



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

SEP 20 2012

Gloria Nagle, PhD, MPA
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 12-024 and is requesting to split the SPA into 12-024A, 12-024B and 12-024C.

SPA 12-024A changes the reimbursement methodology for Non-Designated Public Hospitals (NDPHs) to a Certified Public Expenditure (CPE) methodology.

SPA 12-024B discontinues the supplemental reimbursement program for inpatient hospital services for NDPHs.

SPA 12-024C will add NDPHs to the existing State Plan supplemental payment program that will allow them to obtain reimbursement for the uncompensated costs of providing physician and non-physician practitioner professional services to Medi-Cal beneficiaries.

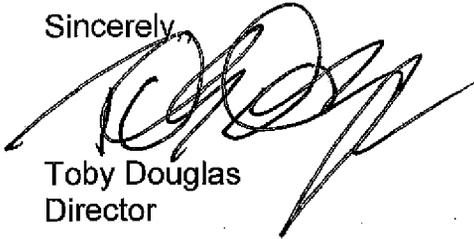
California Assembly Bill (AB) 1467 (Chapter 23, Statutes of 2012) authorized the change in reimbursement methodology to a CPE methodology in State law. Additionally AB 1467 eliminated supplemental payments under the NDPH IGT program established by AB 113 (Chapter 20, Statutes of 2011).

The Department is seeking approval of SPAs 12-024A, 12-024B and 12-024C to implement the changes approved in State law. We are requesting that these SPAs be approved concurrently, in conjunction with the proposed Bridge to Reform Waiver Amendment that the Department submitted to CMS on June 28, 2012.

(Continue Next Page)

If you or your staff have questions or need additional information, please contact Mrs. Pilar Williams, Chief of Safety Net Financing Division, at (916) 552-9130.

Sincerely,

A handwritten signature in black ink, appearing to read 'Toby Douglas', with a long, sweeping underline that extends to the right.

Toby Douglas
Director

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
12-024C

2. STATE
CA

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2012

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 Subpart F and 42 CFR 433.51

7. FEDERAL BUDGET IMPACT:
a. FFY 12/13 \$625,000
b. FFY 13/14 \$625,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 - B, page 52 - 63, 63a, 63b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
Attachment 4.19 - B, page 52 - 63

10. SUBJECT OF AMENDMENT:

Non-Designated Public Hospitals Reimbursement Methodology to Certified Public Expenditure

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 review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Toby Douglas

14. TITLE:

Director

15. DATE SUBMITTED:

SEP 20 2012

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

**REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED AND
NONDESIGNATED PUBLIC HOSPITAL PROVIDERS
FOR COSTS OF PROFESSIONAL SERVICES**

This segment of Attachment 4.19-B provides reimbursement to specified governmental hospitals, nondesignated public 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 governmental hospitals and nondesignated public hospitals specified in Section B 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 governmental hospitals, nondesignated public 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

- + The physician and non-physician practitioner professional costs being addressed in this protocol are limited to professional costs incurred by the governmental hospitals and nondesignated public 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)

NonDesignated Public Hospitals (Effective July 1, 2012)

Alameda Hospital
Antelope Valley Hospital
Bear Valley Community Hospital
Coalinga Regional Medical Center
Colorado River Medical Center
Corcoran District Hospital
Doctors Medical Center – San Pablo Campus
Eastern Plumas Hospital – Portola Campus
El Camino Hospital
El Centro Regional Medical Center
Fallbrook Hospital District
Hazel Hawkins Memorial Hospital
Healdsburg District Hospital
Hi-Desert Medical Center
Jerold Phelps Community Hospital (aka -Southern Humboldt)
John C Fremont Healthcare District
Kaweah Delta District Hospital
Kern Valley Healthcare District
Lompoc Valley Medical Center
Mammoth Hospital
Marin General Hospital
Mayers Memorial Hospital
Mendocino Coast District Hospital
Modoc Medical Center
Mountains Community Hospital
Northern Inyo Hospital
Oak Valley District Hospital
Palm Drive Hospital
Palo Verde Hospital
Palomar Medical Center
Pioneers Memorial Hospital

Plumas District Hospital
Pomerado Hospital
Salinas Valley Memorial Hospital
San Geronio Memorial Hospital
Seneca Healthcare District
Sierra View District Hospital
Sonoma Valley Hospital
Southern Inyo Hospital
Surprise Valley Community Hospital
Tahoe Forest Hospital
Tehachapi Hospital
Tri-City Medical Center
Trinity Hospital
Tulare District Hospital
Washington Hospital - Fremont

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 Worksheet 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.
1. 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.

**REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED AND NON-DESIGNATED PUBLIC HOSPITAL PROVIDERS
FOR COSTS OF PROFESSIONAL SERVICES**

This segment of Attachment 4.19-B provides reimbursement to ~~eligible-specified government-operated governmental~~ hospitals, nondesignated public 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 governmental~~ hospitals and nondesignated public hospitals identified specified 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 governmental~~ hospitals, nondesignated public hospitals, or the government entities with which they are affiliated, will be governed by this segment of Attachment 4.19-B.

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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

4. The physician and non-physician practitioner professional costs being addressed in this protocol are limited to professional costs incurred by the governmental hospitals and nondesignated public 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)

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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)

NonDesignated Public Hospitals (Effective July 1, 2012)

Alameda Hospital
Antelope Valley Hospital
Bear Valley Community Hospital
Coalinga Regional Medical Center
Colorado River Medical Center
Corcoran District Hospital
Doctors Medical Center – San Pablo Campus
Eastern Plumas Hospital – Portola Campus
El Camino Hospital
El Centro Regional Medical Center
Fallbrook Hospital District
Hazel Hawkins Memorial Hospital
Healdsburg District Hospital
Hi-Desert Medical Center
Jerold Phelps Community Hospital (aka -Southern Humboldt)
John C Fremont Healthcare District
Kaweah Delta District Hospital
Kern Valley Healthcare District
Lompoc Valley Medical Center
Mammoth Hospital
Marin General Hospital
Mayers Memorial Hospital
Mendocino Coast District Hospital
Modoc Medical Center
Mountains Community Hospital
Northern Inyo Hospital

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Oak Valley District Hospital
Palm Drive Hospital
Palo Verde Hospital
Palomar Medical Center
Pioneers Memorial Hospital
Plumas District Hospital
Pomerado Hospital
Salinas Valley Memorial Hospital
San Geronio Memorial Hospital
Seneca Healthcare District
Sierra View District Hospital
Sonoma Valley Hospital
Southern Inyo Hospital
Surprise Valley Community Hospital
Tahoe Forest Hospital
Tehachapi Hospital
Tri-City Medical Center
Trinity Hospital
Tulare District Hospital
Washington Hospital - Fremont

~~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;

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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

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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-Worksheet 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.

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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

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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.

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- (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.

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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.

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- 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

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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.

1. 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

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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

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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.

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
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DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

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

DEC 19 2012

Re: Request for Additional Information
California State Plan Amendment 12-024C

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-B of your State Medicaid plan submitted to the Centers for Medicare & Medicaid Services (CMS) on September 20, 2012, under State Plan Amendment (SPA) 12-024C. This SPA extends physician and non-physician practitioner supplemental payments to governmental hospitals classified as "non-designated public hospitals (NDPHs)," effective July 1, 2012. Before we can continue processing this amendment, we need additional or clarifying information. Therefore, we are requesting the following additional information (RAI) pursuant to Section 1915(f)(2) of the Social Security Act (the Act).

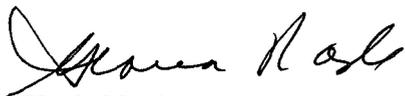
1. On public notice, the documents provided (including the 6/29/2012 CA Regulatory Notice Register and the May revision to the 2012-13 budget) appear to only discuss the NDPH inpatient hospital CPE funding and the elimination of IGT-funded inpatient hospital supplemental payment (covered by SPAs 12-024A and 12-024B respectively). It does not explicitly discuss the physician supplemental payment being extended to also the NDPHs. Please provide documentation that would show that the NDPH physician supplemental payments were part of the public notice.
2. The state's funding question response, Supplement A, appears to provide payment amounts for hospital outpatient services. However, since SPA 12-024C is a physician supplemental SPA, the state should provide physician payment amounts instead.
3. As the state has agreed, the approval of this SPA needs to be coordinated with the SPAs 12-024A and 12-024B as well as the NDPH 1115 waiver amendment that has been submitted.

We are requesting this additional clarifying information under provisions of Section 1915(f) of the Social Security Act (added by P.L. 97-35). This has the effect of stopping the 90-day clock with respect to CMS taking further action on this State plan submittal. A new 90-day clock will not begin until we receive your response to this request for additional information.

In accordance with our guidelines to the State Medicaid Directors dated January 2, 2001, if the State does not respond to our request for additional information or communicate an alternate action plan within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

If you have any questions, please contact Mark Wong at (415) 744-3561 or via email at mark.wong@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Gloria Nagle". The signature is fluid and cursive, with a large initial "G" and a long, sweeping underline.

Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations