STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

COST-BASED REIMBURSEMENT FOR STATE-OWNED CLINICS

A. General Applicability

Notwithstanding any other provision of this State Plan, this Supplement 9 sets forth special payment rules that apply to clinic services, which include professional services provided by physician and non-physician practitioners when those services are provided in freestanding clinics owned and operated by the State of California. This Supplement does not create new medical assistance service categories. This Supplement shall apply only to Medi-Cal covered services rendered to Medi-Cal beneficiaries on or after July 1, 2008. This Supplement does not apply to those Federally Qualified Health Centers (FQHCs) and FQHC look-alikes paid pursuant to the prospective payment reimbursement provisions set forth in Attachment 4.19-B, page 6 *et. seq.* of this State plan.

B. Cost-Based Reimbursement

1. General Methodology. The following general provisions apply to all services identified in section C.

(a) Reimbursement to eligible facilities shall be at 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries. 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 Centers for Medicare and Medicaid Services (CMS)):

(i) The reimbursement methodology for cost-based entities outlined in Title 42 of the Code of Federal Regulations (CFR) Part 413; the Provider Reimbursement Manual (CMS Pub. 15-1); OMB Circular A-87, and other applicable federal directives, which 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 below.

(ii) 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(a)(i) above. In calculating final reimbursement, any payments made by or on behalf of a Medi-Cal beneficiary for services reimbursed under this Supplement 9 shall be used to reduce the amount due from Medi-Cal.

(iii) Each eligible facility will report costs annually on cost reporting forms approved by the Department which will include a certification that the costs included in the report have been expended. The clinics shall use clinic cost reporting forms that are modeled on the CMS approved FQHC cost reporting form and have been approved by the Department and CMS. See Section B.2 below for how allowable costs are determined. Notwithstanding any regulation to the contrary, cost reports are to be submitted by eligible facilities no later than five (5) months after the close of the fiscal year, unless an extension is granted by the Department.

(iv) Annually, the Department will determine interim, all-inclusive payment rates by dividing the total allowable costs from the most recently audited cost reports by total visits from the same reports. The Department may periodically adjust such rates for inflation or to take into consideration increases or decreases in costs not reflected in the most recently audited cost report to ensure that interim payments approximate actual allowable costs; however, in no event shall interim payments exceed 95% of approximated actual allowable costs.

(v) Interim payments are made on a per-visit basis throughout the fiscal year, based on the facility's claims.

(vi) The Department will perform an interim reconciliation of interim payments to allowable costs as reported on the filed costs after receipt of the filed cost reports. In performing this interim reconciliation, the Department may, if appropriate, make adjustments to costs reported on the filed cost reports based on the results of the most recently completed audit of a prior year cost report. The Department will reconcile interim payments as adjusted during the interim reconciliation process to actual allowable costs after an audit of the cost report is completed. If, at the end of either interim reconciliation or

the audit, it is determined that the eligible facility has been overpaid, the overpayment will be properly credited and paid to the Medi-Cal program. If at the end of either interim reconciliation or the audit, it is determined that an eligible facility has been underpaid, the eligible facility will receive an adjusted payment amount. The Department shall follow Federal Medicaid procedures for managing the overpayment of Federal Medicaid funds.

(vii) Eligible facilities that have patients who have coverage under both the Medicare and Medi-Cal programs ("dually eligible patients") shall seek supplemental reimbursement under this Supplement 9 from the State for care to such patients only as follows:

(I) Dually eligible patients treated in the clinics who are entitled to Medi-Cal benefits irrespective of their Medicare coverage shall be treated on the cost report in the same manner as all other Medi-Cal patients, and all Medicare revenue associated with these visits for which there is coverage under both programs shall be deducted from Medi-Cal allowable costs in determining reimbursement.

(II) Dually eligible patients for whom Medi-Cal is responsible only for Medicare cost sharing amounts shall be treated separately for purposes of the cost reports filed under this Supplement 9. Notwithstanding anything else in the Supplement 9, Medi-Cal reimbursement for care to such individuals shall be limited to Medicare cost sharing amounts, or Medi-Cal allowable payment under this Supplement 9 less any payments received by Medicare, whichever is less, in accordance with Supplement 1 to Attachment 4.19B.

2. The costs of clinics include direct clinic costs (including the direct expense of providing ancillary services and compensating physicians and non-physician practitioners), and clinic overhead costs.

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 shall 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, or and the discrete disallowance of expenses, will be recorded on supporting schedules which will be submitted with the approved cost reporting forms.

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

Regardless of the provisions of the regulations and publications at Section B.1 above, all 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 payors. This ratio is then multiplied by paid Medi-Cal visits to determine Medi-Cal costs.

C. Services Eligible for Cost-Based Reimbursement

1. Subject to paragraphs (2) and (3), below, the services that are subject to cost-based 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 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 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 cost-based reimbursement under this Supplement nor may a visit be counted as a Medi-Cal visit under this Supplement 9:

(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.