DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

AUG 0 8 2012

Toby Douglas
Director of Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) Number 06-016. This SPA provides for supplemental payments up to cost, funded by certified public expenditures, for free-standing governmentally-owned and operated clinics.

The effective date of this SPA is October 14, 2006. Enclosed are the following approved SPA pages that should be incorporated into your State Plan:

- Supplement 10 to Attachment 4.19-B pages 1-8

If you have any questions, please contact Kristin Dillon at (415) 744-3579 or at kristin.dillon@cms.hhs.gov.

Sincerely,

/s/
Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

Cc: Kathyryn Waje, California Department of Health Care Service

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 06 — 016

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 2006~~ October 14, 2006

5. TYPE OF PLAN MATERIAL *(Check One)*

☒ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.321
~~Welfare & Institutions Code, Section 14105.965~~

7. FEDERAL BUDGET IMPACT
a. FFY 06-07 $ ~~0~~ 60,000,000
b. FFY 07-08 $ ~~120 million~~ 70,431,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19B ~~pages 52-56~~
Supplement 10, pages 1-8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT
Public Freestanding Outpatient Clinics Supplemental Payment

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to rewview State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Stan Rosentstein

14. TITLE
Deputy Director

15. DATE SUBMITTED
9/29/06

16. RETURN TO
Department of Health Services
Attn: State Plan Coordinator
1501 Capitol Avenue, 71.4083
Sacramento, CA 95814

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 9/29/06

18. DATE APPROVED AUG 0 8 2012

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
10/14/06

20. SIGNATURE OF REGIONAL OFFICIAL
8/8/12

21. TYPED NAME
Gloria Nagle

22. TITLE
Associate Regional Administrator

23. REMARKS

Pen and ink changes made to Boxes 4, 6, 7, and 8 by Regional Office with State concurrence per email dated 6/25/2012.

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

SUPPLEMENTAL REIMBURSEMENT FOR PUBLICLY OWNED OR OPERATED CLINIC SERVICES

This segment of the State Plan provides supplemental reimbursement for services provided by a public freestanding, non hospital-based clinic which is enrolled as a Medi-Cal provider and is owned or operated by the state, city, county, city and county, the University of California, or health care district; herein, referred to as an eligible clinic and which meets specified requirements and provides services to Medi-Cal beneficiaries. This Supplement applies only to Medi-Cal services rendered to Medi-Cal beneficiaries on or after October 14, 2006. Payment rules for State-owned and operated clinics are governed by the provisions set forth in Supplement 9 to Attachment 4-19-B, pages 1-5, effective July 1, 2008; therefore, effective July 1, 2008, such clinics will not be eligible to receive supplemental reimbursement under this segment of the State Plan.

Supplemental reimbursement under this program is available only for costs that are in excess of the payments the eligible clinic receives per-visit or per procedure for services from any source of reimbursement. The State is authorized to make interim Medi-Cal payments to eligible clinics identified in Section A on an annual basis each fiscal year, based on the facility's uncompensated Medicaid fee-for-service (FFS) costs.

A. Definition of an Eligible Clinic

A clinic is determined eligible only if it continuously maintains all of the following characteristics during each State Fiscal Year (SFY) beginning July 1, 2006:

1. Provides clinic services to Medi-Cal beneficiaries.

2. Is enrolled as a Medi-Cal provider.

3. Is owned or operated by the State, 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.

B. Supplemental Reimbursement Methodology – General Provisions

Supplemental reimbursement provided under this program to an eligible clinic is to allow FFP for Medi-Cal uncompensated care costs. Reimbursement to an eligible clinic that is owned or operated by the state, city, county, city and county, University of California, or health care district as identified in

Section A, will be based on allowable Medi-Cal outpatient clinic costs. All determinations will be made on a aggregate basis. The methodology for computing such costs and the required procedures for claiming federal reimbursement are detailed in this Supplement.

1. Costs, as required by this Supplement, will be computed in accordance with Title 42 of the Code of Federal Regulations (CFR) Part 413; the Provider Reimbursement Manual (CMS Pub. 15-1); and other applicable federal directives that establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medi-Cal program, except as expressly modified in this Supplement.

2. The allowable costs reimbursed under this methodology include direct, ancillary, physician/non physician practitioner, and overhead costs which are incurred in providing covered services to Medi-Cal beneficiaries in eligible facilities and determined to be allowable under the regulations and publications in Section B.1, above.

3. Eligible clinics that provide services to Medi-Cal enrollees in local initiatives, commercial plans, county organized health systems, and geographic managed care program health plans are not authorized to seek supplemental reimbursement under this Supplement for uncompensated costs of providing services to such enrollees.

