State/Territory California

Citation Condition or Requirement

REIMBURSEMENT OF REHABILITATIVE MENTAL HEALTH AND TARGETED CASE MANAGEMENT SERVICES

A. GENERAL APPLICABILITY

Reimbursement of rehabilitative mental health and targeted case management services provided by eligible private providers will be limited to the lower of the provider's reasonable and allowable cost, as determined in the CMS approved State-developed cost report, or usual and customary charge for the type of service provided for the reporting period. Reimbursement of rehabilitative mental health and targeted case management services provided by county owned and operated providers and county owned and operated hospital-based providers will be based upon the provider's certified public expenditures pursuant to Section 433.51 of Title 42 Code of Federal Regulations.

B. DEFINITIONS

"Service coordinating organization" means a privately operated entity that contracts with eligible providers and arranges with those providers for the delivery of rehabilitative mental health services and/or targeted case management services provided to Medi-Cal beneficiaries. A service coordination organization does not provide rehabilitative mental health services and/or targeted case management services.

"Cognizant agency" for county owned and operated providers means the California State Controller's Office. The Cognizant agency for other providers means the single federal agency that represents all other federal agencies in dealing with a grantee within common areas, such as the development of an indirect cost rate.

"County owned and operated hospital-based outpatient provider" means a hospital that is owned and operated by a county government and that provides rehabilitative mental health or targeted case management services to Medi-Cal beneficiaries on an outpatient basis.

"County owned and operated provider" means a provider of rehabilitative mental health and targeted case management services that is owned and operated by a county government, which provides services through employed or contracted licensed mental health professionals, waivered/registered professionals and other qualified providers as those providers are defined in Supplement 1 and Supplement

3 to Attachment 3.1-A of the State plan. County government provider does not include a county government hospital-based outpatient provider, individual provider, group provider, or service coordinating organization.

"Eligible provider" means a county owned and operated hospital-based outpatient provider, state owned and operated hospital-based outpatient provider, private hospital-based outpatient provider, county owned and operated provider, state owned and operated provider, private organizational provider, individual provider, group provider, or other qualified provider.

"Group provider" means an organization that provides rehabilitative mental health services through two or more individual providers, such as independent practice associations. Group providers do not include hospital-based outpatient providers, county owned and operated providers, private organizational providers, or administrative service organizations.

"Individual provider" means a licensed mental health professional whose scope of practice permits the practice of psychotherapy without supervision. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and registered nurses with a master's degree.

"Private hospital-based outpatient provider" means a hospital that is owned and operated by a private entity that provides rehabilitative mental health or targeted case management services to Medi-Cal beneficiaries on an outpatient basis.

"Private organizational provider" means a provider of rehabilitative mental health services and/or targeted case management that is owned and operated by a private entity, which provides services through employed or contracted licensed mental health professionals, waivered/registered professionals and other staff who are qualified to provide rehabilitative mental health and/or targeted case management services as described in Supplement 1, pages 8 through 17, and Supplement 3 to Attachment 3.1-A of the State Plan.

"Professional service contract" means a contract between a county owned and operated provider and an individual provider, group provider, service coordinating organization, or other qualified provider of rehabilitative mental health and/or targeted case management services.

"Psychiatric inpatient hospital professional services" means services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

"Rehabilitative Mental Health Services" means any of the following: mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, psychiatric health facility services, and peer support services, provided to individuals who meet medical necessity criteria as defined in Supplement 3 to Attachment 3.1-A of the State plan; and services provided in a treatment foster home.

"Relative value statistic" means a statistic that has been developed from dissimilar elements that acts as a common basis for the purpose of allocating a pool of costs.

"Schedule of Maximum Rates (SMR)" means a schedule of maximum rates per unit of service, as defined in Section G of this Segment, which will be paid for each type ofservice.

"SD/MC hospital" means a hospital as defined in Attachment 3.19-A, Pages 38-40 of the State Plan. A SD/MC hospital may be a UC hospital, may be owned and operated by a county government, or may be owned and operated by a private entity.

"State Owned and Operated Provider" means a provider that is owned and operated by the Regents of the University of California.

"Targeted Case Management" has the meaning defined in supplement 1 to attachment 3.1-A, pages 8-17 of the State Plan.

