators, including calibration and maintenance;

(4) Registered Dietician consultant services;

(5) Respiratory therapy services;

(6) Physical, occupational and speech therapy services, as specified in Section 51215.10(h);

(7) Developmental services;

(8) Service Coordinator activities.

NOTE: Authority cited: Sections 10725, 14105 and 14124.5, Welfare and Institutions Code. Reference: Section 14132.25, Welfare and Institutions Code; and Statutes of 1996, Chapter 162, Items 4260-101-0001 and 4260-101-0890.

HISTORY

1. New section filed 4-13-94 as an emergency; operative 4-1-94. Emergency adoption submitted to OAL for printing only pursuant to section 4, AB 36 (chapter 1030, Statutes of 1993) (Register 94, No. 15).
2. Certificate of Compliance as to 4-13-94 order including amendment of section transmitted to OAL 9-26-94 and filed 10-20-94 (Register 94, No. 42).
3. Editorial correction of subsection (d)(3) and HISTORY 1 and 2 (Register 95, No. 14).
4. Amendment of subsection (a) and NOTE filed 9-19-96 as an emergency; operative 9-19-96 (Register 96, No. 38). A Certificate of Compliance must be transmitted to OAL by 1-17-97 or emergency language will be repealed by operation of law on the following day.
5. Certificate of Compliance as to 9-19-96 order transmitted to OAL 1-17-97 and filed 3-3-97 (Register 97, No. 10).
6. Amendment of section and NOTE filed 6-30-97 as an emergency; operative 6-30-97 (Register 97, No. 27). A Certificate of Compliance must be transmitted to OAL by 10-28-97 or emergency language will be repealed by operation of law on the following day.

TN 98-015
Supersedes
TN _____

Approval Date 6/11/99

Effective Date August 1, 1998

OBRA 1987 Requirements for Nursing Facilities

Effective October 1, 1990

Comparison of Differences in OBRA 1987 Statutory Requirements, HCFA Regulations, and Current State Requirements

California Department of Health Services
Medi-Cal Policy Division

OBRA 1987 Requirement	HCFA Regulation (2/2/89)	Previous Federal Regulation	State Statute/Regulation	Analysis
Management of Personal Funds				
Management of personal funds - Upon a facility's acceptance of written authorization of a resident, the facility must manage and account for the resident's personal funds deposited with the facility as follows:	Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility ... (483.10(c)(2))	N/A	Each facility shall maintain safeguards and accurate records of a patient's monies and valuables entrusted to the facility's care, including the maintenance of a detailed inventory and at least a quarterly accounting of financial transactions made on the patient's behalf. (Title 22, 72529(a)(2))	Currently, management of a resident's personal funds is an optional facility service. Increased administrative cost for those facilities not currently managing patient trust accounts in accordance with OBRA provisions.
o Deposit - The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account that is separate from any of the facility's operating accounts and credits all interest earned to that account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.	The facility must deposit a resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's account to his or her account. (483.10(c)(3)(1))	N/A		

OBRA '.. Requirement	HCFA Regulation (2/2/89)	Previo.. Jeral Regulation	State Statute/Regulation	..alysis
Nursing Facility Consolidation				
Required Nursing Care; and Facility Waivers - (1) General Requirements - With respect to NF services, a NF: o except as provided in (2) below, must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and o except as provided in (2) below, must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Facility Waivers - o A state may waive the requirements in (1) above, if the facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts, to recruit appropriate personnel; if the state determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; and if the state finds that, for any such periods in which licensed nursing services are not available, an RN or physician is obligated to respond immediately to telephone calls from the facility. A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to	Facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: o licensed nurses, except when waived, as specified below; o other nursing personnel; o facility must designate a licensed nurse to serve as charge nurse on each shift. (483.30(a)) RN - o Facility must use an RN for at least 8 consecutive hours a day, 7 days a week (except when waived as specified below). o Facility must designate an RN to serve as DNS on a full-time basis. o The DNS may serve as charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. (483.30(b)) A facility may request a waiver from <u>either</u> the requirement that a facility provide an RN for at least 8 consecutive hours a day, 7 days a week, <u>or</u> the requirement that a facility provide licensed nurses on a 24-hour basis, including a charge nurse as specified in 483.30(a) above, if the following conditions are met: 1) The facility demonstrates to the satisfaction of the state that it has been unable, despite diligent efforts (including offering wages at the community prevailing rate for facilities), to recruit appropriate personnel; 2) The state determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility; 3) The state finds that, for	SNF 405.1124 ICF 442.1124 442.338 442.342	For NFs licensed as SNFs: Nursing service personnel shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for patients admitted for care. (Title 22, 72329(a)) The Department may require the facility to provide additional professional, administrative or supportive personnel when the Department determines through a written evaluation that additional staff is needed to provide for the health and safety of patients. (Title 22, 72501(g)) - Facilities licensed for 59 or fewer beds shall have at least 1 RN or a licensed vocational nurse, awake and on duty, in the facility at all times, day and night. - Facilities licensed for 60 to 99 beds shall have at least 1 RN or LVN, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing. The director of nursing shall not have charge nurse responsibilities. - Facilities licensed for 100 or more beds shall have at least 1 RN, awake and on duty, in the facility at all times, day and night, in addition to the director of nursing. The director of nursing shall not have charge nurse responsibilities. (Title 22, 72329(b,c,d)) Each facility shall employ sufficient nursing staff to provide a minimum daily average of 3.0 nursing hours per patient day. (Title 22, 72393(f)) For NFs licensed as ICFs: - Nursing service personnel shall be employed in the num-	The increased staffing for licensed nurses will impact only NFs currently licensed as ICFs. ICFs will also require a medical director, as defined in OBRA. Because of more stringent state licensing standards, the licensed nurse staffing and medical director requirements will not impact NFs currently licensed as SNFs.

OBRA 1987 Requirement	HCFA Regulation (2/2/89)	Previous
waiver authority by Secretary, shall be accepted to the same extent as is the state's certification of the facility. In granting or renewing a waiver, a state may require the facility to employ other qualified, licensed personnel.	any periods in which licensed nursing services are not available, an RN or physician is obligated to respond immediately to telephone calls from the facility; 4) A waiver granted under these conditions is subject to annual state review; and 5) In granting or renewing a waiver, a facility may be required by the state to use other qualified, licensed personnel.	
o If the Secretary determines that a state has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and exercise the authority of the state to grant waivers. (SSA, 1919(b)(4)(C))		

;ral Regulation	State Statute/Regulation	,lysis

ber and with the qualifications determined by the Department to provide the necessary services for those patients admitted for care. The Department may require a facility to provide additional staff whenever the Department determines through a written evaluation of patients and patient care in the facility that such additional staff are needed to provide adequate nursing care and treatment or to provide for the safety of the patients.

- Facilities shall employ an RN or LVN 8 hours per day on day shift, 7 days per week. In case of facilities where an LVN serves as supervisor of health services, consultation shall be provided by an RN, through formal contract, at regular intervals, but not less than 4 hours weekly.

- Facilities with 100 or more beds shall employ an RN 8 hours per day, on the day shift, 7 days per week. In addition, an RN or LVN employed 4 hours per day, 7 days per week, during the day for each 50 beds or portion thereof in excess of 100.

- Nursing stations shall be staffed by nursing personnel day and night when patients are housed in the nursing unit.

(Title 22, 73319(a,b,c,d))

OBRA . Requirement	HCFA Regulation (2/2/89)	Previo. ..eral Regulation	State Statute/Regulation	.alysis
N/A	Medical Director - The facility must designate a physician to serve as medical director. The medical director is responsible for: 1) implementation of resident care policies; and 2) the coordination of medical care in the facility. (483.75(k))	SNF 405.1122	Medical Director - The facility shall have a medical director who shall be responsible for standards, coordination, surveillance, and planning for improvement of medical care in the facility. The medical director shall act as a liaison between administration and attending physicians; be responsible for reviewing and evaluating administrative and patient care policies and procedures; act as a consultant to the Director of Nursing in matters relating to patient care services; and be responsible for reviewing employees' preemployment and annual health examination reports. (Requirement applies to Skilled Nursing Facilities) (Title 22, 72305)	

OBRA '.. Requirement	HCFA Regulation (2/2/89)	Previou. .deral Regulation	State Statute/Regulation	.nalysis
Social Worker				
Required Social Services - In the case of a facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services. (SSA, 1919(b)(7))	A facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. (483.15(g)(1)) A facility with more than 120 beds must employ a qualified social worker on a full-time basis. (483.15(g)(3)) Qualifications of a SW: A qualified social worker is an individual with: 1) Bachelor's Degree in social work; or 2) 2 years of social work supervised experience in a health care setting working directly with individuals; or 3) Similar professional qualifications. (483.15(g)(4))	SNF 405.1130 ICF 442.344(d) N/A N/A	A social worker is defined as: 1) clinical social worker (which requires a Master's Degree) - licensed by the California Board of Behavioral Science Examiners. 2) social work assistant - baccalaureate degree in the social sciences or related fields and who receives supervision, consultation and in-service training from a social worker. 3) social work aide - a staff person with orientation, on-the-job training, and who receives supervision from a social worker or social work assistant. (Title 22, 72105) Social Service Work Unit - Each social work service unit shall employ a staff for the number of hours to meet the needs of the patients. The social work service unit shall be organized, directed and supervised by a social worker, who is responsible for supervision of other social work staff, including social work assistants and social work aides. Social work service staff may include the social work assistant or the social work aide. Assigned functions and tasks shall be supervised by the social worker. Under conditions specified in the written patient care policies, procedures and job descriptions, the social work aide may be under the supervision of the social work assistant. (Title 22, 72437(a,b,c))	Increased staffing costs for those NFs with more than 120 beds to comply with Social Worker requirements, as defined in federal regulations.

OBRA ... Requirement	HCFA Regulation (2/2/89)	Previo... ...deral Regulation	State Statute/Regulation	...nalysis
Nurse Aide Training				
Required Training of Nurse Aides -				
A NF must not use (on any basis) any individual who is not a licensed health professional as a nurse aide in the facility on or after 1/1/90, for more than 4 months unless the individual: o has completed a training and competency evaluation program, or a competency evaluation program, approved by the state, and o is competent to provide such services. (SSA, 1919(b)(5)(A))	Effective 1/1/90, a facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time, temporary, per diem, or other basis, unless: o that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the state, and o that individual is competent to provide nursing and nursing related services. (483.75(g)(1))	SNF 405.1124 ICF 442.342	A nurse assistant precertification training program shall be conducted by a SNF, agency, or public education institution whose precertification program meets state requirements and is approved by the Department. (Title 22, 72331(i)(1)) No precertification training program to be conducted by a facility shall be approved unless the program meets the following: 1) The program shall be started within 3 months of employment of an uncertified nurse assistant in that facility; and 2) The program shall be presented in its entirety and completed no later than 6 months from the date of employment of any uncertified nurse assistant in the program. (Title 22, 72311(i)(11)(A,B)	California's current Nurse Aide certification program is comparable with OBRA requirements in all areas except the time period in which NFs must require NAs to complete a facility-based training and certification program.
Current employees - A NF must provide, for individuals used as a nurse aide by facility as of 7/1/89, for a competency evaluation program approved by the state, and such preparation as may be necessary for the individual to complete such a program by 1/1/90. (SSA, 1919(b)(5)(B))	Effective 7/1/89, a facility must provide, for individuals used as nurse aides, a competency evaluation program approved by the state, and preparation necessary to complete the program by 1/1/90. (483.75(g)(2))	N/A		
Competency - The NF must not permit an individual, other than in a training and competency evaluation program approved by the state, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use the individual as a nurse aide unless the facility has inquired of the state registry (see 1919(e)(2)(A)) as to information in the registry concerning the individual. (SSA, 1919(b)(5)(C))	Effective 1/1/90, a facility must permit an individual to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competence only when 1) the individual is in a training and competency evaluation program approved by the state, and 2) the facility has asked and not yet evaluated a reply from the state registry for information concerning the individual. (483.75(g)(3))	N/A	A precertification training program shall consist of at least the following: 1) 100 hours of clinical practice under the direct supervision of the instructor or a licensed nurse which shall usually be conducted during normal working hours and which shall include demonstrations of theory and basic nursing skills. Return demonstrations by the student shall be under the immediate supervision of the instructor or a licensed nurse. During clinical practice, there shall be no more than 15 students to each instructor at any time. Clinical practice shall take place in a skilled nursing facility or intermediate care facility and shall be concurrently with classroom instruction.	
Re-training Required - If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed paid nursing or nursing-relat-	Effective 1/1/90, when an individual has not performed paid nursing or nursing-related services for a continuous period of 24 consecutive months since the most recent completion of a training and competency evaluation program, the facility must require the	N/A		

OBRA 1987 Requirement	HCFA Regulation (2/2/89)
ed services, the individual shall complete a new training and competency evaluation program. (SSA, 1919(b)(5)(D))	individual to complete a new training and competency evaluation program. (483.75(g)(4))

Previous Federal Regulation	State Statute/Regulation	Analysis
	2) 50 hours of classroom instruction which may be conducted in a SNF, ICF, or educational institution and shall consist of content and for the duration of hours as specified in state regulations... (Title 22, 72331(i)(19)(A,B))	
	A nurse assistant shall be certified by the Department if the nurse assistant has satisfactorily completed an approved precertification training program. The course instructor shall notify the Department in writing no later than 10 working days after the completion of each program of the names, current address and social security numbers of these nurse assistants who successfully completed the program. The notification shall include the dates on which the course began and ended and the signature of the course instructor. The Department shall then issue the certificate. (Title 22, 72331(j))	
	Expiration and Renewal - Nurse aide certificates shall be renewed every 2 years and renewal shall be conditional upon the certificate holder submitting documentation of completion of 24 hours of in-service training per year obtained through an approved training program or as approved by the state department. A certificate which is not renewed within 4 years after its expiration cannot be renewed, restored, reissued, or reinstated except upon completion of a certification program unless deemed otherwise by the state department... (H&S Code, 1337.6(a,h))	

OBRA 1 Requirement	HCFA Regulation (2/2/89)	Previous Federal Regulation	State Statute/Regulation	Analysis
Resident Assessment				
Requirement - A NF must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which a) describes the resident's capability to perform daily life functions and significant impairments in functional capacity; b) is based on a uniform minimum data set (MDS) specified by the Secretary; c) uses an instrument specified by the state; and d) includes the identification of medical problems. Certification - Each assessment must be conducted or coordinated by an RN who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment. Frequency - An assessment must be conducted promptly upon admission (within 14 days) and by not later than 10/1/91 for each current resident; promptly after a sigificant change in the resident's physical or mental condition; and in no case less often than once every 12 months. The NF must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment. Use - The results of the assessment shall be used in developing, reviewing, and revising the resident's plan of care.	The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. (483.20) Comprehensive assessment - The facility must make a comprehensive assessment of a resident's needs, which a) effective 10/1/90, is based on a uniform data set specified by the Secretary and uses an instrument that is specified by the state; and b) describes the resident's capability to perform daily life functions and significant impairments in functional capacity. The comprehensive assessment must include at least the following information: o Medically defined condition and prior medical history; o Medical status measurement; o Functional status; o Sensory and physical impairments; o Nutritional status and requirements; o Special treatments or procedures; o Psychosocial status; o Discharge potential; o Dental condition; o Activities potential; o Rehabilitation potential; o Cognitive status; and o Drug therapy. (483.20(b)(1)) Accuracy of assessments - Each assessment must be conducted or coordinated, with the appropriate participation of health professionals. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (483.20(c)) (F-260-261)	SNF 405.1124(d) 405.1124(e) 405.1125 405.1129 405.1129(b) 405.1121(h) 405.1121(k)(5)	Nursing service shall include planning of patient care, including identification of care needs based upon an initial written and continuing assessment of the patient's needs with input from health professionals involved in the care of the patient. Initial assessments shall commence at the time of patient admission and be completed within 7 days of admission. (Title 22, 72311(a)(1)) Written and signed orders for diet, care, diagnostic tests and treatment of patients by others shall be required as a physician service in the facility. (Title 22, 72303(b)(5)) Planning of patient care shall include the development of an individual, written patient care plan which indicates the care to be given, the objectives to be accomplished and the professional discipline responsible for each element of care. Objectives shall be measurable and time-limited. Care planning shall also include reviewing, evaluating, and updating of the patient care plan by the nursing staff and other professional personnel involved in the care of the patient at least quarterly, and more often if there is a change in the patient's condition. (Title 22, 72311(a)(1)(B,C))	It is California's understanding that HCFA will be promulgating its resident assessment instrument and the uniform MDS in regulation in the near future. California assumes the instrument and MDS will mirror the draft HCFA released in September 1990.

Miscellaneous One-Time Start-Up Expenses

Various OBRA provisions will require one-time implementation costs, such as forms development, computer software upgrades, and staff orientation and training.

ral Regulation	State Statute/Regulation	lysis
		Because of more stringent written notice requirements, documentation, medical recordkeeping, and resident assessment requirements, California recognizes facilities will need to make miscellaneous changes initially to implement OBRA, including staff orientation and training on the various new provisions.

