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A. Non-institutional services for governmental and private providers listed in Supplement 17 of Attachment 4.19-B are reimbursed the same using the methodology set forth in paragraph (C).

B. The State Agency's rates for non-institutional services listed in Supplement 17 are were posted as of January 1, 2022 and are effective for dates of services on or after that date. The rates for these services are posted on the Medi-Cal Rates website at: https://files.medi-cal.ca.gov/rates/rateshome.aspx.

C. The policy of the State Agency is that reimbursement for each of the other types of care or service listed in Section 1905(a) of the Act that are included in the program under the plan will be at the lesser of usual charges or the limits specified in the California Code of Regulations (CCR), Title 22, Division 3, Chapter 3, Article 7 (commencing with Section 51501) and CCR, Title 17, Chapter 4, Subchapter 13, Sections 6800-6874, for EPSDT health assessment services, or as specified by any other means authorized by state law.

   1. Establishing payment rates may include the following:

      a) The development of an evidentiary base or rate study resulting in the determination of a proposed rate, which may include pertinent input from the public.

      b) To the extent required by State or Federal law or regulations, the presentation of the proposed rate at public hearing to gather public input to the rate determination process.

   2. Effective January 1, 2022, the methodology utilized by the State Agency in establishing payment rates will be as follows:

      a) 80 percent of the lowest maximum allowance established by the federal Medicare program for the same or similar item or service.

         i. The rate described in paragraph C.2.a may be adjusted to keep the Medi-Cal rate at 80 percent of the lowest maximum allowance established by the federal Medicare program, if in calculating the Medi-Cal rate, the conversion indicator or conversion factor used to calculate a unit value results in a rate greater than 80 percent.

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Chapter 3, Article 7 (commencing with Section 51501) and CCR, Title 17, Chapter 4, Subchapter 13, Sections 6800-6874, for EPSDT health assessment services, or as specified by any other means authorized by state law.

1. The methodology utilized by the State Agency in establishing payment rates will be as follows:

   a) The development of an evidentiary base or rate study resulting in the determination of a proposed rate.

   b) To the extent required by State or Federal law or regulations, the presentation of the proposed rate at public hearing to gather public input to the rate determination process.

   c) The determination of a payment rate based on an evidentiary base, including pertinent input from the public.

   d) The establishment of the payment rate through the State Agency's adoption of regulations specifying such rate in the CCR, Title 22, Division 3, Chapter 3, Article 7 (commencing with Section 51501), and CCR, Title 17, Chapter 4, Subchapter 13, commencing with Section 6868, Schedule of Maximum Allowances for EPSDT health assessment, or through any other means authorized by State law.

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(e) Notwithstanding any other provisions of this Attachment to the State Plan pertinent to the methods and levels of reimbursement to providers, rates may be adjusted when required by state statute provided that applicable requirements of 42 CFR Part 447 are met.

(f) (1) In addition, at the beginning of each fiscal year, for the current fiscal year, the director shall establish a monthly schedule of anticipated total payments and anticipated payments for categories of services, according to the categories established in the Governor's Budget. The schedule will be revised quarterly. The director shall report actual total payments and payments for the categories of services monthly to the Director of Finance and to the Joint Legislative Budget Committee.

(2) At any time during the fiscal year, if the director has reason to believe that the total cost of the program will exceed available funds, the director may, first modify the method or amount of payment for services provided that no amount shall be reduced more than 10 percent and no modification will conflict with federal law. At any time during the fiscal year, if the total amounts paid since the beginning of the fiscal year exceed by 10 percent the amounts scheduled, the director shall immediately institute such modification.

(3) At any time during the fiscal year, if the total amount paid for any category of service in the Governor's Budget exceeds by 10 percent the amounts scheduled for that category of service (other than services for which the method or amount of payment is prescribed by the United States Secretary of Health and Human Services pursuant to Title XIX of the federal Social Social Security Act), the director shall modify the method or amount of payment for such category of service to assure that the total amount paid for such category of service in the fiscal year shall be less than 10 percent in excess of the total amount scheduled for the fiscal year for that category of service, provided the total cost of the program to the State General Fund will not exceed appropriated state general funds. If, on the other hand, the director has reason to believe that the total cost of the program to the State General Fund will exceed appropriated state general funds, the method or amount of payment may be further modified as provided in subparagraph (2).

