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/TERRITORY: CALIFORNIA

REIMBURSEMENT FOR MEDI-CAL PERSONAL CARE SERVICES

A. GENERAL PROVISIONS

Medi-Cal Personal Care Services (referred to in this document as Personal Care Services) are services provided pursuant to 42 Code of Federal Regulations 440.167 in accordance with the rules and regulations of the California Department of Health Care Services and the California Department of Social Services.

B. REIMBURSEMENT RATE LIMITATIONS FOR PERSONAL CARE SERVICES

(1) A county may contract with an agency of a city, county, or city and county, a local health district, a voluntary nonprofit agency, a proprietary agency, or an individual for the purpose of providing personal care services. The rate of reimbursement will be negotiated between the county and its contractor or its contractors, consistent with applicable regulations promulgated by the California Department of Social Services or the Department of Health Care Services.

(2) The rate of reimbursement for individual providers will be negotiated between the provider union and the individual county, or the provider union and the public authorities/non-profit consortiums, as applicable.

State Plan Under Title XIX of the Social Security Act
STATE/TERRITORY: CALIFORNIA

C. PUBLICATION OF INDIVIDUAL AND CONTRACTED PROVIDER RATES OF PERSONAL CARE SERVICES

State approved county governmental, contracted, and private individual provider rates are documented in a fee schedule and that fee schedule was last updated on October 1, 2009, and effective for services provided after that date. This fee schedule is published on the California Department of Social Services website at www.cdss.ca.gov/agedblinddisabled/PG1996.htm.

State Plan Under Title XIX of the Social Security Act

STATE/TERRITORY: CALIFORNIA

D. PAYMENTS AND UNITS OF SERVICE

(1) Reimbursements for services will be made only to providers authorized by the California Department of Social Services to provide Personal Care Services to beneficiaries. The rates will be based upon a time-based unit of service. The time-based unit of service is per minute based on 60 minutes per hour.

(2) The methodology for determining the beneficiary's service budget is based on the assessment of needs for the beneficiary and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for such services under the state plan and is adjusted to account for the self-directed services delivery model served in the Sec. 1915 [42 U.S.C. 1396n] (j) program.

In cases where the beneficiary chooses not to have the assessed Personal Care Services of meal preparation, meal cleanup and/or shopping for food services provided in-home, the beneficiary can choose to have their service budget reduced by the amount calculated based on hours allocated for these services and reimbursement of $15.50 per week per person or $31 per week per couple is provided for meal preparation, meal cleanup and/or shopping for food related activities in the Sec. 1915 [42 U.S.C. 1396n] (j) program.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CALIFORNIA

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