OBRA 19(uirement	HCFA Regulation (2/2/89)	Previous F Regulation	State Statute/Regulation	is
Resident Behavior and Facility Practices				
Restraints - Resident has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed a) to ensure the physical safety of the resident or other residents, and b) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.	The resident has the right to be free from any physical restraints imposed; or psychoactive drug administered for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. (483.13(a))	405.1121(k)(7) 442.311(f)	Resident has the right to be free from mental and physical abuse and to be free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician or other person lawfully authorized to prescribe care for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others. (Title 22, 72527(a)(8)) Restraints of any type shall not be used as punishment, as a substitute for more effective medical and nursing care, or for the convenience of staff. (Title 22, 72319(d)) Written policies and procedures concerning the use of restraints and postural supports shall be followed. No restraints with locking devices shall be used or available for use. Restraints shall be used in such a way as not to cause physical injury to the patient and to ensure the least possible discomfort to the patient. Full documentation of the episode leading to the use of the physical restraint, the type of restraint used, the length of effectiveness of the restraint time and the name of the individual applying such measures shall be entered in the patient's health record. When drugs are used to restrain or control behavior or to treat a disordered thought process, the specific behavior or manifestation of disordered thought process to be treated with the drug is identified in the health record. (Title 22, 72319 (in part))	The existing California regulations are comparable and in some cases exceed the OBRA requirement. The OBRA statute and regulation impose no additional requirements. As a result, there is no added facility cost to comply with this OBRA provision.

OBRA 19 quirement	HCFA Regulation (2/2/89)	Previous F

Quality of Care and Quality of Life

Provision of Services and Activities -
To the extent needed to fulfill all plans of care described in 1919(b)(2), a facility must provide or arrange for the provision of:

o nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

o medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

o pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

o dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

o an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident; and

o routine dental services (to the extent covered under the state plan) and emergency dental services to meet the needs of each resident.

Quality of Care -
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of Daily Living (ADLs) - Based on the comprehensive assessment of a resident, the facility must ensure that:

1) a resident's abilities in ADLs do not diminish unless circumstances of the resident's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:
(i) bathe, dress and groom;
(ii) transfer and ambulate;
(iii) toilet;
(iv) eat; and
(v) to use speech, language or other functional communication systems.

2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

3) A resident who is unable to carry out ADLs receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
(483.25(a))

405.1124(e)
442.342
442.343(a),(c)

l Regulation	State Statute/Regulation	
	Each patient shall be encouraged and/or assisted to achieve and maintain the highest level of self-care and independence. Every effort shall be made to keep patients active, and out of bed for reasonable periods of time, except when contraindicated by physician's orders. (Title 22, 72315(e))	In an analysis of the OBRA requirements, California has determined that current standards (in statute and regulation) are comparable to the OBRA requirements. As a result, no added facility cost is foreseen in order to comply with these OBRA quality of care and quality of life provisions.
	The supportive and restorative nursing and personal care needed to maintain maximum functioning of the patient shall be provided. (Title 22, 72315(f))	
	Nursing service personnel shall be employed and on duty in at least the number and with the qualifications determined by the Department to provide the necessary nursing services for patients admitted for care. The Department may require a facility to provide additional professional, administrative or supportive personnel whenever the Department determines through a written evaluation that additional staff is needed to provide for the health and safety of patients. (Title 22, 72319(a))	
	If a facility does not employ qualified personnel to render a specific service to be provided by the facility, there shall be arrangements through a written agreement with outside resources which shall meet the standards and requirements of these regulations. (Title 22, 72511(a))	
	Written arrangements shall be made for obtaining all necessary diagnostic and therapeutic services prescribed by the attending physician, podiatrist, dentist, or clinical psychologist .... If the ser-	

Regulation	State Statute/Regulation	/	s

vices cannot be brought into the facility, the facility shall assist the patient in arranging for transportation to and from the service location.
(Title 22, 72301(d))

PROJECTED COSTS
ASSOCIATED WITH NURSING HOME REFORM LEGISLATION
AS CONTAINED IN
THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (OBRA 87)

California Rate Year 1990/91

Rate Development Branch
Medi-Cal Policy Division
Department of Health Services

March, 1990

OBRA-87 COST ESTIMATES
(All Nursing Facilities)
California Rate Year 1990/91

SUBJECT	REQUIREMENT	COST PER PATIENT DAY [1/]	PROJECTED MEDI-CAL DAYS [5/]	ANNUAL MEDI-CAL COSTS
Protection of Resident Funds	Management of personal funds will be mandatory at patient discretion. Current regulations are optional.	NF/A&B = $ .21 DP NF/B = $ .46	21,865,000 2,135,000	$ 4,592,000 982,000
Nursing Facility Consolidation	Currently licensed freestanding Intermediate Care Facilities (ICFs) will require additional staffing to meet the higher level nursing facility certification requirements.	[2/] NF/A = $ 2.51 NF/B = $ .00 DP NF/B = $ .00	1,155,000 0 0	$ 2,899,000 0 0
Social Services	Facilities with more than 120 beds must employ a full-time qualified social worker.	[3/] NF/A&B = $ .44 DP NF/B = $ .33	8,365,000 1,535,000	$ 3,681,000 507,000
Resident Assessments	Facilities must conduct initially and periodically a comprehensive, standardized and reproducible assessment of each resident's functional capacity.	NF/A&B = $ .35 DP NF/B = $ .45	21,865,000 2,135,000	$ 7,653,000 961,000
	ESTIMATED OBRA ADJUSTMENTS	[4/] $ .56 - 3.51	SUBTOTAL	$ 21,275,000

1/ Refer to pages 3 and 13 - 16 for calculations used in determining the costs per patient day.

2/ This cost per patient day adjustment is applicable only to nursing facilities currently licensed as Freestanding ICFs.

3/ These cost per patient day adjustments are applicable only to the 270 nursing facilities with more than 120 licensed beds.

4/ The cost per patient day adjustment will vary depending on whether the facility is currently licensed as a freestanding ICF and/or is in the 121+ bedsize category.

5/ Medi-Cal days are listed for only those facilities affected by each individual requirement. The total number of projected Medi-Cal days is 24,000,000.

OBRA-87 NURSE AIDE TRAINING AND ONE-TIME START-UP COST ESTIMATES
(All Nursing Facilities)
California Rate Year 1990/91

SUBJECT	REQUIREMENT	COST PER PATIENT DAY 1/	PROJECTED MEDI-CAL DAYS	ANNUAL MEDI-CAL COSTS
Nurse Aide Training	Facilities must not use any individual working in the facility as a nurse aide for more than four months, unless that individual has completed a training and competency evaluation program.	NF/A&B = $ .12 DP NF/B = $ .00	21,865,000 0	$ 2,624,000 0
One-time Start-up Costs	Facilities will incur one-time start-up costs to develop forms, upgrade computer software and provide staff orientation.	NF/A&B = $ .31 DP NF/B = $ .31	9,100,000 900,000	$ 2,821,000 $ 279,000

1/ Refer to pages 3 and 13 - 16 for calculations used in determining the cost per patient day.

OBRA-87 COST ESTIMATES
AVERAGE 99 BED NURSING FACILITY
(All Nursing Facilities)
California Rate Year 1990/91

SECTION	SUBJECT	TOTAL COST PER FACILITY [1/]	NUMBER OF FACILITIES	ESTIMATED OBRA COST	TOTAL PATIENT DAYS	COST PPD
483.10(c)	Protection of Resident Funds	$ 6,275	1,240	$ 7,781,000	37,000,000	$ .210
483.5 483.30 483.75(k)	Nursing Facility Consolidation - Staffing and Medical Director	---	34	$ 1,881,312	750,000	$ 2.508
483.15(g)	Social Services	$ 24,978	270	$ 6,744,060	15,500,000	$ .435
483.20(b)	Resident Assessment	$ 10,510	1,240	$ 13,032,400	37,000,000	$ .352
483.75(g)1	Nurse Aide Training	$ 3,625	1,240	$ 4,495,000	37,000,000	$ .121
n/a	One-time Start-up Costs	$ 3,805	1,240	$ 4,718,200	37,000,000	$ .310 [2/]

1/
Refer to pages 4 - 16 for calculations used to determine facility costs.

2/
The annualized cost PPD for one-time start-up costs is $ .128 ($4,718,200/37,000,000). $ .128 PPD will be adjusted to $ .310 ($ .128 x 12/5) to fully reimburse NFs during rate year 1990/91 (March 1, 1991 - July 31, 1991).

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Protection of Resident Funds (c)(2) Management of Personal Funds: Mandatory at Patient Discretion, (c)(3) Deposit of Funds: $50.00+ in Interest Bearing Accounts, $50.00 or less in non-interest bearing accounts, (c)(4) Accounting and Records: Separate Accounting Records, (c)(5) Notice of Balances: Within $200.00 of SSI Resource Limit, (c)(7) Assurances of Financial Security: Surety Bond,	50% of patients/families will request patient fund service involving both a formal interest bearing account and a petty cash account for immediate fund availability. Half of the residents will be in facilities that do not currently offer this service. The average 99 bed nursing facility has 91 patients x 130% patient turnover = 119 x 25% or 30 additional patient accounts.	40 minutes to establish each new account x 30 patients = 20 hours x cost of administrative staff @ $12.00 per hour = $240.00.	$ 240.00
		20 minutes per month to post each account x 30 accounts = 15.0 hours x $12.00 per hour = $180.00 x 12 months = $2,160.00.	$ 2,160.00
	Additional accounts will require an average of 20 minutes per month bookkeeper time to post and balance both the interest and non-interest bearing accounts. An additional 8 hours per month will be required to balance bank statements, prepare account balance records, provide records to patients, and notify patients if balance of personal funds is within the $200.00 SSI resource limit. Finally, it will require 30 minutes per day to make change from the petty cash fund for the daily needs of patients.	8 hours per month to balance/reconcile bank statements, provide records and SSI resource limit notice to patients, or 8 hours x $12.00 per hour = $96.00 x 12 months = $1,152.00.	$ 1,152.00
		30 minutes per day to make change x 365 days = 182.5 hours x $12.00 = $2,190.00.	$ 2,190.00
	The average balance of funds per patient is $300.00. In the average 99 bed facility, 23 patients will require additional surety bonds at any given time (91 patients x 50% = 46 patients requesting patient fund service x 50% of facilities without current bonding). The average surety bond is $12.50 per $1,000.00 of funds.	$300.00 x 23 patients = $6,900/$1,000 = 6.9 x $12.50 = $86.00.	$ 86.00

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
	Approximately 10% of all nursing facilities have computerized patient accounting systems. Approximately 75% of all nursing facilities are computerized. One time cost to automate patient accounting systems will be capitalized over a five year period.	1240 facilities x 90% = 1116 facilities who will need computer software to do patient accounting. $1,650 for software = $1,650 x 1116 facilities = $1,841,400. 25% of facilities will need hardware @ $3,000 x 310 facilities = $930,000. Average cost per facility = $1,841,400 (software) + $930,000 (hardware) = $2,771,400/1240 facilities = $2,235 average cost per facility. $2,235/5 year capitalized period = $447 per year.	$ 447.00

Cost to Establish New Account	=	$ 240.00
Cost to Update Each Account	=	2,160.00
Cost to Reconcile Statements	=	1,152.00
Cost to Make Change	=	2,190.00
Cost of Surety Bond	=	86.00
Automation Cost	=	447.00
Resident Fund Accounting Cost		**$ 6,275.00**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Nursing Facility Consolidation Federal certification requirements will no longer distinguish between Intermediate Care Facilities (ICFs) and Skilled Nursing Facilities (SNFs). As a result, ICFs will require additional staffing to meet the higher level Nursing Facility (NF) certification requirements.	ICF services are provided exclusively in 34 freestanding facilities, averaging 60 beds per facility. With an occupancy rate of 98%, these facilities report 750,000 ICF patient days annually. It is estimated that 77% of all ICF patients, or 577,500 are Medi-Cal eligible. It is assumed all ICFs will remain as ICF facilities operating under current State licensing requirements. The provisions applicable to these facilities will be the upgrade from LVN to RN staffing on the weekend day shift, additional LVN staffing on the evening and night shift, and the addition of a medical director (28 of which already comply). It is assumed waivers will continue to be available for physical plant requirements. The additional RN staffing on the weekend day shift will affect 29 of the 34 facilities (facilities with less than 100 beds). It is estimated that 7 of the 29 ICFs are currently staffed with an RN on at least the day shift. It is also estimated that 10 of the 34 freestanding ICFs are staffed 24 hours per day with licensed nursing staff. Based on a survey of ICF facilities, it is assumed the remaining 24 facilities average 4.5 hours of LVN coverage during the evening or night shift.	Current RN hourly cost = $ 22.00 Minus LVN cost = (17.50) Net hourly cost = $ 4.50 x 8 hours per day x 8 Daily cost = $ 36.00 x 104 days annually x 104 Annual cost = $ 3,744 X 22 facilities x 22 $ 82,368	$ 82,368
		Current LVN cost = $ 17.50 x 11.5 hours per day x 11.5 Daily cost = $ 201.25 x 365 days annually = x 365 Annual cost = $ 73,456 x 24 facilities x 24 $1,762,944	$ 1,762,944

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
	A medical consultant contract will cost each of the six freestanding ICFs an estimated $500.00 per month. These facilities currently report 130,000 patient days (100,000 Medi-Cal patient days) annually.	Medical consultant contract @ $500.00 x 12 months = $6,000.00. $6,000.00 x 6 facilities = $36,000.00.	$ 36,000
	The remaining ICF patient days are provided in approximately 100 distinct parts of SNF facilities (DP/ICFs). The DP/ICFs already have RN staffing on weekends, 24 hour licensed nurse staffing and medical directors, as part of their SNF licensure. Since DP/ICF rates are based on freestanding ICF costs, the OBRA rate adjustment will impact all ICFs. DP/ICFs report 750,000 ICF patient days annually, of which 577,500 are Medi-Cal covered days.	Cost of RN on Weekend Day Shift =	$ 82,368
		Cost of 24 Hr. Licensed Nursing =	1,762,944
		Cost of Medical Director =	36,000
		Total ICF Cost	**$ 1,881,312**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Social Services Each nursing facility must provide medically-related social services to attain or maintain the highest practicable physical, mental or psychosocial well-being of each resident. The new regulations require nursing facilities with more than 120 beds to employ a full-time qualified social worker. The qualifications of a social worker are: (1) a bachelor's degree in social work, or (2) two years of social work supervised experience in a health care setting working directly with individuals, or (3) similar professional qualifications.	There are approximately 270 nursing facilities with more than 120 beds. The average facility in this category has 168 beds and reports approximately 53,600 patient days per year. It is estimated that 20% of all facilities with more than 120 beds currently employ a full-time qualified social worker.	1.0 full-time social worker = 2080 hours per year @ $15.00 per hour (including employee benefits) = $31,200.00 per year. $31,200.00/53,600 patient days annually = $ .582 per patient day x 80% (facilities with more than 120 beds and without a full-time qualified social worker) = a net cost increase for all facilities with more than 120 beds of $ .466 per patient day. $ .466 x 53,600 patient days annually = $24,978.00.	$ 24,978.00
		Total Social Worker Cost	**$ 24,978.00**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Resident Assessment Upon Admission *Nursing facilities must conduct* initially and periodically (see below) a comprehensive, accurate, *standardized, reproducible* assessment of each resident's functional capacity. The assessment instrument will be specified by the State and shall include a minimum data set, as defined by the Health Care Financing Administration.	Each nursing facility must assess 120 new admissions annually and will require 1.0 hour of RN time.	1.0 hour of RN time @ $22.00 x 120 assessments = $2,640.00.	$ 2,640.00
	Each assessment will require 1.0 hour of staff support per assessment. This staff includes dietary, CNAs, social services and/or activities staff.	1.0 hour of staff support @ $10.00 x 120 assessments = $1,200.00.	$ 1,200.00
	The DSD to conduct training on the resident assessment process and documentation requirements. Two 3.0 hour classes, or 6.0 hours per year. Additional 3.0 hours per year for RNs and CNAs to attend training.	6.0 hours of DSD time @ $18.00 per hour = $108.00.	$ 108.00
	The new assessment requirements *will increase five fold the time* and cost to complete the resident assessment.	The average training class hours will involve RNs (15 hours) and CNAs (20 hours) = 35 total staff hours. The weighted average cost per hour = 15 x $22.00 + 20 x $7.50 = $480.00/35 hours or $13.71 per hour. Twice a year training, or 70 hours x $13.71 per hour = $960.00.	$ 960.00
			$ 4,908.00
		Current assessment cost = 1/5 of projected cost, or $982.00.	($ 982.00)
			$ 3,926.00

Average cost to conduct each resident assessment = $4,908.00/120, or $40.90.