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(4) No modification in method or amount of payment will be made under this paragraph which does not meet all applicable requirements of 42 CFR Part 447. An analysis of provider participation, and the expected impact of any proposed modification on provider participation, will be completed before any modification of payments is made under this paragraph. Where necessary, adjustments to proposed or implemented modifications in method or amount of payment made under this paragraph will be made, to assure compliance with 42 CFR 447.204.

(5) Before any of the above actions are taken, the director shall consult with representatives of concerned provider groups.

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6) For dates of service on or after July 1, 2008, through and including February 28, 2009, reimbursement for the following outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B are reduced by ten percent:

- Outpatient hospital services rendered in and billed by hospital outpatient departments, as described in Attachment 3.1-A, section 2a.
- Emergency medical transportation, as described in Attachment 3.1-A, section 24a, and in Attachment 3.1-B, section 23a.
- Non-drug services provided by a pharmacy, as described in Attachment 3.1-A, including but not limited to sections 7c.1 through 7c.4.
- Providers and services included in Supplement 15 to this Attachment.

The outpatient provider types and services specified below are exempt from the ten percent reduction:

- Services provided and billed by Physicians, as described in Attachment 3.1-A, section 5a.
- Services provided and billed by Clinics, as described in Attachment 3.1-A, section 9.
- Services provided and billed by Optometrists, as described in Attachment 3.1-A, section 6b.
- Services provided and billed by Dentists, as described in Attachment 3.1-A, section 10.

(7) For dates of service on or after July 1, 2008, through and including November 16, 2008, reimbursement for the following outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B are reduced by ten percent:

- Nonemergency medical transportation services, as described in Attachment 3.1-A, section 24a, and in Attachment 3.1-B, section 23a.
- Home health services, as described in Attachment 3.1-A, section 7 (refer to rates on page 20a in this Attachment).

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(8) For dates of service on or after March 1, 2009, reimbursement for the following outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B are reduced by one percent:

- Any and all services provided and billed by Physicians and Clinics to beneficiaries less than age 21, as described in Attachment 3.1-A, sections 5a and 9.
- Home health services, as described in Attachment 3.1-A, section 7 (refer to rates on page 20a in this Attachment).
- For dates of service on or after July 1, 2018, the one percent reduction for home health services, as described in Attachment 3.1-A, section 7, is terminated and no longer applicable.

(9) For dates of service on or after March 1, 2009, through and including May 31, 2011, reimbursement for outpatient services described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B will be reduced by one percent. Providers and services subject to this reduction include:

a. Any and all services provided and billed by Physicians and Clinics to beneficiaries aged 21 and older, as described in Attachment 3.1-A. sections 5a and 9.
b. Medical transportation (emergency and nonemergency), as described in Attachment 3.1-A, section 24a, and in Attachment 3.1-B, section 23a.
c. Services provided and billed by Optometrists, as described in Attachment 3.1-A, section 6b.
d. Services provided and billed by Dentists, as described in Attachment 3.1-A, section 10.
e. Providers and services included in Supplement 15 of this Attachment.

(10) For dates of service on or after March 1, 2009, through and including April 5, 2009, and dates of service on or after January 1, 2011, through and including April 12, 2011, reimbursement for outpatient hospital services set forth in Attachment 3.1-A, section 2a, rendered in and billed by a hospital outpatient department, described on page 1, paragraph (2), otherwise payable in accordance with the methods and standards described on page 1, paragraph (1), in this Attachment 4.19-B, are reduced by one percent.

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(11) For dates of services on or after March 1, 2009, through and including May 31, 2011, reimbursement for non-drug services provided by a pharmacy, set forth in Attachment 3.1-A, including but not limited to sections 7c.1 through 7c.4, otherwise payable in accordance with the methods and standards described on page 1 in this Attachment 4.19-B, are reduced by five percent.

(12) The payment reductions provided in paragraphs (6) and (10) to hospital outpatient department services set forth in Attachment 3.1-A, section 2a, provided and billed by small and rural hospitals, as defined in Section 124840 of California's Health and Safety Code, will be implemented as follows:

- For dates of service provided on or after July 1, 2008, through and including October 31, 2008, a ten percent payment reduction will apply.
- For dates of service provided on or after November 1, 2008, through and including December 31, 2010, no payment reduction will apply.
- For dates of service provided on or after January 1, 2011, through and including April 12, 2011, a one percent payment reduction will apply.
- For dates of services provided on or after April 13, 2011, no payment reduction will apply.