"Services Provided in a Treatment Foster Home" means a bundle of rehabilitative mental health services provided to children and youth up to 21 years of age who have been placed in a Residential Treatment Foster Home and who meet medical necessity criteria for this service as established by the State. The bundle of

rehabilitative mental health services includes plan development, rehabilitation, collateral, and crisis intervention, as those services are defined in Supplement 3 to Attachment 3.1-A of the State Plan. The bundle of services are provided by an other qualified provider under the direction of a licensed mental health professional as those provider types are defined in Supplement 3 to Attachment 3.1-A of the State Plan.

"Third party revenue" means revenue collected from an entity other than the Medi-Cal program for a service rendered.

"UC Hospital" means a hospital that is owned and operated by the University of California Regents.

C. REIMBURSEMENT METHODOLOGY AND PROCEDURES – COUNTY OWNED AND OPERATED PROVIDERS AND PRIVATE ORGANIZATIONAL PROVIDERS

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for rehabilitative mental health and targeted case management services provided by county owned and operated providers and private organizational providers.

1. Interim Payments

Interim payments to county owned and operated providers and private organizational providers are intended to approximate the allowable Medicaid (Medi-Cal) costs incurred by the provider for services rendered to Medi-Cal beneficiaries. Interim payments for rehabilitative mental health and targeted case management services provided by county government providers and private organizational providers will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for each rehabilitative mental health service and targeted case management for each county government and private organizational provider when cost report data is available.

- Include the gross costs allocated to each type of service from the most recently filed CMS-approved State-developed cost report.
- Include the total units of service for each type of service from the most recently filed CMS-approved State-developed cost report.
- Divide the gross costs by the total units of service to calculate the cost per unit for each type of service.
- Multiply the cost per unit by one plus the percentage change in the CMS approved cost of living index.

When cost report data is not available for a rehabilitative mental health service or targeted case management, the State will set the interim rate at the SMIR calculated for the service as described in Section G of this segment.

2. Cost Report Submission
Each county owned and operated provider and private organizational provider that receives reimbursement for rehabilitative mental health and targeted case management services pursuant to this section is required to file a CMS-approved State-developed cost report by December 31st following the close of the State Fiscal Year (i.e., June 30th). Each county owned and operated provider must certify that it's cost report is based on actual, total expenditures as necessary for claiming Federal Financial Participation pursuant to all applicable requirements of state and federal law including Sections 430.30 and 433.51 of Title 42 Code of Federal Regulations.

3. Cost Determination
The reasonable and allowable cost of providing rehabilitative mental health and targeted case management services for each county owned and operated provider and private organizational provider will be determined in the CMS-approved State-developed cost report pursuant to the following methodology.

   - Total allowable costs include direct and indirect costs that are determined in accordance with the reimbursement principles in Part 413 of Title 42 of the Code of Federal Regulations, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy.
   - Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged to rehabilitative mental health and targeted case management services.
   - Indirect costs may be determined by applying the cognizant agency specific approved indirect cost rate to its net direct costs, allocating indirect costs based upon the allocation process in the agency's approved cost allocation plan, or allocating indirect costs based upon direct program costs.
   - Indirect costs allocated pursuant to an approved cost allocation plan will be reduced by any unallowable amount based on CMS' Medicaid non-institutional reimbursement policy.

For the following subset of rehabilitative mental health services – Adult Residential Treatment Services, Crisis Residential Treatment Services, services provided in a treatment foster home and Psychiatric Health Facility Services – allowable costs are determined in accordance to the reimbursement principle in title 42 CFR 413, OMB

Circular A-87 and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies and overhead costs determined using one of the following methods:

- The provider may allocate overhead costs based upon an approved indirect cost rate.
- When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are "directly attributable" to the professional component of providing the medical services using a CMS approved allocation methodology.
- Overhead costs that are not directly attributable to the provision of medical services but would "benefit" multiple purposes and generally be incurred at the same level if the medical service did not occur, will not be allowable (e.g. room and board, allocated cost from other related organizations).

4. Allocating Costs to Services
   Allowable direct and indirect costs will be allocated to each type of rehabilitative mental health service and targeted case management using one or more of the following three methods;

   - Direct assignment: Providers with the ability to determine costs at the service level may directly assign allowable direct and indirect costs.
   - Time study: Providers may allocate allowable direct and indirect costs among services based upon the results of a CMS-approved time study.
   - Relative value: Providers that render multiple types of service may allocate allowable direct and indirect costs among services based upon relative value statistics.