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Resident Assessment After Significant Change in Condition Assessments must be conducted promptly after a significant change in resident's physical or mental condition.	Each patient (120 throughout the year) will have one significant change in condition. This assessment will only require 1/3 of the time necessary to complete the initial resident assessment.	120 assessments x $13.63 (1/3 of $40.90) = $ 1,636.00	$ 1,636.00
Annual Resident Assessment Assessments must be conducted no less often than once every twelve months.	25% of patients require annual assessments or 30 annual assessments. Average cost per assessment = $40.90.	30 annual assessments x $40.90 = $ 1,227.00.	$ 1,227.00
Quarterly Review of Resident Assessments Nursing facilities must examine each resident no less than once every 3 months and, as appropriate, revise the resident's assessment to assure the continued accuracy of the assessment.	Quarterly reassessments will take 1/3 the time to complete the new resident assessment criteria and cost an estimated $13.63 per assessment. Since an annual assessment is required, only 3 quarterly assessments are needed per year. Average of 91 patients year round.	91 patients x 3 reassessments = 273 reassessments x $13.63 per assessment cost = $ 3,721.00.	$ 3,721.00

Cost of RA - Admission	$ 3,926.00
Cost of RA - Change in Condition	1,636.00
Cost of RA - Annual Assessment	1,227.00
Cost of RA - Quarterly Review	3,721.00
Total Resident Assessment Cost	**$10,510.00**

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Required Training of Nurse Aides Nursing facilities must not use any individual working in the facility as a nurse aide for more than four months, on a full-time, temporary, per diem or other basis, unless (1) that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State, and (2) that individual is competent to provide nursing and related services.	Nurse aides are currently required to complete their 150 hour certification program within six months of the date of employment. Nursing facilities who operate an approved facility based program conduct an average of four certification classes each year. The new requirement that nurse aides complete their training within four months will require two additional certification programs per year.	2 new 150 hour certification programs = 300 hours + 25% of class time for preparation and administration = 375 hours. 375 hours of DSD time @ $18.00 per hour = $ 6,750.00.	$ 6,750.00
		Additional training supplies and equipment = $ 500.00.	$ 500.00
			$ 7,250.00
	Half of all nursing facilities operate a facility based certification program, while the other half refer their nurse aides to community based certification programs, such as community colleges or regional occupational programs.	Current community based program costs = 1/2 of projected costs, or $3,625.00.	($ 3,625.00)
			$ 3,625.00
		Total Nurse Aide Training Cost	$ 3,625.00

OBRA Requirement	Assumptions	Cost Impact	Annual Cost
Nursing facilities will incur one-time start-up costs to develop and distribute additional resident notices, upgrade computer software and to provide staff orientation.	Resident notices must be in writing. Current industry practice is typically a telephone or personal discussion. Resident notices will require 40 hours of RN time and 40 hours of administrative staff time to develop new forms and processing procedures. It is assumed the facility will need to make available 4,400 copies of necessary notices.	40 hours of RN time @ $22.00 per hour = $880.00. 40 hours of administrative staff time @ $12.00 per hour = $480.00. 4,400 copies @ $ .05 per copy = $220.00. Total cost to develop forms ($880.00 + $480.00 + $220.00).	$ 1,580.00
	Upgrade of computer software will vary, but average $900.00 per nursing facility.	One-time cost for computer upgrade/software.	$ 900.00
	RN staff must provide the equivalent of one day of training to 2 LVNs and 9 administrative staff.	8 hours of RN time @ $22.00 per hour = $180.00. 16 hours of LVN time @ $17.50 per hour = $280.00. 72 hours of administrative staff time @ $12.00 per hour = $865.00. Total cost to provide staff orientation ($180.00 + $280.00 + $865.00).	$ 1,325.00

Cost to Develop Forms	=	$ 1,580.00
Cost for Computer Upgrade	=	900.00
Cost for Staff Orientation	=	1,325.00
Total One-Time Costs		**$ 3,805.00**

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Protection of Resident Funds

Assumptions

No Hospital-based Distinct Part Nursing Facilities (DP NFs) currently offer resident fund service (vs 50% for the "average 99 bed" Nursing Facility (NF) used in cost calculations), so the relative number of additional trust accounts will be doubled.

Patient turnover is 2.5 times as high for Medi-Cal patients in DP NFs as for all patients in the NF, so proportionately more new trust accounts will need to be set up and more surety bonds will need to be paid.

Additionally, since no DP NFs currently have patient trust accounts, none of them will have computerized patient accounting systems (vs 10% of the NFs) and all will need software.

All DP NFs (vs 75% of NFs) are computerized, so none will need to buy hardware. However, most are tied to a larger central computer with more costly software, not readily reprogrammed for patient trust account transactions. Software purchases and modifications will be approximately three times as costly.

All other assumptions are the same.

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Protection of Resident Funds (continued)

Cost Impact

The cost of patient fund service for NFs is modified as follows for DP NFs:

2 x 2.5 x $240.00 = $1,200.00, an increase of $960.00 to establish new accounts.

2 x $2,160.00 = $4,320.00, an increase of $2,160.00 to update each account.

2 x $1,152.00 = $2,304.00, an increase of $1,152.00 to reconcile statements.

2 x $2,190.00 = $4,380.00, an increase of $2,190.00 to make change.

2 x 2.5 x $86.00 = $430.00, an increase of $344.00 for surety bonds.

1.00/0.90 x $1,485.00 x 3 = $4,950.00, an increase of $3,465.00 for software or $693.00 per year capitalized over five years.

Elimination of the need to purchase hardware at an average cost of $750.00, or $150.00 per year capitalized over five years.

The net change is:

Establish New Account	$ 960.00
Update Each Account	2,160.00
Reconcile Statements	1,152.00
Make Change	2,190.00
Surety Bonds	344.00
Automation - Software	693.00
- Hardware	(150.00)
	$7,349.00

The overall facility cost of $6,275.00 for NFs will increase by $7,349.00 or 117.1% for DP NFs. So, the cost per patient day will increase by 117.1% from $.21 to $.46 for DP NFs.

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Resident Assessments

Assumptions

Patient turnover is 2.5 times as high for Medi-Cal patients in DP NFs as for all patients in NFs. Therefore, 2.5 times as many initial assessments upon admission will need to be done, but the number of assessments after a change in condition will not be different. Because patients do not stay as long on the average in DP NFs, only one fourth as many annual assessments will be required and one half as many quarterly reviews.

All other assumptions are the same.

Cost Impact

The cost of resident assessments for NFs is modified as follows for DP NFs:

2.5 x $3,926.00 = $9,815.00, an increase of $5,889.00 for assessments upon admission.

0.25 x $1,227.00 = $306.75, a decrease of $920.25 for annual assessments.

0.50 x $3,721.00 = $1,860.50, a decrease of $1,820.50 for quarterly reviews.

The net change is:

RA - Admission	$ 5,889.00
RA - Change in Condition	0.00
RA - Annual Assessment	(920.25)
RA -Quarterly Review	(1,860.50)
TOTAL	$ 3,108.25

The overall facility cost of $10,510.00 for NFs will increase by $3,108.25 or 29.6% for DP NFs. So the cost per patient day will increase by 29.6% from $.35 to $.45 for DP NFs.

VARIATION IN ASSUMPTIONS AND COSTS FOR HOSPITAL-BASED DISTINCT PART FACILITIES VS THE AVERAGE 99 BED NURSING FACILITY

Subject: Social Services

Assumptions

Of DP NFs with more than 120 beds, 40% currently employ a full-time qualified social worker (vs 20% for NFs).

Cost Impact

The cost to add a full-time social worker is modified as follows for DP NFs:

0.60/0.80 x $24,978.00 = $18,733.50, a decrease of $6,244.50 or 25.0%.

The overall facility cost of $24,978.00 for NFs will decrease by $6,244.50 or 25.0% for DP NFs. So the cost per patient day will decrease by 25.0% from $.44 to $.33 for DP NFs.

Subject: Nurse Aide Training

Assumptions

Among DP NFs, no facilities now do training programs (vs half of the NFs), and none of the DP NFs will institute them. Relatively fewer nurse assistants are hired in DP NFs and a greater percentage are already certified, so fewer new hires will need training and those who do will be trained in outside training programs.

Cost Impact

The additional cost to train nurse aides is estimated to be zero for DP NFs.

APPENDIX C

NURSING FACILITY RATE COMPARISON
(Rate Year 1989/90, Rate Year 1990/91 (PRE-OBRA '87), AND ESTIMATED RATE YEAR 1990/91 (WITH PROPOSED OBRA '87 ADJUSTMENTS))

1989/90 Peer Groups	1989/90 Rates	1990/91 Peer Groups (Pre-OBRA)	1990/91 Rates (Pre-OBRA)	1990/91 Peer Groups (With Proposed OBRA Adjustments)	Estimated 1990/91 Rates (With Proposed OBRA Adjustments)
SNF 1-59 LA	$ 61.18	SNF 1-59 LA	$ 63.75	NF (Level B) 1-59 LA	$ 64.74
" " BA	66.96	" " BA	70.02	" " " " BA	71.01
" " AO	62.23	" " AO	64.88	" " " " AO	65.87
					1/
SNF 60+ LA	56.66	SNF 60+ LA	61.41	NF (Level B) 60+ LA	62.40 1/
" " BA	66.56	" " BA	74.26	" " " " BA	75.25 1/
" " AO	60.41	" " AO	65.06	" " " " AO	66.05
					2/
DP/SNF (max. rate)	183.97	DP/SNF (max. rate)	192.04	DP/NF (max. rate)	193.26
ICF 1-99 LA	47.40	ICF 1-99 LA	49.72	NF (Level A) 1-99 LA	53.22
" " BA	47.40	" " BA	49.72	" " " " BA	53.22
" " AO	44.13	" " AO	44.84	" " " " AO	48.34
					1/
ICF 100+ LA	43.17	ICF 100+ LA	44.49	NF (Level A) 100+ LA	47.99 1/
" " BA	43.17	" " BA	44.49	" " " " BA	47.99 1/
" " AO	43.17	" " AO	44.49	" " " " AO	47.99
ICF/DD 1-59	78.28	ICF/DD 1-59	85.08	ICF/DD 1-59	85.08
" 60-299	62.01	" 60-299	69.67	" 60-299	69.67
" 300+ (max. rate)	181.33	" 300+ (max. rate)	205.89	" 300+ (max. rate)	205.89
ICF/DDH 4-6	94.12	ICF/DDH 4-6	106.09	ICF/DDH 4-6	106.09
" 7-15	86.21	" 7-15	102.60	" 7-15	102.60
ICF/DDN 4-6	121.61	ICF/DDN 4-6	130.06	ICF/DDN 4-6	130.06
" 7-15	112.35	" 7-15	124.94	" 7-15	124.94
Subacute Hosp. Vent.	332.35	Subacute Hosp. Vent.	351.47	NF (Level B) Subacute Hosp. Vent.	352.69
" Free. Vent.	220.38	" Free. Vent.	233.23	" " " " Free. Vent.	234.22
" Hosp. Non-Vent.	313.94	" Hosp. Non-Vent.	332.19	" " " " Hosp. Non-Vent.	333.41
" Free. Non-Vent.	201.99	" Free. Non-Vent.	213.98	" " " " Free. Non-Vent.	214.97

1/ Nursing facilities (Level A or B) with more than 120 beds will receive an additional $ .44 PPD.

2/ Hospital based nursing facilities with more than 120 beds will receive an additional $ .33 PPD.

APPENDIX D

Report No. 01-89-01

Reimbursement Study:

Skilled Nursing and Intermediate Care Services

Rate Development Branch
Medi-Cal Policy Division
Department of Health Services

July, 1989

DEPARTMENT OF HEALTH SERVICES REPORT

This study establishes Medi-Cal (Medicaid) reimbursement for skilled nursing facilities (SNFs) including subacute services, intermediate care facilities (ICFs), intermediate care facilities for the developmentally disabled (ICF/DDs), and SNFs with special treatment program (STP) services as required by Section 249 of Public Law 92-603, and complies with state legislation and the requirements of the Medi-Cal program. Reimbursement rates for intermediate care facilities for the developmentally disabled-habilitative (ICF/DD-H) and intermediate care facilities for the developmentally disabled-nursing (ICF/DD-N) facilities are established in separate studies, under Section V page 7 of the State Plan Attachment 4.19-D.

SUMMARY OF METHODOLOGY

1. Collected data from cost reports submitted to the Office of Statewide Health Planning and Development (OSHPD) and to the Department's Audits and Investigation Division (A&I) and distributed it to the appropriate reimbursement category by level of care, bed size class, and geographic area where applicable.

2. Applied an adjustment when SNFs reported ICF days, but did not separate ICF and SNF costs. This converted ICF days to SNF days in order to standardize the calculations.

3. Applied an adjustment to all facilities in the universe, reflecting the difference between reported and audited costs and patient days for field audited facilities. The adjustment included an allowance for settled appeals.

4. Updated each facility's adjusted costs from the midpoint of its fiscal year through January 31, 1990, the midpoint of the State's 1989-90 Rate Year, to bring all costs to a common base period. For this purpose, the reported costs were separated into the categories of (1) fixed or capital related costs; (2) property taxes; (3) labor costs; and (4) all other costs.

5. Determined prospective class median rates for each category of reimbursement based on projected costs for each facility.

METHODOLOGY

Data Collection

The Department received cost reports from 1,191 long term care facilities. Data from these cost reports were used for this study. Some cost data may have been excluded from the study because facilities either failed to submit a report on a timely basis or received permission from OSHPD to file a late report.

All cost reports in the universe had fiscal year endings in the State's 87-88 Fiscal Year. After checks for accuracy and completeness of data, the data sheets were keypunched for entry into the computer system. Each data record contained the following elements:

1. Provider number
2. Facility number and address
3. An assigned identification number
4. State facility number (county code)
5. Licensed bedsize
6. Type of ownership (profit, non-profit)
7. Fiscal period
8. Total patient days by level of care
9. Total Medi-Cal patient days by level of care
10. Total reported costs by level of care
11. Total plant operations
12. Plant operations by level of care
13. Fixed or capital related costs
14. Property tax where identified
15. Facility type: freestanding or distinct part of an acute care facility

Audit Adjustment

This adjustment accounts for the difference between reported and audited costs and patient days. Because of the time lag in performing field audits, it was necessary to use the 1987 calendar year field audit findings for this computation.

The randomly selected field audits were performed in accordance with regulations dealing with reasonable and patient related costs as published in Title XVIII of the Social Security Act (Medicare) and Title 22, Division 3, California Code of Regulations. Primary audit guidelines came from the federal Department of Health and Human Services Manual (HCFA 15-1).

In accordance with the field audit requirements, there could be no less than 15 percent of facilities in each of the 1-59 and 60+ bedsize groups selected to develop the audit percentage adjustments. This produced samples of SNFs sufficiently large to produce an audit ratio with 90 percent confidence that did not deviate from the estimated class population by more than 2 percent.

For ICFs and ICF/DDs, there are relatively few facilities in their groups, so the entire universe was audited. Then, where available, facility specific audit adjustments were applied. For facilities who, for some reason, had no audit, the average for their group was computed and applied.

The adjustments were calculated as the simple average of the ratio of audited costs and days to reported costs and days. A computation from settled appeals of cost report audits used in prior rate studies was used to obtain final ratios. The SNF 60-299 bedsize has been combined with the 300+ bedsize and the audit adjustment for this group was applied to the DP/SNF category. The audit average adjustments were:

Bedsize	Ratios
SNF 1-59	.95288
SNF 60 + and DP/SNFs	.95655

ICF Adjustment

An adjustment was made for the differential between SNF costs and ICF costs that were not segregated by the facilities reporting ICF days. The reported ICF days were multiplied by .6871 (the historical ratio of ICF to SNF costs) to equate ICF days to SNF days. The total cost was then divided by the adjusted total patient days to determine SNF cost per patient day.

Cost-of-Living Update

Adjusted costs for each facility were updated from the midpoint of the facility's fiscal year through January 31, 1990.

Adjusted costs were divided into categories and treated as follows:

1. Fixed or Capital Related Costs - These costs represent depreciation, leases and rental, interest, leasehold improvements, and other amortization. As these costs remain relatively constant over a number of years, there was no logical basis to update costs in this category.

2. Property Taxes - These costs, where identified, were updated at a rate of two percent annually converted to a monthly basis of .1667 percent per month. The basis for this adjustment was that Proposition 13 limits property tax increases to two percent a year, except where property is reassessed upon sale.

   Some facilities did not report property taxes, either because they were nonprofit and exempt from such tax, or because they had a lease or rental agreement that included those costs.

3. Labor Costs - A ratio of salary, wage and benefit costs to the total costs of each facility was used to determine the amount of the labor cost component to be updated. This ratio was determined by using the overall ratio of salaries and wages to total costs from data extracted by OSHPD from the labor report. Benefits were added that represent all wage related benefits including vacation and sick leave. The final ratios were: .6550 for SNF's, .5774 for ICFs, and .6645 for ICF/DD's.

   A table of factors was developed to update labor costs for each facility from the midpoint of its cost reporting period to the midpoint of the state's rate year (January 31, 1990). This table used industry specific wage data reported by the facilities through December 31, 1988 to the state's Employment Development Department. The data were then projected to the midpoint of the State's rate year, January 31, 1990.

4. All Other Costs - These costs are the total costs less fixed or capital related costs, property taxes, and labor costs. The update for "All Other Costs" utilized the California Consumers Price Index (CCPI) for "All-Urban Consumers", and figures projected by the Department of Finance through January 31, 1990.

Subacute Services of Skilled Nursing Care

Payment for subacute services in SNFs continues to be based largely on the original reimbursement model due to lack of sufficient cost data from participating facilities.

Increments for Increase in Licensure Fees

An amount was added to the updated cost of each facility for increases in licensure fees which were effective July 1, 1988 and 1989.

Increment for the State's New Minimum Wage Program

Salaries, wages and benefits were updated to reflect the July 1, 1988 increase in the state minimum wage requirements. Added to the updated facility costs was a per diem adjustment which varied by facility level of care, geographical location and bedsize category as determined by the department's study entitled "Long-Term Care Minimum Wage Study" - - Report No. 01-88-02.

Adjustment for OBRA Personal Hygiene Items

The updated cost of each facility was adjusted to include the costs of certain personal hygiene items, as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987. Added to the updated facility costs was a per diem adjustment which varied by facility level of care as determined by the department's study entitled "Study to Determine the Cost of Providing OBRA Personal Hygiene Items" - Report No. 01-89-02.

Class and Median Determination

For SNF's, ICF's and SNF-STP's, classes were grouped by bedsize and three geographical locations: (1) Los Angeles, (2) the six Bay Area counties; Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara, and (3) all other counties. Classes for ICF/DD's were established by bedsize and level of care on a statewide basis, as there was an insufficient number of facilities for geographical groupings. The DP/SNF and ICF/DD 300+ bedsize classes were also determined on a statewide basis by level of care.

RECOMMENDED RATES (August 1989)

Payment to facilities providing skilled nursing and/or intermediate care are recommended as follows:

Rates for SNF Services

Bedsize	Los Angeles County	Alameda, Contra Costa, Marin, San Francisco, San Mateo & Santa Clara Counties	All Other Counties
1-59	$61.18	$66.96	$62.23
60 +	$56.66	$66.56	$60.41

For SNFs that are distinct parts of acute hospitals, regardless of geographical location, the lesser of costs as projected by the Department or the prospective class median rate of $183.97.

Rates for Subacute Services of Skilled Nursing Care

	Freestanding Facility	Hospital-Based Facility
Ventilator Dependent Patient	$220.38	$332.35
Other Subacute Patients	$201.99	$313.94

Rates for ICF Services

Bedsize	Los Angeles County	Alameda, Contra Costa, Marin, San Francisco, San Mateo & Santa Clara Counties	All Other Counties
1-99	$47.40	$47.40	$44.13
100+	$43.17	$43.17	$43.17

Rates for ICF/DD Services

	Bedsize 1-59	60-99	100-299
Range A	$74.53	$58.66	$57.36
Range B	$78.28	$62.01	$62.01

	60-99 With 1-59 Distinct Part	100+ With 1-59 Distinct Part	100+ With 60-99 Distinct Part
Range A	$59.90	$58.65	$58.55
Range B	$62.01	$62.01	$62.01

ICF/DDs with the licensed bed capacity of 300 or more beds shall be entitled to payment for services at the lesser of costs as projected by the Department or the prospective class median rate of $181.33.

Special Treatment Program Services for the Chronic Mentally Disordered

The rate for a supplemental payment to SNF and ICF providers for services to the chronic mentally disordered, as defined in Section 51511.1, Title 22, CCR, will remain at $5.72 per patient day.

Rural Hospital Swing Bed Rates

Reimbursement is established at the prospective class median rate of all SNF nonsubacute distinct parts of rural acute care hospitals which participate in the Medi-Cal program. This rate is $133.71.

Leave of Absence and Bed Hold Rates

Payment is reduced when the patient is on leave of absence or for bed hold as authorized by Sections 51535 and 51535.1, Title 22, CCR. The lesser payment is accounted for by savings in the raw food and dietary costs. The reduction in rates will be $3.28 per patient day, based on the average of the Los Angeles and San Francisco area increases listed in the CPI Selected Areas "Food at Home Costs".

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

TIMELY PAYMENT OF CLAIMS - DEFINITION OF A CLAIM BY TYPE OF SERVICE

A. Pharmacy Services	A claim is defined as one line item of service
B. Long Term Care Facility Services	A claim is defined as one line item of service
C. Hospital Inpatient Services	A claim is defined as a bill for services
D. Hospital Outpatient Services & Other Institutional Outpatient Services	Commencing 12/1/79, a claim is defined as one line item of service
E. Physician Services and Other Medical Services	Through 2/29/80, a claim is defined as a bill for service. Commencing 3/1/80, a claim is defined as one line item of service

TRANSMITTAL # 79-17 EFFECTIVE 1-1-80
REC'D RO 2-28-80 SUPERSEDED BY TRANSM #
APPROVED 4-4-80 EFFECTIVE

State/Territory: California

CONDITIONS UNDER WHICH DIRECT BENEFICIARY REIMBURSEMENT WILL BE MADE UNDER THE MEDI-CAL PROGRAM (Post-Approval Period of Eligibility)

NOTE: Italicized print has been added for clarification only and is not meant to infer a change in meaning from the court-approved Plan of Implementation.

General

The Department of Health Care Services (DHCS) will adjudicate completed beneficiary claims for reimbursement of Medi-Cal covered physician and dentist service expenses incurred and paid for by the beneficiary during the post-approval period (the time period from issuance of the beneficiary's Medi-Cal card and beyond) for valid claims (1) by those Medi-Cal eligible beneficiaries to whom payment may be made in compliance with Section 1905(a) of the Social Security Act as interpreted by 42 CFR 447.25; and (2) for select instances in order to make corrective payments based on a successful appeal by a beneficiary who did not receive continued eligibility for covered services pending the appeal decision, and sought and paid for covered services (in compliance with 42 CFR 431.246 and 431.250(b)). Overpayments of share of cost will be included in the latter instance to the extent the overpayment is established through application of the notice and appeal process.

Adjudication will be within approximately 120 days from receipt of the completed claim(s). *Upon adjudication of approved claims, payment will be made immediately.*

The methods of beneficiary reimbursement during the post-approval period of eligibility will include (1) "cooperative" payments by providers; (2) "recoupment" actions against uncooperative Medi-Cal providers; and, (3) when necessary, direct reimbursement to the beneficiary up to the current Medi-Cal rate for the applicable Medi-Cal covered service(s), *at the time the service was rendered.*

The Medicaid claim for these expenditures will be made at the applicable Medi-Cal rate established for the respective service under the Medi-Cal program, at the time the service was rendered and at the current Federal Medical Assistance Percentage (FMAP) in effect.

Criteria for Processing Beneficiary Claims

Beneficiary claims must meet the following criteria in order to qualify for reimbursement. Claims that do not meet the criteria will be denied. The criteria for processing/adjudicating a beneficiary claim include all of the following:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was (were) provided.
- The claimed service(s) was (were) provided on or after June 27, 1997 *(court-ordered start date for beneficiary reimbursement).*
- The service(s) provided was (were) a Medi-Cal covered service; i.e., a Medi-Cal benefit at the time the service(s) was (were) rendered.
- The beneficiary was eligible to receive the service(s) at the time the service(s) was (were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits *that would have been eligible for Federal Financial Participation (FFP) at the time the service(s) was (were) rendered.*
- The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made.
- The beneficiary has submitted a completed STD 204 form.
- For those services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider(s) that show(s) medical necessity for the service(s).
- The claimed cost(s) was (were) not required to meet co-payments, share of cost or other cost-sharing requirement(s).
- The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, another Medi-Cal funded program, the healthcare provider or by a third party.
- The beneficiary did not have other health coverage at the time the service(s) was (were) rendered that would have been obligated to pay the claimed cost(s).

Claims for Medi-Cal covered service(s) provided during the evaluation period for date(s) of service on or after February 2, 2006 *(court-mandated date before which the State cannot require that the beneficiary seek services only from a Medi-Cal-enrolled provider)* must show that the service(s) was (were) rendered by a provider who at the time the service(s) was (were) rendered, was an active Medi-Cal authorized provider.

Submission Timelines for a Timely Claim

- The claim(s) for services that was (were) provided from June 27, 1997 through Novernber 16, 2006, must be received by DHCS by November 16, 2007 or within 90 days after issuance of the Medi-Cal card, whichever is the longest period of time.

- The claim(s) for services that was (were) provided after November 16, 2006, must be received by DHCS within one calendar year after the date the service(s) was (were) rendered or within 90 days after issuance of the Medi-Cal card or no more than 90 days after the issuance of a final appeals decision.

State/Territory: California (SPA 06-019-A)

CONDITIONS UNDER WHICH DIRECT BENEFICIARY REIMBURSEMENT WILL BE MADE UNDER THE MEDI-CAL PROGRAM
(Retroactive and Evaluation Periods of Eligibility)

NOTE: Italicized print has been added for clarification only and is not meant to infer a change in meaning from the court-approved Plan of Implementation.

General

The Department of Health Care Services (DHCS) will adjudicate completed beneficiary claims for reimbursement of Medi-Cal covered service expenses incurred and paid for (1) during the retroactive period (up to 3 months prior to the first day of the month of application to the Medi-Cal program); and (2) during the evaluation period (from the time of application to the Medi-Cal program until the issuance of the beneficiary's Medi-Cal card). Adjudication will be within approximately 120 days from receipt of the completed claim(s). *Upon adjudication of approved claims, payment will be made immediately.*

The methods of beneficiary reimbursement during the retroactive and evaluation periods of eligibility will include (1) "cooperative" payments by providers; (2) "recoupment" actions against uncooperative Medi-Cal providers; and, (3) when necessary, direct reimbursement to the beneficiary up to the current Medi-Cal rate for the applicable Medi-Cal covered service(s), *at the time the service was rendered.*

The Medicaid claim for these expenditures will be made at the applicable Medi-Cal rate established for the respective service under the Medi-Cal program, at the time the service was rendered and at the current Federal Medical Assistance Percentage (FMAP) in effect.

Criteria for Processing Beneficiary Claims

Beneficiary claims must meet the following criteria in order to qualify for reimbursement. Claims that do not meet the criteria will be denied. The criteria for processing/adjudicating a beneficiary claim include all of the following:

- The beneficiary was eligible for Medi-Cal at the time the service(s) was (were) provided.

- The claimed service(s) was (were) provided on or after June 27, 1997 *(court-ordered start date for beneficiary reimbursement)*.

- The service(s) provided was (were) a Medi-Cal covered service; i.e., a Medi-Cal benefit at the time the service(s) was (were) rendered.

- The beneficiary was eligible to receive the service(s) at the time the service(s) was (were) rendered. Reimbursement to beneficiaries with restricted benefits will be available only for those specific restricted Medi-Cal benefits *that would have been eligible for Federal Financial Participation (FFP) at the time the service(s) was (were) rendered.*

- The beneficiary has submitted a valid claim which includes dated proof of payment by the beneficiary or, for the service(s) received (cancelled check, provider receipts, etc.), with an itemized list of services covered by the payment, and to whom the payment was made.

- The beneficiary has submitted a completed STD 204 form.

- For those services that would have required Medi-Cal authorization, the beneficiary has documentation from the medical or dental provider(s) that show(s) medical necessity for the service(s).

- The claimed cost(s) was (were) not required to meet co-payments, share of cost or other cost-sharing requirement(s).

- The beneficiary was not previously reimbursed for the claimed service(s) by Medi-Cal/Denti-Cal, another Medi-Cal funded program, the healthcare provider or by a third party.

- The beneficiary did not have other health coverage at the time the service(s) was (were) rendered that would have been obligated to pay the claimed cost(s).

Claims for Medi-Cal covered service(s) provided during the evaluation period for date(s) of service on or after February 2, 2006 *(court-mandated date before which the State cannot require that the beneficiary seek services only from a Medi-Cal-enrolled provider)* must show that the service(s) was (were) rendered by a provider who at the time the service(s) was (were) rendered, was an active Medi-Cal authorized provider.

Submission Timelines for a Timely Claim

- The claim(s) for services that was (were) provided from June 27, 1997 through November 16, 2006, must be received by DHCS by November 16, 2007 or within 90 days after issuance of the Medi-Cal card, whichever is the longest period of time.

- The claim(s) for services that was (were) provided after November 16, 2006, must be received by DHCS within one calendar year after the date the service(s) was (were) rendered or within 90 days after issuance of the Medi-Cal card, whichever is the longest period of time.

Third Party Liability

(1) California obtains information for the purpose of determining the legal liability of third parties from data exchanges with the State Wage and Income Collection Agencies (SWICA), SSA wage and earnings data, State Title IV-A Agency, and State Workers Compensation files and from the diagnosis and trauma code edits on a monthly basis.

California has a waiver for conducting a data exchange with the State Department of Motor Vehicles (DMV), since accident reports do not provide enough information to enable identification of a Medicaid beneficiary.

(2) The methods the California Medicaid agency uses for meeting the follow-up requirements contained in 42 CFR 433.138 (g)(1)(i) and (g)(2)(i) are as follows:

SWICA, SSA Wage and Earnings File, and State Title IV-A Agency

The California Medicaid agency's Income and Eligibility Verification System (IEVS) crossmatches applicant and recipient identification data with earning and income files consisting of State wage data; unemployment insurance benefit and income data; social security wage, benefits and income data; and the Internal Revenue Service and/or Franchise Tax Board unearned income data. The IEVS match is performed for all persons applying for, or receiving, Aid to Families with Dependent Children (Title IV-A) and Medi-Cal Only. The Department utilizes the IEVS earnings and income data match to identify potential Other Health Coverage in Medi-Cal cases. The county eligibility worker issues a Health Insurance Questionnaire (form DHS 6155) to an applicant with a current or past work history identified by IEVS, if health coverage is/was an employment benefit. These forms identify whether the county worker obtained the employment information from an IEVS match. The county eligibility worker enters the appropriate OHC code on the Medi-Cal Eligibility Data System (MEDS).

The completed DHS 6155 is then sent to the Department. The Department applies priority processing to the IEVS-identified DHS 6155 forms. Priority processing initiates update to the Health Insurance System (HIS) file within the federally-required forty-five (45) day time period.

Collection of Health Insurance Information During Initial Application and Redetermination Processes for Medicaid Eligibility

Under California's Medicaid Program, eligibility determinations are performed by fifty-eight county welfare departments for individuals applying for Aid to Families with Dependent Children and the Medically Needy Program, and by the Social Security administration (SSA), in accordance with a 1634 agreement for individuals who apply for Supplemental Security Income/State Supplemental Program (SSI/SSP) benefits. Health insurance information is collected by county eligibility and SSA staff and reported to the Department for inclusion in the Medicaid Management Information System (MMIS) data base.

The collection of health insurance information is performed during the initial application and redetermination process. County eligibility and SSA staff ask the applicant whether health insurance is available. Where an indication of insurance exists, the applicant, or the parent or guardian of the applicant is given a health insurance form to complete. The county welfare departments use the Health Insurance Questionnaire (DHS 6155) form and SSA uses the TPL Information Statement (SSA-8019-U2) form to collect and report applicant health insurance information to the Department. The county eligibility workers are also responsible for noting coverage in the eligibility case file and coding the recipients' case records on the automated Medi-Cal Eligibility Data System (MEDS) with Health Insurance indicator codes. Since SSA does not have access to MEDS, the Health Insurance coding of SSI/SSP recipients' case records is performed by the Department. The Health Insurance codes are printed on the Medi-Cal identification cards to alert providers to bill the insurance coverage. Codes are also passed to the State's fiscal intermediary via the Fiscal Intermediary Access to MEDS Eligibility (FAME) file for processing claims involving private health insurance. As federally required, the Department updates the HIS file within sixty (60) of receiving the health insurance information.

Collection of Health Insurance Information by the Child Support Enforcement Program

The Child and Medical Support (IV-D) Program is administered by the Department of Social Services through the County District Attorney Offices, Family Support Divisions. These are known as the California Child Support Enforcement agencies or local IV-D agencies. These IV-D agencies play an important role in medical support establishment and enforcement. They are responsible for securing and enforcing court orders requiring the Absent Parent (AP) to obtain and maintain health insurance coverage for dependent children who do not reside in the AP's home. The IV-D agencies are also required to transmit relevant AP health insurance information to the Department when medical support is secured for the Medi-Cal eligible dependent child through a court or administrative order.

The IV-D agencies report AP health insurance information to the Department via the Medical Insurance Form (DHS 6110). This form is designed to be completed by the Medi-Cal dependent's parents, employer of the AP, other third party providing health insurance to the AP, or the IV-D agency. The completed forms are sent by the IV-D agencies to the Department for review and processing. Since Federal regulations exclude IV-D cases from cost avoidance, the Department updates MEDS with the appropriate post payment recovery code and adds billing information to the Health Insurance System (HIS) file. The only exception to coding with a post payment recovery code is if the Medi-Cal dependent's insurance coverage is through a prepaid health care delivery system; then the case is coded for cost avoidance. The Department updates the HIS file within sixty (60) days of receiving the DHS 6110 form as is federally required.