(13) For dates of service on or after June 1, 2011, reimbursement for the following outpatient services will be reduced by ten percent:

- Any and all services provided and billed by Physicians and Clinics to beneficiaries aged 21 and older, as described in Attachment 3.1-A, sections 5a and 9.
- Providers and services included in Supplement 15 of this Attachment.
- Medical transportation (emergency and nonemergency), as described in Attachment 3.1-A, section 24a, and in Attachment 3.1-B, section 23a.
- Services provided and billed by Optometrists, as described in Attachment 3.1-A, section 6b.
- Non-drug services provided by a pharmacy, set forth in Attachment 3.1-A, including but not limited to sections 7c.1 through 7c.4.
- Dental services, as described in Attachment 3.1-A, section 10.

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(14) The payment reductions specified in paragraphs (6) through (13) do not apply to supplemental payments and only apply to the basic Medi-Cal reimbursement rate.

(15) The payment reductions specified in paragraphs (6) through (13) apply only to those services described in Attachment 3.1-A entitled, Amount, Duration, and Scope of Medical and Remedial Care and Service· Provided to the Categorically Needy and Attachment 3.1-8 entitled, Amount, Duration and Scope of Services Provided Medically Needy Group(s), which are billed to the Department directly by the provider that rendered the service.

(16) The payment reductions specified in paragraphs (6) through (13), set forth on pages 3.1 through 3.4 do not apply to the following provider types and services:
- Federally qualified health center services, described in Attachment 3.1-A, sections 2c and 2d, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1115 of the federal Social Security Act.
- Rural health clinic services, as described in Attachment 3.1-A, section 2b.
- Payments to facilities owned or operated by the State Department of Mental Health for psychology services, as defined in Attachment 3.1-A, section 6d.1 or to the State Department of Developmental Services for targeted case management services, as defined in Attachment 3.1-A, section 19.
- Services provided by local education agencies, as described in Attachment 3.1- A, section 24g, and Attachment 3.1-8, section 23g.
- Breast and cervical cancer treatment services, including but not limited to diagnostic, screening, and treatment services related to breast and cervical cancer, as described in Attachment 3.1-A, sections 2a and Sa.
- Family planning services and supplies, as described in Attachment 3.1-A, item 4c, provided by the Family Planning, Access, Care, and Treatment (Family PACT) Program.
- Hospice services, as described in Attachment 3.1-A, section 18.
- For dates of service on or after January 1, 2022, durable medical equipment classified as complex rehabilitation technology and complex rehabilitation technology services, as described in Attachment 3.1-A, sections 2.a - 2.d under "Outpatient hospital services," and section 7.c under "Medical supplies, equipment, and appliances suitable for use in the home."
- For dates of services on or after July 1, 2022, the following services are exempt from the payment reductions specified in paragraphs (6) through (13):

- Nurses, including certified nurse-midwives, nurse anesthetists, certified pediatric nurse practitioners, certified family nurse practitioners, and group certified pediatric nurse practitioners.
- Alternative Birthing Centers
- Audiologists/hearing aid dispensers
- Respiratory care providers
- Durable Medical Equipment (DME)
- Chronic dialysis clinics
- Emergency medical air transportation services
- Non-emergency medical transportation services
- Doula services
- Community health worker services
- DME and related supplies or accessories, that is a continuous glucose monitoring system or continuous glucose monitoring system supplies and accessories
- Physician services and services by other licensed practitioners delivered via remote patient monitoring (RPM)
- Asthma prevention services
- Dyadic services
- Medication therapy management services
- Clinical laboratory services, that are 2019 novel coronavirus disease (COVID-19) diagnostic testing or specimen collection services
- Blood Banks
- Occupational Therapy
- Orthotists
- Psychologists
- Medical Social Work or Medical Social Services
- Speech pathologists
- Outpatient heroin detoxification services
- Dispensing opticians
- Optometrists, including optometry groups
- Acupuncturist
- Portable imaging services
- The following primary care or specialty clinics:
  - Community clinics
  - Free clinics
  - Surgical clinics
  - Rehabilitation clinics
  - Clinics exempt from licensure under Section 1206 of the Health and Safety Code, including non-hospital county-operated community clinics.
- Services provided under the California Children's Services Program and under the Genetically Handicapped Persons Program

▪ For dates of services on or after January 1, 2023, the following services are exempt from the payment reductions specified in paragraphs (6) through (13):
  - Podiatrists
  - Prosthetists

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(17) The effect of the payment reductions in paragraphs (6) through (13) will be monitored in accordance with the “Fee-For-Service Medi-Cal Program Health Care Access Monitoring Plan” that is published at https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Access_Pub_Notice.aspx.

(18) For dates of service on or after April 1, 2012, the payment reductions specified in paragraph (13), at page 3.3, do not apply to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, as described in Attachment 3.1-A, section 4b, when those services are provided and billed by Pediatric Day Health Care facilities.

(19) For dates of service on or after October 20, 2012, the payment reduction specified in paragraph (13), set forth on page 3.3, does not apply to audiology services, as described in Attachment 3.1-A, section 11c (entitled, “Amount, Duration and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy”), when those services are provided by a Type C Communication Disorder Center located in California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma. A Type C Communication Disorder Center is an identified team in a health care provider office or facility capable of providing audiological evaluation, hearing aid evaluation and speech-language remediation, comprehensive assessment and aural rehabilitative management to children of all ages.

(20) For dates of service on or after August 31, 2013, the payment reduction specified in paragraph (13), set forth on page 3.3, will not apply to nonprofit dental pediatric surgery centers which provide at least 99 percent of their dental procedure under general anesthesia to children with severe dental disease under the age of 21.

(21) For dates of service on or after December 1, 2013, the payment reduction specified in paragraph (13), set forth on page 3.3, will not apply to dental pediatric surgery centers provided that they serve at least 95 percent of their Medi-Cal beneficiaries under the age of 21.

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(22) For dates of service on or after July 1, 2015, the payment reduction specified in paragraph (13), set forth on page 3.3, does not apply to dental services and applicable ancillary services provided to beneficiaries of all ages.

(23) For dates of service on or after July 1, 2022, the payment reductions specified in paragraph (13), at page 3.3, do not apply to Community Health Worker Services, as described on page 3N of this Attachment.

(24) For dates of service on or after July 1, 2022, the payment reductions specified in paragraph (13), at page 3.3, do not apply to Asthma Preventive Services, as described on page 3O of this Attachment.

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REIMBURSEMENT METHODOLOGY FOR ESTABLISHING REIMBURSEMENT RATES FOR DURABLE MEDICAL EQUIPMENT, ORTHOTIC AND PROSTHETIC APPLIANCES, AND LABORATORY SERVICES

1. The methodology utilized by the State Agency in establishing reimbursement rates for durable medical equipment as described in State Plan Attachment 3.1-A, paragraph 2a, entitled "Hospital Outpatient Department Services and Organized Outpatient Clinic Services", and Paragraph 7c.2, entitled "Home Health Services Durable Medical Equipment", will be as follows:

   (a) Reimbursement for the rental or purchase of durable medical equipment with a specified maximum allowable rate established by Medicare, except wheelchairs, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, shall be the lesser of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1, entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public or the net purchase price of the item (as documented in the provider's books and records), plus no more than a 100 percent mark-up. (Refer to Reimbursement Methodology table at page 3e.)

      (2) Effective January 1, 2020, reimbursement rates will not exceed 80 percent of the allowable rate for California established by the federal Medicare program for the same or similar item or service, as provided under the Medicare rural fee schedule for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. (Refer to Reimbursement Methodology Table at page 3e.)

   (b) Reimbursement for the rental or purchase of a wheelchair, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, with a specified maximum allowable rate established by Medicare shall be the lowest of the following:

      (1) The amount billed in accordance with California Code of Regulations, Title 22, Section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item (as documented in the provider's books and records), plus no more than 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3e.)

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(2) Effective January 1, 2020, reimbursement rates will not exceed 100 percent of the allowable rate for California established by the federal Medicare program for the same or similar item or service, as provided under the Medicare rural fee schedule for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies. (Refer to Reimbursement Methodology Table at page 3e.)

(c) Reimbursement for the rental or purchase of all durable medical equipment billed to the Medi-Cal program utilizing HCPCS codes with no specified maximum allowable rate (either non-covered by Medicare or Medicare did not establish a reimbursement rate), except wheelchairs, wheelchair accessories, and wheelchair replacement parts, shall be the lowest of the following:

(1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item, (as documented in the provider's books and records) plus no more than 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3e.)

(2) The actual acquisition cost plus a markup to be established by the State Agency based on rate studies and periodic reviews to provide a reasonable reimbursement and maintain adequate access to care. (Refer to Reimbursement Methodology Table at page 3e.)