4. Allowable costs will be derived from the eligible facility's general ledger, and reported on the approved clinic cost reporting forms. General ledger supporting schedules which group costs into direct service and overhead cost centers will accompany the filed clinic cost reports. Direct service costs and overhead expenses will be reported on separate cost center lines, and non-allowable costs will either be reclassified to non-reimbursable cost centers or removed through discrete adjustments. Reclassifications and adjustments to the working trial balance, including the assignment of costs to non-reimbursable cost centers, and the discrete disallowance of expenses, will be recorded on supporting schedules which will be submitted with the approved cost reporting forms.

5. Clinic overhead costs will be equitably allocated to non-allowable activities based on the use of such overhead costs by the non-allowable activities.

6. The data used for the computations will come from a cost report provided by each eligible clinic. The clinic cost reports are subject to audit and settlement by the Department.

7. Clinic costs will be apportioned to the Medi-Cal program by aggregating all allowable direct and overhead costs and dividing them by total visits for all payers to determine a rate per visit. This rate per visit will then be multiplied by the number of paid Medi-Cal FFS visits to determine the total Medi-Cal costs allowable under this Supplement 10. As set forth in paragraph 13 below, the number of FFS visits shall be derived from the MMIS reports for services furnished during the applicable cost reporting period.

8. The supplemental reimbursement for each eligible clinic will be based on the clinic's cost report which includes data for visits. The clinic cost report will determine the per-visit cost for a patient. To be counted as a visit, the patient must be examined or treated and the services provided must be documented by the provider.

9. (a) For Medicare covered services rendered to patients who have coverage under both the Medicare and Medi-Cal programs ("dually eligible patients"), the lower of (1) the allowable Medi-Cal cost per visit as computed pursuant to Paragraphs B.1 through B.8 above, or (2) the Medicare allowable amount for the services provided during the visit will be determined.

   (b) The results in (a) above will be aggregated, and reduced by the aggregate amounts paid by Medicare (and other payers if applicable), and the cost sharing amounts for the services already paid by Medi-Cal for the dual eligible visits.

   (c) The negative or positive result of the aggregate determination made in Paragraph B.9(b) will be applied to either reduce or increase the uncompensated care costs that may be submitted for reimbursement under this Supplement as determined under Paragraph B.10.

10. Payments made by, or on behalf of, a Medi-Cal beneficiary for services for which the costs are included pursuant to Paragraphs B.1 through B.8 above will be applied to reduce the amount of uncompensated cost that may be submitted for reimbursement under this Supplement. All revenues from Medi-Cal and other sources, including but not limited to, third party payments and copayments made by patients, for the Medi-Cal FFS clinic services including Medi-Cal base payments described in paragraph 13, below, will be deducted from the total Medi-Cal FFS costs for the clinic. The difference, after taking into account the aggregate adjustment determined under paragraph B.9 above, will be the uncompensated

costs for the clinic. The reductions under this paragraph shall not duplicate the reductions made under paragraph B.9 above.

11. Allowable Medi-Cal uncompensated care costs computed pursuant to this Supplement will determine the amount of FFP that can be claimed and paid as supplemental payments.

12. In no instance shall the total uncompensated costs claimed for FFP, when combined with the amount received and payable for Medi-Cal FFS clinic services from the Medi-Cal program and all other sources of reimbursement, exceed 100 percent of the allowable costs for services to Medi-Cal recipients at each eligible clinic.

13. Medi-Cal base payments for the eligible clinics are derived from the fee-schedule established for reimbursements payable by the Medi-Cal program by procedure code. The payments for these eligible clinics are FFS payments. The reimbursement rates applicable to public and private providers for the Medi-Cal program effective September 15, 2008, are accessible at: www.medi-cal.ca.gov located at the "References" tab to the "Medi-Cal Rates" section. The primary source of paid claims data and other Medi-Cal reimbursements is the California Medicaid Management Information System (MMIS). The number of paid Medi-Cal FFS visits is derived from and supported by the MMIS reports for services furnished during the applicable cost reporting period.

14. Services that are otherwise payable by or reimbursable under the prospective payment system or the alternative payment methodology for Federally Qualified Health Centers (FQHCs) and rural health clinics set forth earlier in this Supplement, or the cost-based reimbursement methodology set forth in Supplement 5 to this Attachment, are not eligible for Medi-Cal uncompensated care costs under this supplemental reimbursement methodology.

C. Services Eligible for Supplemental Reimbursement

1. Subject to paragraphs (2) and (3), below, the services that are subject to supplemental reimbursement in eligible facilities (as defined in paragraph A, above) include only Medi-Cal-covered ambulatory care services rendered to Medi-Cal beneficiaries, as described in applicable State law and this State Plan.