Other Health Insurance Collection Sources

The Department also obtains beneficiary health insurance information from other sources. These sources are as follows:

Referrals:

Referrals are acknowledgments received either through correspondence or telephone calls from beneficiaries, medical providers, and other government or private agencies informing the Department that a Medi-Cal beneficiary has other health coverage. Each referral is developed by Department staff in order to obtain all necessary beneficiary health insurance information. Referrals that require additional information are researched through the source of the referral or by sending a Health Insurance Questionnaire (DHS 6155A) to the beneficiary. Once complete health insurance information is obtained, it is input into the Health Insurance System (HIS) file to be utilized for program post payment billings and cost avoidance. The Department also updates MEDS with the appropriate Other Health Coverage (OHC) indicator code.

Medi-Cal Claims Processing System:

Within the Medi-Cal claims processing system, the Medi-Cal Fiscal Intermediary (FI) identifies claims with potential third party liability. The providers are instructed to enter any insurance payments in a field on the claim called "Amount Other Coverage Paid". If an amount is entered in this field, the FI looks at the Other Health Coverage (OHC) code on the FAME file. The FI creates a monthly file of Social Security Numbers of beneficiaries whose claims have an amount in this field, but no OHC code on the FAME file. The Department then mails Health Insurance Questionnaires (DHS 6155As) to these beneficiaries to obtain specific health insurance information. Upon receipt of the completed DHS 6155A, the Department enters the new health insurance information on the Health Insurance System (HIS) file and updates MEDS with the appropriate OHC indicator code. This in turn creates a transaction to the FI which provides sufficient information to bill the insurance carrier for any claims paid on behalf of these beneficiaries where the provider had not indicated an insurance payment. The HIS information is also input to the FAME file and coded on the Medi-Cal card so that future claims will be cost avoided.

Health Insurance Premium Payment TPL Review:

When an individual inquires about participation in the Health Insurance Premium Payment (HIPP) Program, Department staff requests the individual's Social Security Number in order to review MEDS for share of cost, Other Health Coverage (OHC) information, Medicare entitlement and Medi-Cal eligibility. If MEDS indicates no OHC code, the individual is asked if he/she has health insurance coverage. If the individual responds in the affirmative, he/she is asked to provide specific health insurance information (i.e., carrier name, carrier address, policy number, and scope of coverage). Once complete information is obtained, the Department updates MEDS with the appropriate OHC indicator code and the Health Insurance System (HIS) file.

Workers' Compensation

California's Medicaid agency receives copies of all Workers' Compensation Appeals claims. Within sixty (60) days, these claims are matched against eligibility files to identify Medi-Cal eligibles. If Medi-Cal eligibility is identified, a potential third party liability case is established and an investigation is made to determine if a recovery can be made. In addition, copies of applications for adjudication are sent to the Department of Social Services (DSS). In turn, DSS sends these copies to the appropriate local IV-D agency District Attorney (DA) office. If the absent parent has employer related health insurance coverage available, the county DA office provides follow-up service to identify whether the appeal can be linked to an active Medi-Cal dependent IV-D case. If the DA discovers employer coverage, the DA requires the absent parent, through a court or administrative order, to provide health insurance and to complete a medical insurance form (DHS 6110). The completed DHS 6110 forms are sent by the DA's office to the Department.

(3) As stated in Section "Third Party Liability (1)", California's Medicaid agency does not obtain information from DMV.

(4) The Medicaid agency conducts edits of paid claims to identify treatment provided as a result of injury using diagnosis codes 800 through 999, with the exception of 994.6. The Department generates letters, seeking potential third party liability information, to recipients who have received $500 or more in paid services when the service listed on the claim relates to an injury diagnosis. If there is no response within sixty (60) days and paid claims exceed $750, a second letter is sent. If no response is received, a follow-up file is printed and personal contact is attempted by staff.

A quarterly report is generated indicating the number and total dollar value of all cases by individual trauma code. A second report, generated semi-annually, lists recoveries made by trauma code.

(5) In addition to the federally required data exchanges, the California Medicaid agency also conducts the following optional data exchanges:

Private Health Insurance Carrier Data Exchanges

To identify Medi-Cal eligibles with private health coverage, the California Medicaid agency conducts data matches with a variety of private health insurance carriers and other third party entities. Carriers are identified for data matches based on carrier size and cost benefit of the match. Data matches are also conducted by the Department's private contingency fee contractor(s). The Department or its contractor negotiates contracts and produces exchange tapes. From the resulting information, the Department updates beneficiary health insurance information on MEDS and the Department's HIS file. Through data matches, Medi-Cal beneficiaries having health coverage with the health insurance carrier at present or any time during the past six months are identified.

BENDEX

The California Medicaid agency uses the BENDEX system to identify the Social Security status and changes to a Medi-Cal beneficiary's Social Security benefits or earnings. The Department also uses the BENDEX system to identify Medicare Part A and B entitlement, option codes, effective dates, termination dates, and termination codes. The automated Buy-In system interfaces with MEDS to extract Medicare entitlement information from the BENDEX file and initiates changes on MEDS. This information is then used in the Medicare coding of the Medi-Cal card.

The Department of Social Services uses the BENDEX file for verification of AFDC recipient unearned income. This information is provided to counties through the Payment Verification System (PVS), which is a subset of IEVS. In addition, verification of wages is provided to counties from information in the Beneficiary Earnings Exchange Record (BEER) through the PVS. The BEER is part of the BENDEX.

Third Party Liability

(1) The State Medicaid agency will use the pay and chase method for the purpose of recovering Third Party Liability when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. Pay and chase activities are initiated in accordance with the established threshold for seeking reimbursement of medical benefits from a liable third party.

Non-emergency wheelchair van and litter/medi-van transportation (medical services codes 0015-0029) and Adult Day Health Care(ADHC)services(medical services codes Z8500-Z8506) are not benefits covered by the health insurance industry. Therefore, the Department is exempting these services from cost avoidance and post-payment billings because the cost to the State to edit the claims to cost avoid such services and to create post-payment billings on a recovery basis is not justified.

(2) The threshold amounts used in determining whether to seek reimbursement from a liable third party are as follows:

a) Payments for care to eligibles with health insurance are computer billed monthly when $100 in accumulated health care services have been paid by Medi-Cal. If the $100 threshold is not reached within three (3) years, no claim is generated.

b) Potential Casualty Insurance and Worker Compensation cases are established when Medi-Cal payments of $500 and over have been made.

c) When unsolicited money of any value is received, it is retained, researched to identify why it was received and credited to the proper account or returned to sender.

d) Estate Recovery claims are filed in the probate or distribution of assets of deceased Medi-Cal beneficiaries when the health care services paid by the State exceed $750.

e) Provider and beneficiary overpayments are billed when the amount of the overpayment liability exceeds $100.

(3) The dollar amount or timeframe, used by the State Medicaid Agency for accumulating health care services payments to determine whether to bill a particular third party are defined in #2 above.

State/Territory: California

State Methodology on Cost-Effectiveness of Individual and Group Health Plans

I. The methodology used by California for determining cost-effectiveness of paying private or employer related health insurance premiums for existing coverage shall be as follows:

A. Any Medi-Cal beneficiary who has an existing, medically confirmed, medical condition that has been determined by the Department of Health Care Services (DHCS) to be a cost-effective condition is deemed to meet the cost-effectiveness criteria for the Health Insurance Premium Payment (HIPP) program.

B. If A is not applicable, then the following steps are used to determine cost-effectiveness:

Step 1. Use the insurance carrier evidence of coverage policy booklet to identify that health care services provided to the individual and/or family is covered for the specific condition.

Step 2. Calculate cost-effectiveness by using the amount Medi-Cal would pay for the specific condition annually, deduct the individual's and/or family's Share of Cost (SOC), then divide by the annual insurance premium cost.

Step 3. If the result is 1.1 or more, it is cost-effective to pay the premiums for an individual and/or family.

NOTE: The HIPP program shall pay the premiums for additional family members, who are not HIPP eligible, if the individual's premium amount cannot be separated from the family premium amount. In determining cost-effectiveness, the entire cost of the premium will be calculated against the estimated medical costs associated with the Medi-Cal eligible beneficiary.

II. Purchasing or paying for health insurance coverage is deemed NOT cost-effective when:

A. A Medi-Cal/Medicare beneficiary is enrolled in Medicare.

B. A Medi-Cal beneficiary's insurance is provided through the Major Risk Medical Insurance Board or the Managed Risk Medical Insurance Program.

C. A non-custodial parent has been ordered by the court to provide medical support.

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

Third Party Liability

(1) The methods the California Medicaid agency uses for meeting the requirement of prompt notice to the child support enforcement (CSE) agency for referral whenever medical assistance is furnished to families who may be in need of CSE services are through regulation and manual procedure instruction to the county welfare departments. Prompt notice would be no later than two working days after a determination of medical assistance eligibility has been made.

Title 22, California Code of Regulations (CCR), Section 50157(j) states what forms must be forwarded within two days to the Family Support Division/District Attorney.

Our Medi-Cal Eligibility Manual (MEM), Article 23, at Section 23F, Referral Process, instructs the counties that, "All new applicants for Medi-Cal in the appropriate aid codes will be referred within two days of the Medi-Cal eligibility determination for medical support enforcement services."

(2) The methods the California Medicaid agency used for meeting the requirement to describe the criteria and procedures by which the Medicaid agency implemented referral of Medicaid cases to the CSE agency are:

(a) By implementation of the medical support regulations (Title 22, Sections 50060.6, 50771.5, 50101, 50157, 50175, 50185, 50227, 50351, and 50379) which were effective April 16, 1993.

(b) Medi-Cal Eligibility Manual (MEM)--Article 23 contains the procedures for Medicaid case referrals to the CSE agencies. The program was initially implemented on July 1, 1993 with Article 4R of MEM, which is now Article 23 of MEM.

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

Partial Procedures are as follows:

23B. **CONDITION OF ELIGIBILITY**

1. **MEDI-CAL ONLY**

The county must inform an applicant for or beneficiary of Medi-Cal only that, as a condition of eligibility, the applicant or beneficiary must:

- o Assign to the State the applicant's or beneficiary's rights to any medical support and payments;
- o Cooperate in obtaining medical support and payments;
- o Cooperate in establishing paternity for a child born out of wedlock for whom aid is requested;
- o Cooperate in identifying and locating the absent parent; and
- o Provide information about possible entitlement to medical support and payments available through any third party.

If the applicant or beneficiary is found ineligible for Medi-Cal because of the above, this will not affect the child(ren)'s Medi-Cal eligibility. The applicant can withdraw the application, close the case, or become an ineligible member of the Medi-Cal Family Budget Unit (MFBU).

STATE: CALIFORNIA

CITATION | CONDITION OR REQUIREMENT

23C. PATERNITY ESTABLISHMENT

1. **PURPOSE**

As a condition of Medi-Cal eligibility, an applicant/recipient must cooperate in paternity establishment when there is a child born out of wedlock for whom Medi-Cal is being sought. A referral is made to establish the existence of a father and child relationship and the duty of support. When two unmarried adults seek Medi-Cal for themselves and their children but do not cooperate with medical support, then the county must make a medical support referral for the children. A referral should be made whenever a child is born out of wedlock. (Title 22, CCR, Section 50101(b).)

23D. PETITION TO THE COURT

The county must notify each applicant or beneficiary placed in the following aid codes that the California Child Support Enforcement (IV-D) Agencies must, by law, petition to the court to include health insurance coverage in support orders when a child receives Medi-Cal. Referral in aid codes cited below will be for children under 18 with an absent parent or when a child is born out of wedlock. HOWEVER, NO UNDOCUMENTED PERSONS, NO PREGNANT WOMEN, ~~AND NO ONE APPLYING FOR MINOR CONSENT SERVICES~~ WILL BE REFERRED. Also, referrals for infants will be made after the 60-day postpartum period. (For explanation of absent parent situations, please refer to MEM Article 1-B.) PSD

In situations where the applicant is filing for retroactive Medi-Cal only, no referral will be made. In situations where the absent parent is already providing health insurance, no referral is necessary.

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

MEDI-CAL AID CODES (See Pages 4a to 4h) PJD

The following aid codes are the ones for which the Medi-Cal Eligibility Worker must refer the children with an absent parent.

7A	34	51	72	83
24	37	64	79	
27	47	67	82	

AFDC AID CODES (See Pages 4a to 4h) PJD

The following aid codes are the ones for which child support referrals, including medical support, should have already been made by the AFDC or Foster Care Intake Worker for AFDC or foster care cases.

30	33	40	45
32	35	42	

1. **PREGNANT WOMEN**

Medical support referrals will **NOT** be made on the absent/unmarried parent of an unborn child until the end of the 60-day postpartum period. If the absent/unmarried parent of the unborn has other eligible children in the MFBU, a medical support referral for these children will **NOT** be made until the end of the 60-day postpartum period of the pregnant caretaker parent. If a pregnant caretaker parent has other eligible children in the MFBU with a different absent parent than for the unborn, a medical support referral will **NOT** be made on the children of the absent or unmarried parent(s) until the end of the 60-day postpartum period of the pregnant caretaker parent.

22	NO MEDI-CAL ISSUED		Aid to the Blind-Special Circumstances (BLIND-SC--Optional)--Special circumstances payments to blind adult recipients of SSI/SSP and SSP only.	
23	FULL	Y/N	Aid to the Blind-LTC Status (FFP). Covers persons who meet the federal criteria for blindness, are medically needy, and are in LTC status.	
24	FULL	NO	Aid to the Blind Medically Needy (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant but are eligible ~~for Medi-Cal~~ only.	
26	FULL	NO	Aid to the Blind-Pickle Eligibles (FFP). Covers persons who meet the federal criteria for blindness and are covered by the provisions of Lynch v. Rank. (See aid code 16 for definition of Pickle eligibles).	
27	FULL	YES	Aid to the Blind-Medically Needy, SOC (FFP). Covers persons who meet the federal criteria for blindness who do not wish or are not eligible for a cash grant, but are eligible for Medi-Cal only. SOC is required of the beneficiaries.	
28	FULL	NO	Aid to Blind-IHSS (FFP). Covers persons who meet the federal definition of blindness and are eligible for IHSS. (See aid code 18 for definition of eligibility for IHSS).	
3A	FULL	NO	California Alternative Assistance Program - Aid to Families with Dependent Children. Family Group (CAAP-AFDC [FG]) (FFP). Individuals who have declined a federal cash grant and instead will receive child care assistance and Medi-Cal.	
3C	FULL	NO	California Alternative Assistance Program - Aid to Families with Dependent Children. Unemployed Parent Group (CAAP-AFDC [U]) (FFP). Individuals who have declined a federal cash grant and instead will receive child care assistance and Medi-Cal.	
3P	FULL	NO	AFDC Unemployed Parent (FFP) cash--Aid ~~to Families in which a child is deprived~~ because of the unemployment of a parent living in the home and the unemployed parent meets all federal AFDC eligibility requirements. This population is the same as aid code 35, except that they are exempt from the AFDC grant reductions.	X

3R	FULL	NO	Aid to Families with Dependent Children (AFDC)-Family Group (FFP) in which the child(ren) is deprived because of the absence, incapacity, or death of either parent. This population is the same as aid code 30 except that they are exempt from the AFDC grant reductions.	X
30	FULL	NO	AFDC-FG (FFP). Provides Aid to Families with Dependent Children in a family group in which the child(ren) is deprived because of the absence, incapacity, or death of either parent.	
32	FULL	NO	AFDC-FG ~~(State Only) (non-FFP cash grant/~~ FFP for Medi-Cal eligibles). Provides aid to families in which a child is deprived because of the absence, incapacity, or death of either parent, who does <u>not</u> meet all federal requirements, but State rules require the individual(s) be aided.	
33	FULL	NO	AFDC-Unemployed Parent (State Only) (non-FFP cash grant/FFP for Medi-Cal eligibles). Provides aid to pregnant women (before their last trimester) who meet the federal definition of an unemployed parent but are not eligible because there are no other children in the home.	
34	FULL	NO	AFDC MN (FFP). Covers families with deprivation or parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only.	
35	FULL	NO	AFDC-U (FFP Cash). Provides aid to families in which a child is deprived because of unemployment of a parent living in the home, and the unemployed parent meets all federal AFDC eligibility requirements.	
36	FULL	NO	Aid to Disabled Widow/ers (FFP). Covers persons who began receiving Title II SSA before age 60 who were eligible for and receiving SSI/SSP and Title II benefits concurrently and were subsequently discontinued from SSI/SSP but would be eligible to receive SSI/SSP if their Title II disabled widow/ers reduction factor and ·bsequent COLAs were disregarded.	
37	FULL		AFDC-MN (FFP). Covers families with deprivation of parental care or support who do not wish or are not eligible for a cash grant but are eligible for Medi-Cal only. SOC required of the beneficiaries.	