(3) The manufacturer's suggested retail purchase price, documented by a printed catalog or hard copy of an electronic catalog page published on a date defined by Welfare and Institution Code section 14105.48, reduced by a percentage discount of 20 percent. (Refer to Reimbursement Methodology Table at page 3e.)

(d) Reimbursement for the rental or purchase of wheelchairs, wheelchair accessories, and wheelchair replacement parts billed to the Medi-Cal program utilizing codes with no specified maximum allowable rate (either non-covered by Medicare or Medicare did not establish a reimbursement rate) shall be the lowest of the following:

(1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1 entitled "Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual

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charges made to the general public, or the net purchase price of the item, (as documented in the provider's books and records) plus no more than 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3e.)

(2) The actual acquisition cost plus a markup to be established by the State Agency based on rate studies and periodic review to assure adequate reimbursement and access to care. (Refer to Reimbursement Methodology Table at page 3e.)

(3) The manufacturer's suggested retail purchase price, documented by a printed catalog or a hard copy of an electronic catalog page published on a date defined by Welfare and Institutions Code section 14105.48, reduced by a percentage discount of 20 percent, or by 15 percent if the provider employs or contracts with a qualified rehabilitation professional. (Refer to Reimbursement Methodology at page 3f.)

(e) Reimbursement for the purchase of all durable medical equipment supplies and accessories without a specified maximum allowable rate (either non-covered by Medicare or Medicare did not establish a reimbursement rate), and which are not described in subparagraphs (a)-(d) above, shall be the lesser of the following;

(1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1 entitled ("Upper Billing Limit", that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item (as documented in the provider's books and records) plus no more than 100 percent mark-up. (Refer to Reimbursement Methodology Table at page 3e.)

(2) The acquisition cost for the item, plus a 23 percent markup. (Refer to Reimbursement Methodology Table at page 3f.)

2. Except as otherwise noted in the State Plan, state-developed fee schedule rates established in accordance with Attachment 4.19-B, beginning on page 3a, are the same for both governmental and private providers of DME and the fee schedule.

3. Except as otherwise noted in the State Plan, state-developed fee schedules are the same for both governmental and private providers of prosthetic and orthotic appliances as described in State Plan Attachment 3.1-A, paragraph 12c, entitled "Prosthetic and Orthotic Appliances."

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4. Effective for dates of service on or after July 1, 2021, reimbursement rates for clinical laboratory or laboratory services as described in State Plan Attachment 3.1-A, page 1, paragraph 3, entitled "Other Laboratory and X-ray services," will be established based on rates in effect and approved in the State Plan as of December 31, 2019.

   a) The ten percent payment reductions described in paragraph (13) on page 3.3 of this Attachment shall apply to the new rates established using the methodology described in this paragraph.
      (i) For dates of services on or after July 1, 2022, clinical laboratory services that are 2019 novel coronavirus disease (COVID-19) diagnostic testing or specimen collection services are exempt from the ten percent payment reductions described in paragraph (13) on page 3.3 of this Attachment.
   b) The Department's fee schedule rates are set as of July 1, 2021 and are effective for services on or after July 1, 2021. All rates for clinical laboratories and laboratory services are published at: http://files.medi-cal.ca.gov/rates/RatesHome.aspx
   c) For clinical laboratory or laboratory services that do not appear in the December 31, 2019 fee schedule, the following methodology shall apply: Reimbursement for clinical laboratory or laboratory services shall not exceed the lowest of the following:
      (1) the amount billed,
      (2) the charge to the general public,
      (3) 80% of the lowest maximum allowance established by the federal Medicare Clinical Laboratory fee schedule and Medicare Physician fee schedule effective January 1, 2021 for the same or similar service

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Reimbursement Methodology Table

Paragraph	Effective Date	Percentage/Methodology	Authority
1(a)(1), (b)(1), (c)(1), (d)(1), (e)(1)	August 28, 2013	No more than 100 percent markup	California Code of Regulations, title 22, section 51008.1
1(a)(2)	January 1, 2020	Does not exceed 80% of the allowable rate for California established by the federal Medicare program for the same or similar item or service, as provided under the Medicare rural fee schedule for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	California Welfare and Institutions Code section 14105.48
1(b)(2)	January 1, 2020	Does not exceed 100% of the allowable rate for California established by the federal Medicare program for the same or similar item or service, as provided under the Medicare rural fee schedule for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies	California of Welfare and Institutions Code section 14105.48
1(c)(2)	November 1, 2003	The acquisition cost plus a 67% markup	Rate Study
1(c)(3)	November 1, 2003	The manufacturer’s suggested retail purchase price reduced by percentage discount of 20%	California Welfare and Institutions Code section 14105.48
1(d)(2)	January 1, 2004	The acquisition cost plus a 67% markup	Rate Study