5. Apportioning Costs to Medicaid (Medi-Cal)
   Total allowable direct and indirect costs allocated to a type of service will be apportioned to the Medi-Cal program based upon units of service. For each type of rehabilitative mental health and targeted case management service, the provider will report on the CMS-approved State-developed cost report, the total units of service it provided to all individuals. Units of service will be measured in increments of time as defined in Section H below. The total direct and indirect costs allocated to a particular type of rehabilitative mental health service or to targeted case management will be divided by the total units of service reported for the same type of service to determine the cost per unit of service.

   For each type of rehabilitative mental health and targeted case management service, the provider will report the total units of service provided to Medi-Cal

beneficiaries. The cost per unit calculated for each rehabilitative mental health service and for targeted case management will be multiplied by the total units of that service provided to Medi-Cal beneficiaries to apportion costs to the Medi-Cal program.

For each type of rehabilitative mental health service and for targeted case management, the provider will also report all third party revenue and patient share of cost collected for the services rendered to Medi-Cal beneficiaries. The costs apportioned to the Medi-Cal program for each type of rehabilitative mental health service and for targeted case management will be reduced by the total third party revenue and patient share of cost the provider collected for each type of service rendered to determine the cost eligible for reimbursement.

6. Reconciliation
   No later than eighteen months after the close of the State Fiscal Year, each county government provider and private organizational provider will reconcile the units of service that were provided to Medi-Cal beneficiaries as reported in its filed CMS-approved state-developed cost report with the provider's records received from the State regarding the result of the State's claims adjudication.

7. Interim Settlement
   Not later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of each county government provider's and private organizational provider's reconciled cost report. The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the CMS-approved State-developed cost report. Total reimbursable costs for private organizational providers are equal to the lower of the provider's reasonable and allowable costs or usual and customary charge for the services provided for the reporting period. Total reimbursable costs for county government providers are equal to the provider's reasonable and allowable costs for the services provided for the reporting period. If the total reimbursable costs are greater than the total interim payments, the State will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR 433.316.

8. Final Settlement Process
   The State will complete the audit process of the interim settled state-developed cost report, as described in Section C.7, within three years of the date the

certified reconciled state-developed cost report is submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS-approved state-developed cost report are reasonable, allowable, and in accordance with State and Federal rules and regulations, including Medicare principles of reimbursement issued by CMS and CMS' Medicaid non-institutional reimbursement policy. The audit will also determine that the provider's CMS-approved state-developed cost report represents the actual cost of providing rehabilitative mental health and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, CMS' Medicaid non-institutional reimbursement policy, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. If the total reimbursable costs are greater than the total interim payments, the state will pay the provider the difference.

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D. REIMBURSEMENT METHODOLOGY AND PROCEDURES – COUNTY OWNED AND OPERATED HOSPITAL-BASED OUTPATIENT PROVIDERS, STATE OWNED AND OPERATED HOSPITAL-BASED OUTPATIENT PROVIDERS AND PRIVATE HOSPITAL-BASED OUTPATIENT PROVIDERS

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for rehabilitative mental health and targeted case management services provided by county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers.

1. Interim Payments

   Interim payments to county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers are intended to approximate the Medicaid (Medi-Cal) costs incurred by the provider for services rendered to Medi-Cal beneficiaries. Interim payments for rehabilitative mental health and targeted case management services provided by county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for each

rehabilitative mental health service and targeted case management for each county owned and operated and private hospital-based outpatient provider.

- Include the gross costs allocated to each type of service from the most recently filed CMS 2552 and supplemental schedules.
- Include the total units of service for each type of service from the most recently filed CMS 2552 and supplemental schedules.
- Divide the gross costs by the total units of service to calculate the cost per unit for each type of service.
- Multiply the cost per unit by one plus the percentage change in a CMS approved cost of living index.

When cost report data is not available for a rehabilitative mental health service or targeted case management, the State will set the interim rate at the SMIR calculated for the service as described in Section G of this segment.

2. Cost Report Submission
Each county owned and operated hospital-based outpatient provider, state owned and operated hospital-based outpatient provider and private hospital-based outpatient provider that receives reimbursement for rehabilitative mental health and targeted case management services pursuant Section D will be required to file a CMS 2552 hospital cost report and supplemental schedules by December 31st following the close of the State Fiscal Year (i.e., June 30th). Each county owned and operated hospital-based outpatient provider must certify that it's cost report is based on actual, total expenditures as necessary for claiming Federal Financial Participation pursuant to all applicable requirements of state and federal law including Sections 430.30 and 433.51 of Title 42 Code of Federal Regulations.

3. Cost Determination
The reasonable and allowable cost of providing outpatient services for each county owned and operated hospital-based outpatient provider and private hospital-based outpatient provider will be determined on the CMS 2552 hospital cost report and supplemental schedules.

4. Apportioning Costs to Medicaid (Medi-Cal)
The reasonable and allowable cost of providing outpatient services as determined on the CMS 2552 hospital cost report will be apportioned to rehabilitative mental health services (except for adult residential treatment, crisis residential treatment, services provided in a treatment foster home, and psychiatric health facilities) and targeted case management, as described under

Section H, provided to Medi-Cal beneficiaries based upon a cost-to-charge ratio. Each hospital-based outpatient provider will transfer the total costs for each outpatient cost center as determined on the CMS 2552 hospital cost report to a supplemental schedule. Each hospital will report its total charges for outpatient services provided in each outpatient cost center on the supplemental schedule. The supplemental schedule will divide the total costs by the total charges for each outpatient cost center to calculate the cost-to-charge ratio. Each hospital based outpatient provider will report on the supplemental schedules, the total charges for rehabilitative mental health and targeted case management services provided in each outpatient cost center to Medi-Cal beneficiaries. The supplemental schedules will multiply the Medi-Cal charges for rehabilitative mental health and targeted case management services by the cost-to-charge ratio for each outpatient cost center to calculate the outpatient costs apportioned to the Medi-Cal program for each outpatient cost center.

5. Reconciliation
   No later than eighteen months after the close of the State Fiscal Year, each hospital-based outpatient provider will reconcile the Medi-Cal charges it reported on the supplemental schedules for rehabilitative mental health and targeted case management services. Each hospital-based outpatient provider will reconcile the Medi-Cal charges it reported with records it received from the State regarding the results of claims adjudication.

6. Interim Settlement
   No later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of the CMS 2552 hospital cost report and supplemental schedules submitted by each county owned and operated hospital-based outpatient provider, state owned and operated hospital-based outpatient provider and private hospital-based outpatient provider. The interim settlement will compare interim payments made to each county owned and operated hospital-based outpatient provider and private hospital-based outpatient provider with the total reimbursable costs. The CMS 2552 and supplemental schedules is used to calculate total reimbursable costs. Total reimbursable costs for private hospital-based outpatient providers and state-owned and operated hospital-based outpatient providers are equal to the lower of the provider's allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules or usual and customary charge for the services provided. Total reimbursable costs for county owned and operated hospital-based outpatient providers are equal to the provider's reasonable and allowable costs determined in the CMS 2552 hospital cost report and supplemental

schedules for the services provided for the reporting period. The State will pay the provider an additional amount if the total reimbursable cost is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

7. Final Settlement Process
   The State will complete its audit of the interim settled CMS 2552 hospital cost report and supplemental schedules within three years of the date the certified reconciled CMS 2552 hospital cost report and supplemental schedules are submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS 2552 hospital cost report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the CMS. The audit will also determine that the provider's CMS 2552 hospital cost report and supplemental schedules represent the actual cost of providing rehabilitative mental health and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the provider an additional amount if the total reimbursable cost is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

E. REIMBURSEMENT METHODOLOGY AND PROCEDURES – PSYCHIATRIC HOSPITAL PROFESSIONAL SERVICES PROVIDED IN SD/MC HOSPITALS
   The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for psychiatric hospital professional services provided in SD/MC hospitals.

   1. Interim Payments
      Interim payments for psychiatric hospital professional services provided in SD/MC hospitals are intended to approximate the Medicaid (Medi-Cal) costs incurred by the SD/MC hospital for the services rendered to Medi-Cal beneficiaries. Interim payments for psychiatric hospital professional services provided in SD/MC hospitals will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for psychiatric hospital professional services provided in each SD/MC hospital.

- Include the gross costs allocated to each type of service from the most recently filed CMS 2552 and supplemental schedules.
- Include the total units of service for each type of service from the most recently filed CMS 2552 and supplemental schedules.
- Divide the gross costs by the total units of service to calculate the cost per unit for each type of service.
- Multiply the cost per unit by one plus the percentage change in a CMS approved cost of living index.

2. Cost Report Submission
Each SD/MC hospital that receives reimbursement for psychiatric hospital professional services pursuant to this section will be required to file a CMS 2552 hospital cost report and supplemental schedules by December 31st following the close of the State Fiscal Year (i.e., June 30th). Each SD/MC hospital that is owned and operated by a county government must certify that it's cost report is based on actual, total expenditures as necessary for claiming Federal Financial Participation pursuant to all applicable requirements of state and federal law including Sections 430.30 and 433.51 of Title 42 Code of Federal Regulations.

3. Cost Determination
The reasonable and allowable cost of providing psychiatric hospital professional services for each SD/MC hospital will be determined on the CMS 2552 hospital cost report and supplemental schedules.

4. Apportioning Costs to Medicaid (Medi-Cal)
The reasonable and allowable cost of providing psychiatric hospital professional services as determined on the SD/MC hospital's CMS 2552 hospital cost report will be apportioned to the Medi-Cal program based upon a cost-to-charge ratio. Each SD/MC hospital will transfer the total costs for hospital professional services as determined on the CMS 2552 hospital cost report to a supplemental schedule. Each hospital will report its total professional services charges for each cost center on the supplemental schedule. The supplemental schedule will divide the total costs by the total charges for each cost center containing hospital professional service costs and charges. Each SD/MC hospital will report, on another supplemental schedule, the total charges for psychiatric hospital professional services provided to Medi-Cal beneficiaries in each cost center. The supplemental schedule will multiply the Medi-Cal charges for psychiatric hospital professional services by the

cost-to-charge ratio for each cost center to calculate the hospital professional service costs apportioned to the Medi-Cal program for psychiatric hospital services.

5. Reconciliation
   No later than eighteen months after the close of the State Fiscal Year, each SD/MC hospital will reconcile the Medi-Cal charges it reported on the supplemental schedules for psychiatric hospital professional services. Each SD/MC hospital will reconcile the Medi-Cal charges it reported with records it received from the State regarding the results of claims adjudication.

6. Interim Settlement
   No later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of the CMS 2552 hospital cost report and supplemental schedules submitted by each SD/MC hospital. The interim settlement will compare interim payments made to each SD/MC hospital with the total reimbursable cost. The CMS-approved state developed cost report is used to calculate the total reimbursable costs. Total reimbursable costs for SD/MC hospitals that are owned and operated by a private entity are equal to the lower of the SD/MC hospital's allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules or usual and customary charge for the psychiatric hospital professional services provided. Total reimbursable costs for SD/MC hospitals that are a UC hospital or owned and operated by a county government are equal to the provider's reasonable and allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules. The State will pay the SD/MC hospital an additional amount if the total reimbursable costs are more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

7. Final Settlement Process
   The State will complete its audit of the interim settled CMS 2552 hospital cost report and supplemental schedules within three years of the date the certified reconciled CMS 2552 hospital cost report and supplemental schedules are submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS 2552 hospital cost report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the Centers for Medicare and Medicaid Services (CMS). The audit will also determine that the provider's CMS 2552 hospital cost report and supplemental

schedules represent the actual cost of providing rehabilitative and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the provider an additional amount if the total reimbursable costs is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

F. REIMBURSEMENT METHODOLOGY AND PROCEDURES – INDIVIDUAL AND GROUP PROVIDERS AND OTHER QUALIFIED PROVIDERS

Individual and group providers and other eligible providers that render rehabilitative mental health services and/or targeted case management services will be reimbursed based upon the SMIR.

G. SCHEDULE OF MAXIMUM RATES

The State originally calculated the Schedule of Maximum Interim Rates (SMIR) for targeted case management services and rehabilitative mental health services, except crisis stabilization, crisis residential treatment, and adult residential treatment, using data from state fiscal year 1998-99 cost reports. These rates are updated on an annual basis and published in an information notice that is posted to the single state agency's website. The following describes the methodology the State used to calculate the original SMIR and the methodology the state will use to annually update those rates.

1. Extract from each provider's cost report the reported gross costs for each type of service and reported units of service for each type of service. Gross costs do not include county administrative and utilization review costs.
2. Divide gross costs by units of service for each type of service.
3. Remove from the data set those providers that have a cost per unit that is one standard deviation above the mean.
4. After completing step 3, remove those providers that have a cost per day in the top ten percent of the remaining providers.
5. From the remaining providers, calculate the sum of gross costs reported for each type of service.