38	FULL	NO	Continuing Medi-Cal Eligibility (FFP). Edwards v. Kizer court order provides for uninterrupted, no SOC Medi-Cal benefits for families discontinued from AFDC, until the family's eligibility for Medi-Cal only has been determined and an appropriate Notice of Action sent.	
39	FULL	NO	Initial Transitional Medi-Cal (TMC) - Six Months Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to increased earnings, or hours of employment, or loss of the $30 and 1/3 disregard.	
4C	FULL	NO	AFDC-FC Voluntarily Placed (Fed) (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been voluntarily placed in foster care.	
4K	FULL	NO	Emergency Assistance (EA) Program (FFP). Covers juvenile probation cases placed in foster care.	
4O	FULL	NO	AFDC-FC/Non Fed (State FC). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care.	
42	FULL	NO	AFDC-FC/Fed (FFP). Provides financial assistance for those children who are in need of substitute parenting and who have been placed in foster care (IV-A) (IV-E).	
44	Restricted to pregnancy-related services	NO	Income Disregard Program. Pregnancy (FFP). United States Citizen/Permanent Resident Alien/PRUCOL Alien. Provides family planning, pregnancy-related, and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level.	
45	FULL	NO	Children Supported by Public Funds (FFP). Children whose needs are met in whole or in part by public funds other than AFDC-FC	
47	FULL	NO	Income Disregard Program (FFP). Infant - United States Citizen/Permanent Resident Alien/PRUCOL Alien. Provides full Medi-Cal ~~benefits to infants up to one year old~~ and continues beyond one year when inpatient status, which began before first birthday, continues and family income is at of below 200 percent of the federal poverty level.	

TN No. 94-002 Approval 6/11/01 Effective 4/1/94

48	Restricted to pregnancy-related services	NO	Income Disregard Program. Pregnant-Undocumented/Nonimmigrant Alien (But Otherwise Eligible). Provides family planning, pregnancy-related, and postpartum services for any age female if family income is at or below 200 percent of the federal poverty level.	
49 Phasing Out	Restricted to pregnancy-related services	NO	Income Disregard Program. Pregnancy-Amnesty Alien. Provides planning, pregnancy-related, and postpartum services to any age female with income at or below 200 percent of the federal poverty level.	
5F	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers non-immigrant and undocumented pregnant aliens who do not have proof of permanent resident alien, PRUCOL, or amnesty alien status, but who are otherwise eligible for Medi-Cal.	
5K	FULL	NO	Emergency Assistance (EA) Program (FFP). Covers child welfare cases placed in EA foster care.	
50	Restricted to CMSP emergency services only	Y/N	CMSP MI-Restricted. Covers persons who have undetermined immigration status.	
51 (Expires 12/31/94)	FULL	Y/N	IRCA Aliens - Full Medi-Cal Benefits. Pre-1982 Amnesty Alien (ABD or under 18).	
52 (Expires 12/31/94)	Restricted to pregnancy and emergency services	Y/N	IRCA Aliens - Restricted Medi-Cal Benefits. Pre -1982 Amnesty Alien (Not ABD; not under 18).	
53	Restricted to LTC services only	Y/N	Medically Indigent - LTC (Non-FFP). Covers persons age 21 or older and under 65 years of age who are residing in a Skilled Nursing or Intermediate Care Facility (SNF or ICF) and meet all other eligibility requirements with or without a SOC. Medi-Cal does not cover Acute Inpatient Hospital Care.	
54	FULL	NO	Four-Month Continuing Eligibility (FFP). Covers persons discontinued from AFDC ~~due to the increased collection of~~ child/spousal support payments.	

TN No. 94-002 Approval 6/11/01 Effective 4/1/94

55	Restricted to pregnancy and emergency services	NO	Aid to Undocumented Aliens in LTC Not PRUCOL. Covers undocumented aliens in LTC not Permanently Residing Under Color of Law (PRUCOL). LTC services: State-only funds; Emergency and pregnancy-related services: State and federal funds. Beneficiaries will remain in this aid code even if they leave LTC.	
56 (Expires 12/31/94)	FULL	Y/N	IRCA. Amnesty Aliens SAWS/RAWS (ABD or under 18). Covers amnesty SAWS/RAWS who are aged, blind, disabled, or under 18 years old and otherwise eligible.	
57 (Expires 12/31/94)	Restricted to pregnancy and emergency services	Y/N	IRCA. Amnesty Aliens SAW/RAW (Not ABD, not under 18). Covers amnesty SAWS/RAWS who are 18 through 64 years old, not blind or disabled, and who are otherwise eligible to Medi-Cal.	
58	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers nonimmigrant and undocumented aliens who do not have proof of permanent resident alien, PRUCOL, or amnesty alien status, but who are otherwise eligible to Medi-Cal.	
59	FULL	NO	Additional TMC - Additional Six Months Continuing Eligibility (FFP). Covers persons discontinued from AFDC due to increased earnings, or hours of employment, or loss of the $30 and 1/3 disregard.	
6A	FULL	NO	Disabled Adult Child(ren) (DAC)/Blindness (FFP)	
6C	FULL	NO	Disabled Adult Child(ren)/Disabled (FFP).	
60	FULL	NO	SSI/SSP Aid to the Disabled (FFP). A cash assistance program administered by the SSA that pays a cash grant to needy persons who meet the federal definition of disability.	
62	NO MEDI-CAL CARD ISSUED		Aid to the Disabled-Special Circumstances (DISABLED-SC--Optional)-- Special circumstances payments to adult recipients of SSI/SSP and SSP only.	
63	FULL	Y/N	Aid to the Disabled-LTC Status (FFP). Covers persons who meet the federal definition of disability who are medically needy and in LTC status.	
64	FULL	NO	Aid to the Disabled-Medically Needy (FFP). Covers persons who meet the federal definition of disability and do not wish or are not eligible for cash grant, but are eligible for Medi-Cal only.	

65	FULL	Y/N	Aid to the Disabled Substantial Gainful Activity/Aged, Blind, Disabled-Medically Needy IHSS (non-FFP). Covers persons who: (a) were once determined to be disabled in accordance with the provisions of the SSI/SSP program but became ineligible because of engagement in substantial gainful activity as defined in Title XVI regulations; (b) also continue to suffer from the physical or mental impairment that was the basis of the disability determination; and (c) have the costs of IHSS deducted from their monthly income.	
66	FULL	NO	Aid to the Disabled Pickle Eligibles (FFP). Covers persons who meet the federal definition of disability and are covered by the provisions of the Lynch v. Rank lawsuit. No age limit for this aid code.	
67	FULL	YES	Aid to the Disabled-Medically Needy, SOC (FFP). (See aid code 64 for definition of Disabled-MN). SOC is required of the beneficiaries.	
68	FULL	NO	Aid to the Disabled IHSS (FFP). Covers persons who meet the federal definition of disability and are eligible for IHSS. (See aid codes 18 and 65 for definition of eligibility for IHSS.)	
69	Restricted to emergency services	NO	Income Disregard Program. Infant (FFP) - Undocumented/Nonimmigrant Alien (But Otherwise Eligible). Provides emergency services only for infants under one year of age and beyond one year when inpatient status, which began before first birthday, continues and family income is at or below 200 percent of the federal poverty level.	
7A	FULL	NO	100 Percent Program. Child (FFP) United States Citizen, Lawful Permanent Resident/PRUCOL/IRCA Amnesty Alien [ABD or Under 18]. Provides full benefits to otherwise eligible children born after September 30, 1983, ages 6 to 19 and ~~beyond when inpatient status began before~~ the 19th birthday and family income is at or below 100 percent of the federal poverty level.	

TN No. 94-002 Approval 6/11/01 Effective 4/1/94

72	FULL	NO	133 Percent Program. Child-United States Citizen/Permanent Resident Alien/PRUCOL Alien (FFP). Provides full Medi-Cal benefits to children ages one up to six and beyond when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.	
73	Restricted to Parenteral Hyperalimenation-related expenses	Y/N	Medi-Cal TPN Only Program/Medi-Cal TPN Supplement Program (Non-FFP). Covers persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.	
74	Restricted to emergency services	NO	133 Percent Program (OBRA). Child Undocumented/Nonimmigrant Alien (but otherwise eligible) (FFP). Provides emergency services only for children ages one up to six and beyond when inpatient status, which began before sixth birthday, continues, and family income is at or below 133 percent of the federal poverty level.	
75 Phasing Out	Restricted to pregnancy-related services	NO	Asset Waiver Program (Pregnant). Provides family planning, pregnancy related, and postpartum services for amnesty aliens under the state-only funded expansion of the Medi-Cal program for a pregnant woman having income between 185% and 200% of the federal poverty level. (State-Only Program).	
76	Restricted to 60-Day Postpartum Services	NO	60-Day Postpartum Program (FFP). Provides Medi-Cal at no SOC to women who, while pregnant, were eligible for, applied for and received Medi-Cal benefits. They may continue to be eligible for postpartum services and family planning. This coverage begins on the last day of pregnancy and ends the last day of the month in which the 60th day occurs.	
79 Phasing Out	FULL	NO	Asset Waiver Program (Infant). Provides full Medi-Cal benefits to infants up to 1 year, and beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is between 185% and 200% of the federal poverty level (State-Only Program).	
8A	(QDWI) No Medi-Cal Issued		Qualified Disabled Working Individual (QDWI) (FFP) -- Provides state paid Medicare Part A premiums for working disabled individuals under age 65. No Medi-Cal card will be issued; the Medicard care will be used for services.	

8C	(SLMB) No Medi-Cal Issued		Specified Low-Income Medicare Beneficiaries (SLMB) (FFP) – Provides state paid Medicare Part B premiums for certain specified low-income Medicare beneficiaries. No Medi-Cal card will be issued. The Medicare card will be used for Part B services.	
8F	CMSP services only (companion aid code)	Y/N	CMSP Companion Aid Code. Covers persons eligible for certain benefits under the Medi-Cal program and other benefits under CMSP. 8F is used in conjunction with Medi-Cal aid codes 52, 53, and 57 to facilitate the payment of claims for covered benefits. 8F will appear as a special aid code and will entitle the eligible client to full-scope CMSP coverage for those services not covered by Medi-Cal.	
80	Restricted to Medicare expenses	NO	Qualified Medicare Beneficiary (QMB). Provides payment of Medicare Part A and B premiums and Part A and B coinsurance and deductibles for eligible low-income aged, blind, or disabled individuals.	
81	FULL	Y/N	MI-Adults Aid Paid Pending (Non-FFP). Aid Paid Pending for persons over 21 but under 65 with or without share of cost.	
82	FULL	NO SOC	MI-Person (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent. Covers persons until age 22 who were in an institution for mental disease before age 21. Persons may be continued in this aid code until age 22 if they have filed for a State hearing.	
83	FULL	YES	MI-Person SOC (FFP). Covers medically indigent persons under 21 who meet the eligibility requirements of medically indigent.	
84	CMSP Services Only (No Medi-Cal)	NO	CMSP MI-A (Non-FFP). Covers medically indigent adults age 21 and over but under 65 years who meet the eligibility requirements of medically indigent.	
85	CMSP Services Only (No Medi-Cal)	YES	CMSP MI-A (Non-FFP). Covers medically indigent adults age 21 and over but under 65 years, who meet the eligibility requirements of medically indigent.	
86	FULL	NO	MI-Confirmed Pregnancy (FFP). Covers persons aged 21 years or older, with confirmed pregnancy, who meet the eligibility requirements of medically indigent.	

TN No. 94-002 Approval 6/11/01 Effective 4/1/94

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

When a woman with a child(ren) has applied for Medi-Cal but refuses to cooperate in medical support and does not claim good cause, she becomes ineligible for Medi-Cal and designated as an ineligible member of the MFBU. The woman's child(ren) may be eligible for Medi-Cal if otherwise eligible and she has not withdrawn the application or asked to close the case. If this caretaker parent then becomes pregnant and applies for Medi-Cal, she may be eligible until her 60-day postpartum period ends. A referral for the caretaker parent and the new child can be made at the completion of the 60-day postpartum period.

If a caretaker parent has a child(ren) and has cooperated with medical support requirements, but then becomes pregnant, the medical support referral process should not be interrupted. The pregnancy should be reported to the FSD/DA, but no referral on the new child should be made until the 60-day postpartum period ends. The rule in on-going medical support cases is if there is any change in the case, it should be reported to the FSD/DA via Form CA 371. The FSD/DA should be advised of any changes (e.g., discontinuance from AFDC, new Medi-Cal case).

An unmarried/absent parent may apply for Medi-Cal and medical support services for the caretaker parent at the hospital if the caretaker parent is unable to fill out an application. Under Title 22, CCR, Section 50143, if a person is unable to file an application for Medi-Cal, "(2) a person who knows of the applicant's need to apply" may file the application. An unmarried/absent person would qualify under this definition.

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

2. **OBRA REFERRALS**

If the caretaker parent or mother is undocumented and her children are also undocumented, no medical support referral will be made. If the caretaker parent/mother is undocumented and the children are citizens or IRCA's (Immigration Reform and Control Act), a medical support referral will be made. No undocumented children will be referred.

If the caretaker parent has both OBRA children and citizen children and requests that both be referred for medical support enforcement, the county will only make a referral on the citizen children. Medical support enforcement referrals will not be made on the OBRA children. There are no referrals on OBRA children because they receive restricted benefits and the absent parent may not be a citizen or in the United States.

3. **CONTINUING ELIGIBILITY**

Under this program, infants born to Medi-Cal eligible women are automatically "deemed eligible" for one year, provided they continue to live with their mother and the mother remains eligible for Medi-Cal, or would remain eligible if she were still pregnant. There is no parental allocation from the father to the infant during the period of Continued Eligibility; only the mother's income, before any increases, will be allocated to the infant. However, for purposes of medical support enforcement, the father/absent parent still has a legal responsibility for the health and welfare of his children and, at the end of the 60-day postpartum period, a medical support referral must be made.

4. **FOSTER CARE CHILDREN**

Medical support enforcement referrals will not be done by the county Medi-Cal Eligibility Worker on foster care children. The AFDC or Foster Care Intake Workers will make child support referrals, including medical support for all foster care children. Foster care children are automatically eligible for Medi-Cal after utilizing whatever other health coverage is available. ~~This is clarified in Section 903 of the Welfare & Institutions Code, Liability for Costs of Support. This section prohibits any imposition of medical costs upon the natural parent(s) until the county has first exhausted any eligibility the child may have under private insurance coverage, standard or medically indigent Medi-Cal coverage, and the Robert W. Crown California Children's Services Act. If there are any costs over and above 100 percent of the average Medi-Cal payment that are not covered under any of the coverages listed, the county may choose to impose those costs.~~ PJD

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

~~The Medi-Cal program automatically grants a Medi-Cal card to children in foster care, and providers are instructed to bill the Medi-Cal program first. Medi-Cal will pay the provider of service. Then Medi-Cal will seek repayment from the other health coverage.~~ RSD

5. **ADULT CHILDREN**

Adult children under Medi-Cal are persons 14 to 18 years of age who are not living in the home of a parent or caretaker relative and who do not have a parent, caretaker relative or legal guardian handling any of their financial affairs (Title 22, CCR, Sec. 50014). Also, the parents do not claim the child as a dependent in order to receive a tax credit or deduction for state or federal income tax purposes. Adult children would not be referred for medical support enforcement.

Disabled Adult Children under the Pickle program are at least 18 years of age or older. They will not be referred for medical support enforcement. Referrals are for those under 18.

6. **TRANSITIONAL MEDI-CAL**

No transitional Medi-Cal cases are to be referred. This includes children in aid codes 39, 54, and 59. These families were initially on AFDC and lost their cash grant due to increased earnings, increased hours of employment, or increased allocation of child/spousal support payments. Transitional Medi-Cal is provided to these families as an aid in helping them become self-sufficient. If they apply for Medi-Cal Only at the end of their transition period, they should be treated as a new case and a referral should be made.

STATE: CALIFORNIA

CITATION | CONDITION OR REQUIREMENT

7. **DECEASED ABSENT PARENT**

No medical support enforcement referral will be initiated for deceased absent parents. However, sufficient substantiation of the fact that the absent parent is deceased is required.

23F. REFERRAL PROCESS

DHS has adopted the Department of Social Services' (DSS') child support procedures, including the forms and referral process, for the Medi-Cal program. The county welfare department shall refer Medi-Cal Only absent parent cases to the Family Support Division/District Attorney (FSD/DA) for applicable support enforcement services. The county welfare department will also make referrals for paternity establishment services to the FSD/DA when there is a child born out of wedlock. These services will be provided without application or application fee.

All new applicants for Medi-Cal in the appropriate aid codes will be referred **within two days** of the Medi-Cal eligibility determination for medical support enforcement services. No referral is to be made until a Medi-Cal determination is approved. Existing cases will be referred at the time of redetermination. These redeterminations will be face-to-face for proper notification and forms completion by the beneficiary. The county welfare department will inform Aid to Families with Dependent Children (AFDC) recipients of changes related to medical support enforcement. Whenever the county becomes aware that an on-going case is an absent parent situation or there is a child born out of wedlock, a medical support referral should be made. Do not wait for redetermination if there is a change in the case.

Please notify the applicant or beneficiary if he or she receives direct payment for medical support for services which were paid for by Medi-Cal. Payments made in this situation should be forwarded to DHS. If payments are not forwarded to DHS, the Department's Third Party Liability Branch will pursue reimbursement from him or her. (Further information can be found in Section 23M.)

Each applicant for Medi-Cal with an absent parent or a child born out of wedlock will be advised of child support services available through the FSD/DA. If a Medi-Cal applicant indicates all child support services are wanted, the case should be handled in the same manner as a non-aid case, except that medical support is assigned to the State. All current child support collected on behalf of Medi-Cal only families must be paid to the family in accordance with the State's non-AFDC policy.