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Paragraph	Effective Date	Percentage/Methodology	Authority
1(d)(3)	January 1, 2004	The manufacturer's suggested retail purchase price reduced by a percentage discount of 20%, or by 15% if the provider employs or contracts with a qualified rehabilitation professional	California Welfare and Institutions Code section 14105.48
1(e)(2)	October 1, 2003	The acquisition cost plus a 23% markup	California Welfare and Institutions Code section 14105.48
3	July 1, 2015	As referenced in Attachment 4.19-B, Page 3c, Paragraph Number 3	California Welfare and Institutions Code section 14105.21

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Reimbursement Methodology Table

Paragraph	Effective Date	Percentage/Methodology	Authority
4	July 1, 2021	Reimbursement rates for clinical laboratory or laboratory services will be established based on rates in effect for Medi-Cal as of December 31, 2019, effective for dates of service on or after July 1, 2021. For clinical laboratory or laboratory services that do not appear in the December 31, 2019 fee schedule, reimbursement rates shall not exceed the lowest of the following: (1) the amount billed, (2) the charge to the general public, (3) 80% of the lowest maximum allowance established by the federal Medicare Clinical Laboratory fee schedule and Medicare Physician fee schedule on January 1, 2021 for the same or similar service.	California Welfare and Institutions Code sections 14105.22 and 14105.222

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REIMBURSEMENT METHODOLOGY FOR RADIOLOGY SERVICES

1) Except as otherwise noted in the State Plan, state-developed fee schedules are the same for both governmental and private providers of radiological services. Effective January 1, 2022, the department's fee schedule rates for radiology services will be adjusted. All Medi-Cal Fee for Service rates are published at: **https://files.medi-cal.ca.gov/rates/rateshome.aspx**

2) Effective January 1, 2022, the reimbursement rates for radiology services will continue to be set at no more than 80 percent of the corresponding Medicare 2022 Physician Fee Schedule rates. Any rate at or below 80 percent of the applicable Medicare rate will not be decreased.

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REIMBURSEMENT METHODOLOGY FOR TELEHEALTH SERVICES DELIVERED VIA REMOTE PATIENT MONITORING

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1. The reimbursement rates for physician services and services by other licensed practitioners described in Sections 1905(a)(5)(A), 1905(a)(6), 1905(a)(17), and 1905(a)(21) of the Act, and as described in State Plan Attachments 3.1-A and 3.1-B, delivered via remote patient monitoring will be calculated by the Department of Health Care Services (DHCS) using the following methodology:
   a. For dates of service on or after July 1, 2021, the reimbursement rates for services delivered via remote patient monitoring are established at the lowest of the following:
      i. the amount billed,
      ii. the charge to the general public, or
      iii. 80 percent of the corresponding Medicare 2021 Physician Fee Schedule rates for the same or similar service.
   b. The payment reductions, described in paragraphs (6) through (13), set forth on pages 3.1 through 3.4 of this Attachment, shall apply to reimbursement for services delivered via remote patient monitoring as described in this section. For dates of service on or after July 1, 2022, the payment reductions described in paragraphs (6) through (13), set forth on pages 3.1 through 3.4 of this Attachment shall no longer apply to services delivered via remote patient monitoring as described in this section.
   c. The DHCS fee schedule rates are set as of July 1, 2021 and are effective for services provided on or after that date. All Medi-Cal Fee-For-Service rates for services delivered via remote patient monitoring are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx.

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REIMBURSEMENT METHODOLOGY FOR BIO-ENGINEERED SUBSTITUTE (SKIN GRAFT) CODES

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1. Notwithstanding any other provision of this Attachment, the methodology utilized by the State Agency in establishing reimbursement rates for bio-engineered substitutes (skin graft), as described in State Plan Attachment 3.1-A and 3.1-B, will be calculated by the Department of Health Care Services (DHCS) using the following methodology:

    a. For dates of service on or after January 1, 2022, the reimbursement rates shall be the lowest of the following:

        i. the amount billed
        ii. the charge to the general public
        iii. the rate in effect on the Medi-Cal Fee schedule for the current rate year, which shall be the lowest of the following:
            1. the rate in effect on the Medi-Cal Fee schedule as of December 31 of the preceding rate year.
            2. 100 percent of the corresponding lowest maximum Medicare Average Sales Price (ASP) rate, for the same or similar service provided in the current rate year.

                a. The rate described in paragraph 1.a.iii.2 may be adjusted to keep the Medi-Cal rate below 100 percent of the lowest maximum allowance established by the federal Medicare program, if in calculating the Medi-Cal rate, the conversion indicator or conversion factor used to calculate a unit value results in a rate greater than 100 percent.

    b. The ten percent payment reduction included in paragraph (13) on page 3.3 of this Attachment, shall apply to the services described in this section.