6. From the remaining providers, calculate the sum of the units of service reported for each type of service.
7. Divide the sum of gross costs determined in step 5 by the sum of the units of service as determined in step 6 to calculate the statewide average cost per unit for each type of service.
8. The statewide average cost per unit calculated in step 7 will be increased on an annual basis, effective the first day of each state fiscal year, using the change in the home health agency market basket index.

The State calculates that the SMIR for peer support services will be equal to the interim rate set for targeted case management services. The statewide average cost per unit for peer support services will be increased on an annual basis, effective the first day of each state fiscal year, using the change in the home health agency market basket index. The annually updated cost per unit for peer support services will be published in an annual information notice that is posted to the single state agency's website.

The State originally calculated the SMIR for crisis stabilization using a cost survey of fourteen county programs that provided services for up to 24 hours in an emergency room setting. The statewide average cost per unit for crisis stabilization services will be increased on an annual basis, effective the first day of each fiscal year, using the change in the home health agency market basket index. The annually updated cost per unit for crisis stabilization services will be published in an annual information notice that is posted to the single state agency's website.

The State originally calculated the SMIR for crisis residential treatment and adult residential treatment services based on a cost survey from approximately sixty facilities. The survey distinguished between the cost of treatment from the cost for room and board, which is excluded from the SMIR for crisis residential treatment and adult residential treatment. The statewide average cost per unit for crisis residential treatment and adult residential treatment will be increased on an annual basis, effective the first day of each fiscal year, using the change in the home health agency market basket index. The annually updated cost per unit for crisis residential treatment and adult residential treatment will be published in an annual information notice that is posted to the single state agency's website.

The SMIR for services provided in a treatment foster home will initially be set at $87.40 per day and the State will annually increase this SMIR based upon the change in the home health agency market basket index. The $87.40 daily rate is

based upon the existing rate the State pays providers for a similar service called intensive treatment foster care. The treatment component of these rates are based upon an hourly rate of $23 for an in-home support counselor multiplied by the number of hours the in-home support counselor is likely to provide treatment to the child. The most intensive level of treatment expects the in-home support counselor to provide 114 hours of treatment per month, which is 3.8 hours per day. The hourly rate of $23 multiplied by 3.8 hours per day of treatment equals the daily rate of $87.40.

H. ALLOWABLE SERVICES (ALSO USED IN THE COST REPORT)
Allowable Rehabilitative Mental Health and Targeted Case Management Services and units of service are as follows:

Service	Units of Service
Mental Health Services	One Minute Increments
Medication Support Services	One Minute Increments
Day Treatment Intensive	Half-Day or Full-Day
Day Rehabilitation	Half-Day or Full-Day
Crisis Intervention	One Minute Increments
Crisis Stabilization	One-Hour Blocks
Adult Residential Treatment Services	Day (Excluding room and board)
Crisis Residential Treatment Services	Day (Excluding room and board)
Psychiatric Health Facility Services	Day (Excluding room and board)
Targeted Case Management	One Minute Increments
Services provided in a treatment home	Day (Excluding room and board)
Peer Support Services	15 Minute Increments

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

REIMBURSEMENT FOR MEDI-CAL PERSONAL CARE SERVICES

A. GENERAL PROVISIONS

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

B. REIMBURSEMENT RATE LIMITATIONS FOR PERSONAL CARE SERVICES

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

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

(3) The Individual Provider Rate includes Wages, Payroll Tax, Benefits, Administrative Costs, and Paid Time Off within the negotiated rate.

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

State approved county governmental, contracted, and private individual provider rates are documented in a fee schedule and that fee schedule was last updated July 1, 2018, and is effective for services provided after that date. This fee schedule is published on the California Department of Social Services website at:
http://www.cdss.ca.gov/Portals/9/IHSS/IHSS_Sick_Leave_Rate_as_of_July-1-2018.pdf?ver=2018-10-10-165722-833

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

D. PAYMENTS AND UNITS OF SERVICE

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

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

In cases where the beneficiary chooses not to have the assessed Personal Care Services of meal preparation, meal cleanup and/or shopping for food services provided in-home, the beneficiary can choose to have their service budget reduced by the amount calculated based on hours allocated for these services and reimbursement of $15.50 per week per person or $31 per week per couple is provided for meal preparation, meal cleanup and/or shopping for food related activities in the Sec. 1915 (42 U.S.C. H96n] (j) program.

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

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

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

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

D. PAYMENTS AND UNITS OF SERVICE

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: CALIFORNIA

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