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

1. **FORMS REFERRAL**

For application and referral of Medi-Cal cases to the IV-D agencies, the county shall use the following forms:

Page Not Applicable PJD

- **MC 219 (Cover Sheet) (11/93) and MC 210 (8/93)**--Applicant is advised of rights regarding medical support enforcement referrals and third party liability. A copy is given to applicant; the original is placed in file. If the applicant refuses to sign and cooperate, then a notice of action denying Medi-Cal is sent to applicant.

- **Health Insurance Questionnaire (DHS 6155, 10/90)**--Applicant fills out form if there is other health coverage available through the absent parent. County sends a copy both to DHS Third Party Liability Branch and to the FSD/DA.

- **Child/Spousal and Medical Support Notice and Agreement (CA 2.1 Notice and Agreement (12/89))**--Applicant reviews and signs the agreement. If this form is not signed and good cause is claimed, a CA 51 (Child Support--Good Cause Claim for Noncooperation) must be completed and sent to the FSD/DA with evidence of good cause. If form is signed, then medical support process begins and all documents are sent to FSD/DA via CA 371.

- **Child Support Questionnaire (CA 2.1 Q Support Questionnaire (3/93))**--Applicant fills out form, and original is sent to the FSD/DA within two days. The FSD/DA may set up interview with applicant if form is not complete.

- **Child Support--Good Cause Claim for Noncooperation (CA 51 (3/93))**--If applicant claims good cause for failure to cooperate with medical support enforcement requirements, applicant must fill out the form and send the original with evidence of good cause to the FSD/DA. The FSD/DA will return it to the county with a recommendation. The county will make a final decision and, if good cause is denied, the county will give the applicant an opportunity to withdraw the application, close the case, or be designated as an ineligible member of the MFBU. The county will send a copy of the CA 51 to the FSD/DA with the final determination.

STATE: CALIFORNIA

CITATION	CONDITION OR REQUIREMENT

- **Child Support Enforcement Program Notice (CS 196 (12/93))**--A copy shall be given to all applicants who claim Medi-Cal for children with absent parent. This is an information notice which explains child and medical support enforcement program, services available, and rights of applicant.

- **Referral to District Attorney (CA 371 (3/93))**--This is a cover sheet to transmit absent parent information to FSD/DA (one form for each absent parent). The county sends a CA 371 to the FSD/DA with originals of CA 2.1 Questionnaire, CA 51 when good cause is claimed (with evidence), and DHS 6155. This form is used to convey any information regarding the status of the case back and forth between the county and the FSD/DA.

- **Medical Insurance Form (DHS 6110 10/91)**--Applicant fills out this form if there is other health coverage available through the absent parent. The FSD/DA sends the form to DHS Third Party Liability Branch. DHS will then send a copy to county welfare department.

- **Attestation Statement (CS 870)**--The FSD/DA will use the CS 870 to give the applicant an opportunity to attest (swear), under penalty of perjury, that he or she has provided all available information regarding the absent parent. A determination of noncooperation cannot be made without giving the applicant the opportunity to complete this form.

NOTE: ~~The county must ask the applicant or beneficiary to state whether he or she wants child support, medical support, or both, and must indicate services requested on the CA 2.1 Questionnaire and on the CA 371. The CA 371 will be used by the county and FSD to communicate subsequent changes or additional information on the case.~~ **THE COUNTY MUST EMPHASIZE TO THE APPLICANT OR BENEFICIARY THAT, FOR RECEIPT OF MEDI-CAL ONLY, CHILD SUPPORT SERVICES ARE AVAILABLE BUT NOT MANDATORY, AND THAT REFUSAL OF CHILD SUPPORT SERVICES WILL NOT AFFECT MEDI-CAL ELIGIBILITY** ~~(CS 196 AND CA 2.1).~~

State/Territory: California

Citation	Sanctions for Psychiatric Hospitals
1902(y)(1), 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. terminate the hospital's participation under the State plan; or 2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

Sanctions for Psychiatric Hospitals

California assures that the requirements of Section 1902(y)(1), (y)(2), and (y)(3) of the Act (with all the subsections inclusive) are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation under the Medicaid Program.

California's State law (Section 14123 of the California Welfare and Institutions Code) permits the director of the State Department of Health Services to suspend a provider of service under the Medicaid program for violation of any provision of rule or regulation promulgated by the director or for violation of related state statute. The provider is automatically suspended upon the conviction of any crime involving fraud or abuse of the Medicaid program. The suspension may be for a definite or indefinite period of time and with or without conditions or may be imposed with the operation of the suspension stayed or probation granted. Appeal procedures are provided.

In reference to Section 1902(y)(2)(A), the suspension by the director of any provider of service shall preclude the provider from submitting claims for payment for any services or supplies the provider has provided under the program starting from the date of the suspension. Notice of suspension must be sent to the Department's Licensing and Certification Program.

State: California

Citation
1932(e)
42 CFR 428.726

Sanctions for MCOs and PCCMs

(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

Penalties

Penalties for a determination of non-compliance, are specified under Federal and State law and regulation, and the managed care contract and include but not limited to the following:

- **Civil monetary penalties in specified amounts, and duration;**
- **Appointment of temporary management;**
- **Granting enrollees the right to terminate enrollment without cause;**
- **Suspension of all new enrollment;**
- **Suspension of payment for recipients enrolled after date of sanction.**

Implementation of Sanctions

For repeated breach or material breach, the State will follow a formal monitoring action plan that will include the following:

- **A fact finding to determine that a breach has been made.**
- **A corrective action process to allow the plan to correct any breaches of the contract with a well thought out plan with a specific timeline for addressing the deficiencies and correcting them.**
- **If the breach is not corrected within the allotted timeline then a sanction proceeding will commence.**

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Definitions:

- **Breach: A breach of contract is a violation that is identified by an audit report (routine and non-routine), is complaint-driven, or identified by other monitoring methods that result in corrective action. A corrective action plan is developed to remedy the violation and must be completed and verified within 6 months or less of the notification.**
- **Repeated Breach: A Breach of contract demonstrated by the contractor by repeated violation of one or more specific requirements of the contract, and failure to complete a corrective action plan, that may trigger a sanction process.**
- **Material Breach: Disregard of one or more significant contract requirement(s), that may include the potential for material harm to the enrollee(s), and that triggers a sanction process, which may result in the imposition of penalties.**

In all cases, the contractor will be afforded due process protections specified in State and Federal law and regulations and Managed Care contracts.

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

___ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CALIFORNIA

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

Applicant Data

When the identifying information is received from the CWDs, the SDHS will process the Applicant data in the following manner:

1) Cross Match with the State Welfare Files. This includes the IEVS Applicant File and the State MEDS/CDB (Medi-Cal Eligibility Data System/Central Data Base) Files. The Applicant File will identify individuals who have applied and/or been approved for aid in another county within the last 90 days. The MEDS/CDB File will contain information on individuals who have been on Medi-Cal and/or have received Food Stamps within the last 13 months.

2) Records are then sent to the Employment Development Department (EDD) to be cross matched with UI/DI (Unemployment/Disability benefits) and State wage information files. EDD is the agency that administers the Unemployment/Disability compensation benefits and it is also the State Wage Information Collection Agency.

3) Records are also sent to the State Franchise Tax Board to be cross matched with interest and dividend files of banks, insurance companies, financial and investment institutions based in California.

4) And beginning in late 1988, records will be sent to Social Security Administration (SSA) for SSN verification, Title II (RSDI), and Title XVI (SSI) benefit information.

Recipient Data

The Recipient System consists of three subsystems:

1) Payment Verification System (PVS) - Input for PVS is extracted by SDSS monthly from the county input to the MEDS/CDB file. The status of benefits is determined by matching the MEDS file with the SSA Beneficiary Data Exchange (BENDEX) for RSDI information, and with the payment history file at the EDD for UI and DI benefits information.

4.32 Income and Eligibility Verification System (IEVS)

ATTACHMENT 4.32-A

2) Integrated Fraud Detection System (IFDS) - The Welfare Recipient File (Wages reported to the counties by beneficiaries) or the MEDS file (case information on Medi-Cal beneficiaries) are cross matched with employer reported wage data from EDD on a Quarterly basis.

3) Assets Clearance Match (ACM) - The Welfare Recipient File or the MEDS file is matched against the State Franchise Tax Board's (FTB) annual interest and dividend file to identify Medi-Cal beneficiaries who received interest or dividend income in the previous year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

California has several methods of issuing Medicaid cards to homeless individuals. Medicaid cards may be mailed to post office boxes; in care of a friend or relative; to temporary shelters for the homeless, providing the individual is residing at such a place. Homeless individuals may also make arrangements to personally receive their cards each month at the local Medicaid office.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

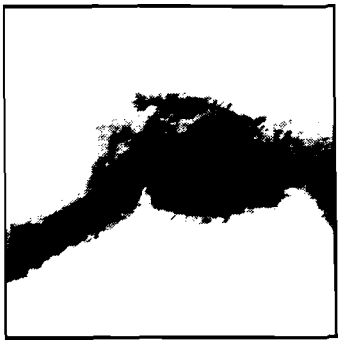
REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

See attached "Supplement 1 to Attachment 4.34-A" entitled "Your Right to Make Decisions about Medical Treatment." A camera-ready copy of this brochure was distributed to all hospitals, nursing facilities, home health agencies, hospices, and health maintenance organizations on November 18, 1991 (a copy of the transmittal letter is also attached). In addition, the California Department of Health Services will notify applicable Medi-Cal providers of implementation of the Patient Self-Determination Act via a "Medi-Cal Provider Bulletin" in the near future.

Supplement 1 to
Attachment 4.34-A

Your Right To Make Decisions About Medical Treatment



This brochure explains your rights to make health care decisions and how you can plan what should be done when you can't speak for yourself.

A federal law requires us to give you this information. We hope this information will increase your control over your medical treatment.

SPA# 91-29 Date Approved Superceded
Supercedes
SPA# _____ Eff. Date _____ SPA# _____

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 327-4343

November 18, 1991

TO: ALL HOSPITALS, NURSING FACILITIES, HOME HEALTH AGENCIES, HOSPICES, AND HEALTH MAINTENANCE ORGANIZATIONS

SUBJECT: IMPLEMENTATION OF PATIENT SELF-DETERMINATION PROVISIONS OF OBRA 90

Federal law mandates new requirements for specific Medicare and Medi-Cal providers, effective December 1, 1991. These requirements are related to patient self-determination--the right of individuals to make medical treatment decisions and to make advance directives, such as living wills and Durable Powers of Attorney for Health Care. Information about the new requirements and instructions to assist you in meeting this mandate are found below.

While this federal statute applies to health care providers who receive funding from Medi-Cal or Medicare, it is requested that all providers make information available concerning medical treatment decision-making and advance directives. All providers must comply with state law requirements related to advance directives and medical treatment decision-making.

BACKGROUND

These requirements were enacted as part of the federal Omnibus Budget Reconciliation Act (OBRA) of 1990, P.L. 101-508, Sections 4206 and 4751. Changes to the Medicare requirements may be found at 42 U.S.C. 1395cc(a)(1)(Q) et seq. Medicaid changes are at 42 U.S.C. 1396a(a)(57) et seq. These changes take effect on December 1, 1991.

SUMMARY OF THE REQUIREMENTS

Every hospital, nursing facility, home health agency, hospice, and health maintenance organization (HMO) that receives funds under Medicare or Medi-Cal must:

1. Provide written information to each adult individual as required about the right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right, under California law, to formulate advance directives;

SPA# 91-29 Date App'd FEB 25 1992 Superceded
Supercedes by
S Eff. Date 12/1/91 SPA# _____

2. Maintain and provide to individuals written information about their policies respecting the implementation of such rights;

3. Document in the individual's medical record whether or not the individual has executed an advance directive;

4. Not condition the provision of care or otherwise discriminate based on whether or not the individual has executed an advance directive;

5. Ensure compliance with state law regarding medical treatment decision-making and advance directives; and

6. Provide education to staff and the community on issues concerning advance directives. (Providers can demonstrate compliance with this Medicaid requirement by conducting educational campaigns. This can be accomplished by newsletters, articles in the local newspapers, local news reports, or commercials.)

The written information in numbers 1 and 2 above must be provided to adult individuals as follows:

- o A hospital must give information at the time of the individual's admission as an inpatient.
- o A nursing facility must give information at the time of the individual's admission as a resident.
- o A provider of home health care or personal care services must give information to the individual in advance of the individual's coming under the care of the provider.
- o A hospice program must give information at the time of initial receipt of hospice care by the individual.
- o An HMO must give information at the time the individual enrolls with the organization, i.e., when the HMO enrolls or reenrolls the individual.

IMPLEMENTATION

To assist in the implementation of this federal statute, the California Consortium on Patient Self-Determination was formed. The Consortium is composed of health care providers, professionals, consumers, the Commission on Aging, and the California Department of Health Services. The Consortium

developed a description of the rights of individuals to make medical treatment decisions and advance directives in California. This description is entitled "Your Right to Make Decisions about Medical Treatment" and is presented in brochure format.

This brochure has been adopted as the description of California law which must be provided to individuals as required by this law. It is intended to be used as a brochure to provide patients, residents, and HMO enrollees with basic information about their rights. A copy is enclosed and directions for its use are found below.

How to Use the Brochure, "Your Right to Make Decisions about Medical Treatment"

You may reproduce the enclosed brochure as provided--or you may use exactly the same wording, but have it printed in a brochure of your own. Please ensure that nothing is added or removed within the text.

Please note that the following statement must appear at the end of the description of law: "The California Consortium on Patient Self-Determination prepared the preceding text, which has been adopted by the California Department of Health Services to implement Public Law 101-508."

Information about your own facility's or organization's policies and procedures related to medical treatment decision-making and compliance with advance directives may be added after this approved text. Space is provided at the end of the brochure to either add written information about your policies or to indicate that policy information can be found on an accompanying brochure.

Customizing of the brochure may begin with the answer to the very last question, "How can I get more information about advance directives?" The answer to this question may be modified to provide specific information about where individuals may obtain more information about advance directives either within your organization or in your community. You may also wish to provide a copy of the more detailed brochure titled "Making an Advance Directive", which may be obtained from the Pacific Center for Health Policy and Ethics (See "Resources for Further Information", Page 4).

UPDATES

You will be notified if further information or direction is received from the U.S. Department of Health and Human Services about the requirements of this

law. It is anticipated that federal regulations will be issued in the near future to implement this statute. Also, if changes in California law necessitate a change to the text of the description of the law, a revised version will be mailed to you by the California Department of Health Services.

RESOURCES FOR FURTHER INFORMATION

The Consortium has developed the Patient Self-Determination Handbook to assist health care providers in complying with these new requirements. The handbook includes a legal summary and copies of related statutes, model policies and procedures, information on providing education and training, and other information to assist providers in implementation of this federal law. Please see the enclosed "PSDA Handbook" brochure for information on how to order the Handbook. For more information and to order copies of the patient brochure in other languages, please contact the Pacific Center for Health Policy and Ethics at (213) 740-2541.

Questions regarding implementation of this new federal statute may also be directed to Marilyn I. Pearman, Health Program Specialist, Licensing and Certification at (916) 324-8628.

Margaret DeBow
Deputy Director

Enclosure

SPA# 91-29 Date App'd FEB 25 1992 Superceded by
Eff. Date 12-1-91 SPA# ____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1)

California does not use other factors to determine the seriousness of deficiencies issued for violation of federal regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE

SOCIAL SECURITY ACT

State: California

In January of 1990, Medicaid Program Memorandum 90-2 was issued. This memorandum includes a State Plan Amendment provision for an incentive program (attached). Subsequently, State Operations Manual (SOM) Transmittal 248, dated February 1992, was also issued. This transmittal clarifies how states may apply incentive programs for high quality care in NFs (attached). The state option to establish an incentive program is in Section 1919(h)(2)(F) of the Social Security Act (attached).

Incentive programs may be in the form of a public recognition award to NFs. This appears consistent with the Best Practices Program established by Licensing and Certification. SOM 248 states that the expenses incurred in carrying out such a program are considered expenses necessary for the proper and efficient administration of the State Plan under Medicaid, and references Section 1903(a)(7) of the Social Security Act (attached).

California's Best Practices Program is designed to identify exemplary practices in long-term care facilities and to publicly acknowledge the facilities who have developed and implemented these practices. Inherent in this program is the dissemination of the models to other facilities. The program will include a presentation conference(s) for care providers, and the publication of a manual which will compile the selected "Best Practices".

STATE PLAN UNDER TITLE XIX OF THE

SOCIAL SECURITY ACT

State: California

A "Best Practice" can be drawn from any care area of the resident's life. Loosely described, it is any intervention a facility has developed which improves the residents' lives or living conditions. The practice may relate to a variety of issues including residents' rights, provision of care, or administrative practices which result in improved care.

The program has an annual cycle with a focus on a selected topic. Focusing on a specific topic each year will result in development of a manual which will be a resource to caregivers to review and consider numerous options of care models.