STATE PLAN UNDER TITLE XIX OF SOCIAL SECURITY ACT
STATE: California

REIMBURSEMENT METHODOLOGY FOR
COMMUNITY HEALTH WORKER SERVICES

1. Notwithstanding any other provision of this Attachment, the methodology utilized by the State Agency in establishing reimbursement rates for Community Health Worker (CHW) services, as described on pages 18e-18g of the Limitations on Attachment 3.1-A, will be calculated by the Department of Health Care Services (DHCS) using the following methodology:
   a. For dates of service on or after July 1, 2022, the reimbursement rates shall be the lowest of the following:
      i. the amount billed,
      ii. the charge to the general public, or
      iii. 80 percent of the lowest maximum allowance established no earlier than July 1, 2022 by the federal Medicare program for the same or similar item or service.
         1. The rate described in paragraph 1.a.iii may be adjusted to keep the Medi-Cal rate below 80 percent of the lowest maximum allowance as established on July 1, 2022 by the federal Medicare program, if in calculating the Medi-Cal rate, the conversion indicator or conversion factor used to calculate a unit value results in a rate greater than 80 percent.
   b. The services described in this section is exempt from the ten percent payment reduction described in paragraph (13) on page 3.3 of this Attachment.
   c. All Medi-Cal Fee-For-Service rates for CHW services established using this methodology can be found at: https://files.medi-cal.ca.gov/rates/rateshome.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

REIMBURSEMENT METHODOLOGY FOR
ASTHMA PREVENTIVE SERVICES

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1. Notwithstanding any other provision of this Attachment, the methodology utilized by the State Agency in establishing reimbursement rates for Asthma Preventive Services, as described in State Plan Attachment 3.1-A, section 13c, will be calculated by the Department of Health Care Services (DHCS) using the following methodology:
    a. For dates of service on or after July 1, 2022, the reimbursement rates shall be the lowest of the following;
        i. the amount billed,
        ii. the charge to the general public, or
        iii. 80 percent of the lowest maximum allowance as established on July 1, 2022 by the federal Medical program for the same or similar item or service.
            1. The rate described in paragraph 1.a.iii may be adjusted to keep the Medi-Cal rate below 80 percent of the lowest maximum allowance as established on July 1, 2022 by the federal Medicare program, if in calculating the Medi-Cal rate, the conversion indicator or conversion factor used to calculate a unit value results in a rate greater than 80 percent.
    b. The services described in this section are exempt from the ten percent payment reduction described in paragraph (13) on page 3.3 of this Attachment.
    c. All Medi-Cal Fee-For-Service rates for Asthma Preventive Services established using this methodology can be found at: https://files.medi-cal.ca.gov/rates/rateshome.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

REIMBURSEMENT METHODOLOGY FOR
LICENSED PHARMACISTS SERVICES

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1. Notwithstanding any other provision in this Attachment, the methodology utilized by the State Agency in establishing reimbursement rates for Licensed Pharmacists Services, as described in Limitations on State Plan Attachment 3.1-A pages 12a.7 through 12a.7a and Limitations on State Plan Attachment 3.1-B pages 12a.7 through 12a.7a, will be calculated by the Department of Health Care Services (DHCS) using the following methodology:
    a. Licensed Pharmacists Services, other than Medication Therapy Management (MTM) Services, are reimbursed at 85 percent of the current Medicare fee schedule. Payment for Licensed Pharmacist Services, including Pharmacist delivered MTM, does not include dispensing services outlined in Supplement 2 to Attachment 4.19-B.
        i. Reimbursement rates for MTM Services are set as of July 1, 2021 and are effective for services provided on or after that date. All rates for MTM Services with the associated Current Procedural Terminology (CPT) billing codes are shown in the table below:

CPT Code	CPT Code Description	Reimbursement Rate
99605	Medication therapy management service(s) provided by pharmacist, individual, **face-to-face** with patient, with assessment and intervention if provided; **new** patient visit, initial 15 minutes	$ 43.00
99606	Medication therapy management service(s) provided by pharmacist, individual, **face-to-face** with patient, with assessment and intervention if provided; **established** patient visit, initial 15 minutes	$43.00
99607	Add-on code for each additional 15-minute increment	$32.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: California

REIMBURSEMENT METHODOLOGY FOR GENETIC DISEASE SCREENING PROGRAM SERVICES

1. Newborn Screening (NBS) Program: Notwithstanding any other provision in this Attachment, effective July 1, 2022, the Department of Health Care Services (DHCS) will establish the reimbursement rates for the NBS Program's Newborn Metabolic Screening Panel (code S3620), as described in Attachment 3.1-A, section 13c, in accordance with the rate table below. The rate for the Newborn Metabolic Screening Panel is established based on the participation fees providers are charged by the California Department of Public Health as of July 1, 2022.

   Rate Table:

Procedure Code	Rate	Effective Date
Newborn Metabolic Screening Panel, code S3620	$211.00	July 1, 2022

2. Prenatal Screening (PNS) Program: Notwithstanding any other provision in this Attachment, effective September 19, 2022, the reimbursement rate for the PNS Program's Maternal Serum Alpha-Fetoprotein (MSAFP) Screening (code 82105), as described in Attachment 3.1-A, section 13c, will be in accordance with the rate table below. The rate for the MSAFP Screening is based on the participation fees providers are charged by the California Department of Public Health as of September 19, 2022.

   Rate Table:

Procedure Code	Rate	Effective Date
Maternal Serum Alpha-Fetoprotein (MSAFP) Screening Program, code 82105	$85.00	September 19, 2022

3. The ten percent payment reduction, described in paragraph (13) on page 3.3 of this Attachment, shall apply to reimbursement for GDSP services if billed by a non-exempt provider as described on pages 3.4 and 3.5.

4. All Medi-Cal Fee-For-Service rates, including the rates for GDSP Services, are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: California

REIMBURSEMENT METHODOLOGY FOR NON-EMERGENCY MEDICAL TRANSPORTATION

1. Notwithstanding any other provision in this Attachment, the Department of Health Care Services (DHCS) will establish the following reimbursement rates for the below Non-Emergency Medical Transportation (NEMT) services, for dates of service on or after July 1, 2022:

NEMT Service	Rate
Non-emergency transportation: wheelchair van	$20.30
Basic Life Support (BLS) mileage (per mile) (use for wheelchair and litter van transports only)	$1.50

   a. All Medi-Cal Fee-For-Service rates for NEMT services are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

REIMBURSEMENT METHODOLOGY FOR DOULA SERVICES

1. Notwithstanding any other provision of this Attachment, the methodology utilized by the State Agency in establishing Medi-Cal fee-for-service reimbursement rates for Doula services, as described in paragraph 13(c) and paragraph 29.b of the Limitations on Attachment 3.1-A, as well as paragraph 13(c), and paragraph 28.b of the Limitations on Attachment 3.1-B, will be calculated by the Department of Health Care Services (DHCS) using the following methodology:
    a. For dates of service on or after January 1, 2023, the reimbursement rates for doula services will be established based on the Medi-Cal Fee-For-Service fee schedule rates in effect on December 31, 2022, for the same or similar services.
    b. The services described in this section are exempt from the ten percent payment reduction described in paragraph (16) on page 3.4 of this Attachment.
    c. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of doula services. Medi-Cal Fee-For-Service rates for Doula services were set as of January 1, 2023, and are effective for services provided on or after that date. All rates are published at: https://files.medi-cal.ca.gov/rates/rateshome.aspx

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Terrirory California

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES (OTHER THAN INPATIENT HOSPITAL, AND LONG TERM CARE FACILITIES).

X Case Management Services

See Case Management Rates (Attached).

Reimbursement Unit of Services

For client data purposes and research, a case management unit of service is defined by DMH as a face-to-face or telephone contact with a client, regardless of the length of time. That contact is documented in the client case management record and, ultimately, reported to the State as part of the Client Data System. For purposes of cost analysis, rate development, and reimbursement, the case management unit of service is defined as a service period (accumulated contacts with the client, the client's family, significant others, and care providers) of fifteen minutes; partial units of time are rounded to the nearest quarter-hour increment. The unit of time serves as the basis for reimbursement for both Short-Doyle (State funds only) and SD/MC (State funds and FFP).