2. For the purposes of supplemental reimbursement of services that are paid on a per-visit basis, a "visit" is defined as a face-to-face encounter between a clinic Medi-Cal patient and any of the following:

(a) A physician, physician assistant, nurse practitioner, clinical psychologist, or licensed clinical social worker, 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 authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.

(ii) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.

(iii) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.

(iv) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license.

(v) A doctor of dental surgery (dentist) authorized to practice dentistry by the State 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).

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) When the clinic patient is seen by a dentist and sees any one of the following providers: physician (as defined in subparagraphs C.2(a)(i)-(iv)), physician assistant, nurse practitioner, clinical

psychologist, or licensed clinical social worker, two visits may be counted.

4. The following services are not subject to supplemental reimbursement under this Supplement nor may a visit be counted as a Medi-Cal visit under this Supplement 10:

   (a) Medi-Cal specialty mental health services, including Medi-Cal Short Doyle services, under the State's consolidated Section 1915(b) waiver.

   (b) Medi-Cal alcohol and drug program services paid through the State Department of Alcohol and Drug Programs.

   (c) Adult Day Health Care services.

D. Interim Supplemental Payments and Adjustments to Costs

1. The interim supplemental payments will be based on the clinic's as-filed cost report that is submitted to the Department five months after the close of the clinic's fiscal year.

2. For the calculation of interim supplemental reimbursement, net Medi-Cal cost will be computed using cost, visit, and payment data for the fiscal year covered by the as-filed cost report.

3. The Department may, if appropriate, make adjustments to costs reported on the as-filed cost report based on the results of the most recently completed audit of a prior year cost report.

4. Net Medi-Cal costs are computed Medi-Cal costs reduced by all payments made for and/or by Medi-Cal beneficiaries for the period consistent with paragraph B 10 above.

E. Final Reconciliations

1. Medi-Cal FFS visit and Medi-Cal FFS payment data will be reconciled to the MMIS reports generated for the cost reporting period.

2. Interim payments will subsequently be reconciled to the clinic's finalized cost report as audited and settled by the Department. During this final reconciliation, net Medi-Cal cost will be computed using cost, visit, and payment data for the fiscal year as finalized by the Department during its audit and settlement process. Updated MMIS reports will be used to determine final Medi-Cal FFS visits and Medi-

Cal FFS payments in the final reconciliation. Actual net Medi-Cal cost is compared to the interim payments made for the period.

3. If, at the end of the final reconciliation, it is determined that the eligible facility has been overpaid, the facility shall repay the Medi-Cal program, and the Department shall follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If, at the end of the final reconciliation, it is determined that the eligible facility has been underpaid, the facility shall receive an adjusted payment amount.

4. Reconciliation will be made on a date-of-service basis. Adjustments for prior year payments must be properly accounted for on the CMS 64.P.

5. All cost report information for which Medi-Cal payments are determined and reconciled are subject to CMS review and must be furnished upon request.

6. The Department will complete the reconciliations for the claiming period within three years of the postmark date of the cost report.

7. The Department will reconcile actual expenditures and payments to any amounts used initially to determine the supplemental payment.

F. Eligible Clinic Reporting Requirements

The governmental entity that reports on behalf of any eligible clinic must do all of the following:

1. Report costs annually on cost reporting forms approved by the Department. The clinics will use clinic cost reporting forms that are modeled on the CMS approved FQHC cost reporting form, and that have been approved by the Department and CMS. Cost reports will be submitted by eligible clinics no later than five (5) months after the close of the fiscal year, unless an extension is granted by the Department.

2. Annually file and certify a cost report within five months of the close of its fiscal year to determine the unreimbursed Medi-Cal clinic costs eligible for supplemental payment.

3. Provide evidence supporting the cost report and the cost determination as specified by the Department.

4. Submit data as specified by the Department to determine the appropriate amounts to report as expenditures qualifying for FFP.

5. Keep, maintain and have readily retrievable, such records as specified by the Department to fully disclose reimbursement amounts to which the eligible clinic is entitled, and any other records required by the Centers for Medicare & Medicaid Services.

G. Department's Responsibilities:

1. The Department will submit claims for FFP based on expenditures for clinic 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 FFP will include only those expenditures that are allowable under federal law.

3. Total Medi-Cal reimbursement provided to eligible clinics will not exceed applicable federal upper payment limits as described in 42 C.F.R. 447.321.

4. The Department will have in place an audit and settlement process for clinic cost reports.

ENCLOSURE

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

06-016*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	**Insert Page (s)**
None	Supplement 10 to Attachment 4.19-B pages 1-8