The critical program steps include selection of the "Best practices" models, acknowledgement of the facilities who have developed the practices, dissemination of information and assisting other providers in replicating the care models.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy	___ Alternative Remedy
(Will use the criteria and notice requirements specified in the regulation.)	(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

Section 1919 of the Social Security Act (42 U.S.C. 1396r) provides at Subsection (h) (2) (F) that "a State may establish a program to reward, through public recognition, incentive payments, or both nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this title. For purposes of Section 1903 (a) (7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title."

California's Health and Safety Code Section 1417.4 establishes a Quality Awards Program for nursing homes. The statute provides that "the department shall establish criteria under the program, after consultation with stakeholder groups for recognizing skilled nursing facilities that provide exemplary care to residents" and that "monetary awards shall be made to Quality Awards Program recipients that serve high proportions of Medi-Cal residents to the extent funds are appropriated each year in the annual Budget Act." These monetary awards are to be passed along to employees of the recipient facilities in the form of bonuses.

The Quality Awards Program provides monetary awards to facilities that provide the highest quality care. The Department's criteria for awards are based on a facility's actual performance. For example, facilities would only be eligible for the Quality Award if, over a specified period of time and at the time of the Award, they had received no federal deficiencies or state citations that indicate sub-standard quality of care. Monetary awards would only be available to those whose resident population contains a high proportion of Medi-Cal residents -- residents entitled to medical assistance under the State plan.

The Quality Awards Program complements the Best Practices Program, which more generally recognizes any particularly noteworthy intervention developed by a facility to improve quality of care or quality of life for skilled nursing residents.

The Quality Awards Program will operate on an annual cycle. Administration of the Program will entail establishment and ongoing refinement of selection criteria, selection of facilities for receipt of either general recognition or a monetary award (depending on the proportion of Medi-Cal recipients they serve), distribution of the Awards, and monitoring the appropriate use of monetary awards.

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

DEFINITION OF SPECIALIZED SERVICES

I. Specialized services do not include mental health or mental retardation services which are of lesser intensity than specialized services and/or services furnished to NF residents as NF services and/or within the scope of services that the NF is required to provide or arrange, pursuant to 42 USC § 1396r, subdivisions (b)(2), (b)(4) and (e)(7)(G)(iii); and 42 CFR § 483.120, 483.124, 483.126 and 483.130.

II. For individuals with Serious Mental Illness (SMI), defined in 42 CFR § 483.102 (b)(1), specialized services, as defined in 42 CFR § 483.120 (a)(1), means the services specified by the State which, combined with services provided by the NF, results in the continuous and aggressive implementation of an individualized plan of care that:

A. Is developed under and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and, as appropriate, other professionals;

B. Prescribes specific therapies and activities for the treatment of individuals experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and

C. Is directed toward diagnosing and reducing the individual's behavioral symptoms that necessitated institutionalization, improving his/her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

III. For individuals with mental retardation (MR), defined in 42 CFR § 483.102 (b)(3), specialized services, as defined in 42 CFR § 483.120 (a)(2), means the services specified by the State, which, combined with services provided by the NF or other service providers, results in treatment which meets the requirements of 42 CFR § 483.440 (a)(1), i.e., a continuous active treatment program, which includes aggressive,

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

DEFINITION OF SPECIALIZED SERVICES Cont.

consistent implementation of a program of specialized and generic training, treatment, and health related services that are directed toward:

A. The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and

B. The prevention or deceleration of regression or loss of current optimal functional status.

This does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program.

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

CATEGORICAL DETERMINATIONS

I. The State mental health or mental retardation authority may make advance group determinations that NF services are needed under the categories below, pursuant to 42 CFR § 483.130 (b)(1), (c), (d) and (e). In all other categories, and for convalescent care, terminal illness, and severe physical illness, an individualized specialized services evaluation must be completed under 42 CFR § 483.134 or 483.136.

A. CONVALESCENT CARE:

The individual is admitted directly from a hospital (after receiving acute in-patient care) to a NF for convalescent care from an acute physical illness, under the following conditions:

1. The acute physical illness required hospitalization;

2. Convalescent care is required to treat a condition other than the one for which the individual received care in a hospital; and

3. Prior to admission to the facility, the attending physician has certified that the individual is likely to require fewer than 30 days of NF services.

B. TERMINAL ILLNESS:

The individual's attending physician certified prior to NF admission, an explicit terminal medical prognosis that the individual has a life expectancy of 6 months or less if the illness runs its normal course.

C. SEVERE PHYSICAL ILLNESS:

As a result of a severe physical illness, the individual's level of impairment is so severe that the individual could not be expected to benefit from specialized services.

D. RESPITE CARE:

The individual is admitted to a NF for a period not to exceed 30 days a year in order to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return (home) following this NF stay.

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

CATEGORICAL DETERMINATIONS, Cont.

E. EMERGENCY SITUATIONS:

Provisional admission pending further assessment in emergency situations requiring protective services, with placement in a NF not to exceed 7 days.

F. DELIRIUM:

Provisional admission pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears, with placement in a NF not to exceed 7 days. The individual must have a primary diagnosis of delirium, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition (DSM-III-R).

II. The State mental health or mental retardation authority may make advance group determinations that specialized services are not needed under the categories set forth below, pursuant to 42 CFR § 483.130 (b)(1), (c), (d)(4)-(6), (e), (f) and (h). In all other categories, including Convalescent Care, Terminal Illness and Severe Physical Illness, a determination that specialized services are not needed must be based on an individualized evaluation under 42 CFR § 483.134 or 483.136.

A. INDIVIDUALS WITH DEMENTIA, WHICH EXISTS IN COMBINATION WITH MENTAL RETARDATION:

The State mental retardation authority may make categorical determinations that individuals with dementia, which exists in combination with mental retardation or a related condition, do not need specialized services.

B. DELIRIUM:

Provisional admission pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears, with placement in a NF not to exceed 7 days. The individual must have a primary diagnosis of delirium, as defined in the DSM-III-R.

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

CATEGORICAL DETERMINATIONS, Cont.

C. EMERGENCY SITUATIONS:

Provisional admission pending further assessment in emergency situations requiring protective services, with placement in the NF not to exceed 7 days.

D. RESPITE CARE:

The individual is admitted to a NF for a period not to exceed 30 days a year in order to provide respite to in-home caregivers, to whom the individual with MI or MR is expected to return (home) following this NF stay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

Licensing and Certification conducts a vigorous outreach and education program to disseminate information on current regulations, procedures, and policies. The program includes the following formal and informal components:

A. All facility Letters. Changes in federal or State statute, regulation or policy are announced and explained in letters to affected facilities. These letters provide the initial learning opportunity for new requirements or procedures.

B. "Rap Sessions". District Office managers schedule and conduct periodic educational forums with facility staff and representatives. These seminars focus on issues raised by changes in regulations or procedures or on issues raised by industry. These sessions include presentations of regulatory findings, discussion of procedures used in the survey, certification and enforcement processes, and evaluatory feedback on both survey agency and facility performance. The sessions are also used as planning opportunities for proposed changes.

C. Quarterly Consultant Meetings. The various consultant disciplines (Medical, Nursing, Nutrition, Pharmacy, Occupational Therapy and others) provide educational and information programs for facilities on requirements, techniques and current state of the practice.

D. Headquarters/Industry/Advocate Monthly Meetings. Top and middle managers meet with representative groups each quarter to provide information regarding federal and State activities in the regulatory program. These meetings use a formal agenda which comprises items mutually agreed upon as important. The goal of the meetings is achievement of a shared perspective or roles and actions undertaken by the parties.

Continued

Survey and Certification Education Program

E. Special Purpose Programs. Licensing and Certification organizes specific purpose events as part of its outreach and education program. The latest example was a successful "Best Practices" Conference which presented innovative programs in industry for commendation and potential replication in other locations.

F. Entrance and Exit conferences. The most frequent opportunity for direct learning of policies and procedures takes place in the survey entrance and exit conferences. Survey staff are trained and prepared to discuss regulatory requirements and survey procedures with facility staff and residents. This front-line opportunity continues to have the most direct educational value.

G. Informational Brochures and Fact Sheets. As part of its comprehensive outreach activities, the program employs a permanent intermittent staff member assigned the responsibility to prepare, publish and distribute informational brochures, fact sheets and other documents to meet the needs of residents, industry and the public. Examples of the publications include brochures on resident rights, conduct of the regulatory compliance survey, and how to file a complaint.

Revision: HCFA-PM-92-3 (HSQB)
APRIL 1992

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: CALIFORNIA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

California has implemented enforcement procedures related to nurse aides who are involved in substantiated cases of abuse, neglect, misappropriation of property, or any other act which is determined to have a direct effect on the nurse aide's ability to perform nursing duties. Included in the enforcement process is the screening for criminal convictions which directly relate to the duties/functions of a nurse assistant prior to certification in California.

As required by OBRA, all nurse aides are provided the opportunity to make statements for the registry in regards to any accusation or enforcement action taken against them and are afforded an appeal process for any action taken against them. This information is cross referenced from the nurse aide registry to the enforcement files.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The State takes the following actions to assure that standard surveys occur unannounced:

1. Training. Surveyor staff receive indoctrination as to the criticality of meeting the federal requirement for unannounced visits for the purpose of conducting standard surveys. This subject is carefully covered in their initial Academy training, in HCFA's Regional Office Orientation and in HCFA's Basic Surveyor Training program. Surveyor staff are also trained to alter the hours of visit entry to facilities in order to get a more complete, accurate view of the quality of health care practices in a facility.

2. Code of Conduct. The conduct of unannounced visits is a part of the surveyor's performance evaluation. Disregard of the standard is grounds for disciplinary action. Section 606 of the program's Policy and Procedure Manual specifically states that it is illegal for any employee of the program to give notice of an impending visit to any person connected with the facility to be visited.

3. Workload Scheduling. Survey and investigation workload scheduling is conducted by management and supervisory staff using automated management information. Last survey dates are reviewed for the opportunity to eliminate any predictable pattern in future scheduling. Survey schedules are held in confidence by supervisory and management staff and are released as part of the District's monthly work plan.

4. Contract Coordination. Licensing and Certification contracts with the Office of the State Fire Marshal for the conduct of the Life Safety Code survey in health facilities. Strong contract language has been added to the long-standing agreement between the agencies to reinforce the requirement for unannounced visits.

Continued

Procedure for Scheduling and Conduct of Standard Surveys

The State takes the following steps in conducting facility surveys:

1. Standard surveys are scheduled according to a user-defined report from OSCARS. The report displays facilities according to ascending order to date of the current survey. These dates are used to monitor the 15-month maximum survey interval as well as the 12-month average for survey intervals.

2. The State maintains supplies of current HCFA survey forms in each of its District Offices and in the County of Los Angeles. Supervisors monitor the survey team's use of HCFA's forms as well as the protocols established in the State Operations Manual.

3. The State uses a centralized database of surveyor qualifications and record of required and additional training completed. Information from the centralized database is shared with District Managers and Administrators to assure that only qualified individuals approve survey documents.

4. The State maintains the policy discretion to conduct a special survey of a facility following a change in ownership or significant change in administrative or key health care personnel. Decisions to conduct these special surveys are made in consultation with Regional Office staff following examination of information concerning the quality of care at the facility.

5. The State conducts extended surveys immediately following a completed standard survey where there has been a finding of substandard care.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The Licensing and Certification program uses several means in addition to supervisory and management direction to assure consistency of survey processes and results:

A. Training. All newly hired survey staff participate in a twelve week Academy developed and conducted by the Licensing and Certification. Trainees learn the doctrine, regulations and consistent procedures used in the survey process. The Academy course alternates between classroom work and field application under the guidance of experienced surveyor and supervisory staff. From the Academy, all new surveyors participate in HCFA's Basic Surveyor Training which is a quality assurance program on a national level.

B. Preceptors. Survey staff have access to expert mentors who actively review survey methods and results for consistency. Preceptor staff meet regularly to discuss findings of surveyor performance throughout the State and, to propose additional training or systems changes necessary to gain greater consistency.

C. The On-site Surveyor Performance Assessment and Training Survey (OSPATS). OSPATS is the federal, real-time evaluation of surveyor performance of the survey. The Licensing and Certification program uses the results of these evaluations to assess areas for improving surveyor consistency.

D. District Manager/District Administrator Meetings. The top managers in the District Offices meet each month to review work production reports from the program's management information systems and assess any discrepancy in workload performance. This monthly forum also provides for information sharing regarding consistent application of policies and procedures.

E. Consistency Advisory Committee. The Deputy Director has chartered this committee with the responsibility to review any aspect of the regulatory program and make recommendations in areas which would benefit from greater consistency. The Committee is chaired by a District Administrator and utilizes the services of an Ad Hoc Advisory Group which includes representatives from industry, advocate groups, the State Ombudsman and the Department of Aging. The Committee has proposed several areas for study and has released its first recommendation for a consistent protocol addressing Immediate and Serious Threat determinations.

Continued

Programs to Measure and Reduce Inconsistency

F. Survey Review Tool. Program supervisors in District Offices use the quality assurance tool available in ASPEN. The tool provides a systematic review of a written deficiency matched against the standards in the Principles of Documentation. The tool has proven effective in realizing greater consistency in the documented record of survey findings.

G. District Office Production Reviews. As part of its organizational structure, the program includes an internal management analysis and evaluation unit. The work of this unit includes review of survey results, work procedures and systems to assess the extent of consistent application of statutes, regulations, policies and administrative procedures. Management reports highlight variations which may be foundation of further analysis or the development of changes.

H. Policy and Procedure Manual. The Program updates and maintains a Policy and Procedure Manual to establish a consistent basis for administering operational aspects of its regulatory responsibilities. The Manual is available in multiple copies in each District Office. Updates are used as the basis for training of staff in the Districts.

The State takes the following actions in organizing and using its survey teams:

A. Survey teams are multidisciplinary and include at least one Registered Nurse. The most prevalent employee classification used by the State in its survey work is Health Facilities Evaluator Nurse. This classification carries a requirement for maintenance of licensure as a Registered Nurse. All teams have access to consultant support in the areas of Medical/Physician services, dietary and nutrition, medical records, physical therapy, occupational therapy and pharmacy.

B. The State uses a code of conduct for its survey team members which precludes surveying of a facility at which the team member may have been previously employed, or may have served as a consultant, or may have family ties. Survey team members affirm that they have read, understand and will comply with this requirement.

Programs to Measure and Reduce Inconsistency

C. Survey staff who have not completed the Program's own New Surveyor Academy, the HCFA Regional Office orientation and HCFA's Basic Surveyor Training may accompany facility survey teams and conduct tasks or parts of tasks, under supervision, as part of their development process. Completion of all required training is necessary prior to full, independent participation as a survey team member. Passage of the SMQT is a requirement to support a survey team member's authorization to sign survey documents on behalf of the Program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

The Licensing and Certification procedures for processing complaints are detailed in the program's Policy and Procedure Manual beginning with Section 400. Complaint investigations form the highest priority of the program's workload under its agreement with the Health Care Financing Administration. The procedures for complaint investigation assure facility compliance with federal requirements . The process for complaint investigation is as follows:

1. Complaint intake. District Office staff record all pertinent information regarding the complaint and the complainant. (Requests for anonymity are honored). All complaints are entered into the program's automated management information system and assigned a control number.

2. Supervisor review. Complaints are assigned to supervisors for review and priority determination. Priority 1 complaints carry an imminent threat to life and safety and are investigated within 24 hours. Priority 2 complaints are less threatening and are investigated within ten days. Priority 3 complaints do not carry a threat to health and safety and are investigated during the next scheduled activity in a facility.

3. Complainant contact. Investigating staff confer with complainants prior to an investigation to acquire as much information as possible to assist a thorough investigation. Complainants are also briefed as to their involvement and how they will be notified about findings. (Continued on next page)

Process for Investigations of Complaints and Monitoring

4. On-site investigation. All complaints are investigated at the facility by trained survey personnel. All complaint investigations visits are unannounced.

5. Collection of evidence and documentation. The surveyor conducts interviews, reviews facility records and records observations regarding substantiation of the complaint. Substantiated complaints and findings of deficiency(ies) are written on the HCFA 2567 and given to the facility. All complaints requiring a formal plan of correction receive a follow-up visit for determination of compliance.

6. Completion of the investigation report. All investigations are recorded on a Complaint Report Form to include a narrative of the findings and disposition of the investigation. This report is provided to the complainant along with appeal procedures. A copy of the report is entered into the facility file along with any notice of levy of a fine or civil monetary penalty. The final disposition of the complaint is entered into the automated information management system for the facility.

7. Public access to information. Facility files are public records which may be reviewed at the District Office during business hours. In addition, reports from the automated information management system on facility profile data are available to the public under the State's and the federal governments access to information statutes and regulations.

8. The Program has an established, formal relationship with the State's Office of the Long-Term Care Ombudsman. Under the agreement, the Program provides an updated copy of the facility database to the Ombudsman so that that office may disseminate facility-specific information to ombudsmen working out of the regional office network. District Offices provide copies of the HCFA 2567 to the ombudsman following completion of surveys and the ombudsman is a recipient of any adverse action notice.

9. Following a survey in which a finding of substandard quality care is determined, District Office staff secure a list of attending physicians from the facility and then complete a required form letter to notify them of the finding. A copy of this notification is provided to the Board of Examiners for Nursing Home Administrators (BENHA) in the State's Department of Consumer Affairs.