Rates for Health Care Services Policy
County Medical Services Program

Effective January 1, 2024
(Originally Adopted September 22, 2005;
This amendment adopted on December 14, 2023)

The rates of payment reflected in this **Rates for Health Care Services Policy** (Policy) shall be for the dates specified herein; rates of payment for prior dates not specified herein shall be as specified in the preceding version of this Policy as amended July 27, 2023, and effective January 1, 2024.

The County Medical Services Program Governing Board (Board) sets the rates of payment for the provision of medically necessary health care services to County Medical Service Program (CMSP) members (which includes members to any program or benefit plan of Board). The Board entered into a contract with a benefits administrator, Advanced Medical Management, Inc. (Administrator), for the administration of CMSP medical and dental benefits as of April 1, 2015, as amended. (This Policy does not address pharmacy services.)

The Board shall not pay for services that are not included in the CMSP benefit plan(s) that Board administers for its CMSP members.

Updates to these rates shall be made by the Administrator from time to time subject to the approval of the Board or its designated representative. Such updates may include provisional rates for CPT codes when such codes are established or become obsolete.

PART A. CONTRACTING PROVIDERS

The Board, or the Administrator on behalf of the Board, may enter into contracts with providers for the provision of medically necessary health care services to CMSP members. These providers shall be located in CMSP Counties and counties contiguous to CMSP Counties unless otherwise approved by the Board or its designated representative. These contracts will be at the rates set forth below, as may be revised by the Board from time to time. Payments made pursuant to these contracts, net any share of cost collections, shall constitute payment in full to these providers.

The Board shall not pay for services that are not medically necessary.

I. Outpatient Services

A. Physician Services Provided by Contracting Physicians

Effective April 1, 2015, the CMSP rates for all CMSP benefit programs shall be equal to the Medi-Cal rates for such services in effect on July 1, 2007, plus twenty percent (20%). Such rate shall be adjusted annually by the Medicare Economic Index (MEI) adjustment approved for Federally Qualified Health Centers.

For selected primary care and specialty providers, the Administrator may enter into a contract at alternative rates to promote the availability of such physician, subject to approval by the Board or its designated representative.

B. Hospital Outpatient Services Provided by Contracting Hospitals

Effective April 1, 2015, the CMSP rates shall be equal to the CMSP rates in effect on December 31, 2011, plus five percent (5%). Such rates shall be made available to all contracting providers through the Administrator.

C. Services Provided by Contracting Federal Qualified Health Centers and Rural Health Clinics (FQHC/RHC)

Effective January 1, 2012, the CMSP rate shall be equal to the CMSP rate in effect on December 31, 2011. Such rate shall be an encounter based rate that is equivalent to the Medi-Cal rate for such services. Such rate shall be adjusted annually by the Medicare Economic Index (MEI). Any other adjustments shall be made bi-annually.

Only the following services shall be paid with the encounter based rate: covered medical services and covered dental services for all CMSP benefit programs.

D. Services Provided by Contracting Tribal Health Program Providers (THP)

Effective January 1, 2012, the CMSP rate shall be equal to the CMSP rate in effect on December 31, 2011. Such rate shall be equivalent to the Medi-Cal rate for such services. Any adjustments to this rate shall be made annually.

Only the following services shall be paid with the encounter based rate: covered medical services and covered dental services for all CMSP benefit programs.

II. Inpatient Hospital Services

Effective January 1, 2009, the Board established an all-inclusive per diem payment methodology in contracts for inpatient hospital services that provides hospital-specific per diems for specified bed types and does not require any subsequent audit and cost settlement process to reconcile overpayments and underpayments. With the exception of payment for implants/devices as provided herein, the per diem shall be all-inclusive and the hospital shall not be entitled to any additional payment. Per diem payment amounts shall be based upon the level of hospital care required for each day of care provided based upon medical necessity.

A. Services Provided by Contracting California Hospitals

1. Inpatient Hospital Services (excluding inpatient mental health services)

Beginning with dates of service on or after January 1, 2009, payment for inpatient hospital services shall be based upon per diem payment rates established by the Administrator as set forth herein for each contracting hospital. Depending on the hospital and the actuarial sufficiency of the paid claims data, per diem payment rates shall be set for the following bed types:

a. Intensive Care Unit (ICU);
b. Trauma;
c. Burn;
d. Acute Care (Med/Surg);
e. Percutaneous Transluminal Coronary Angioplasty (PTCA)/Cardiac Catheterization (Cath);
f. Cardiovascular Surgery; and,
g. Subacute Care.

All inpatient bed types not otherwise specified above, including but not limited to acute rehabilitation, shall be paid at the Acute Care (Med/Surg) per diem payment rate. Per diem payment amounts shall be based upon the level of hospital care required for each day of care provided based upon medical necessity.

Payment for the following implants/devices shall be paid separately from any per diem payment: Hip; Knee; Pacemaker; Automatic Implantable Cardioverter Defibrillator (AICD); and Spine. Payment for these implants/devices shall be limited to manufacturer or distributor invoice price plus ten percent (10%), subject to reasonable maximum allowances as determined by the Board.

Per diem payment rates for each hospital shall be the payment amounts in effect for each hospital on December 31, 2013 (“base per diem rates”). For dates of service on January 1, 2014, through December 31, 2023, these base per diem rates shall be adjusted as follows:

- Service Year 1 – (January 1, 2014, through December 31, 2014) – the product of the base per diem rate and 1.02. Stated as an equation: Base per diem rate x 1.02 (“Service Year 1 per diem rate”)

- Service Year 2 – (January 1, 2015, through December 31, 2015) – the product of the Service Year 1 per diem rate and 1.02. Stated as an equation: Service Year 1 per diem rate x 1.02 (“Service Year 2 per diem rate”)

- Service Year 3 – (January 1, 2016, through December 31, 2016) – the product of the Service Year 2 per diem rate and 1.02. Stated as an equation: Services Year 2 per diem rate x 1.02 ("Service Year 3 per diem rate")

- Service Year 4 – (January 1, 2017 through December 31, 2017) – the product of the Service Year 3 per diem rate and 1.02. Stated as an equation: Services Year 3 per diem rate x 1.02.

- Service Year 5 – (January 1, 2018 through December 31, 2018) – the product of the Service Year 4 rate and 1.02. Stated as an equation: Services Year 4 rate x 1.02.

- Service Year 6 – (January 1, 2019 through December 31, 2019) – the product of the Service Year 5 rate and 1.02. Stated as an equation: Services Year 5 rate x 1.02.

- Service Year 7 – (January 1, 2020 through December 31, 2020) – the product of the Service Year 6 rate and 1.02. Stated as an equation: Services Year 6 rate x 1.02.

- Service Year 8 – (January 1, 2021 through December 31, 2021) – the product of the Service Year 7 rate and 1.02. Stated as an equation: Services Year 7 rate x 1.02.

- Service Year 9 – (January 1, 2022 through December 31, 2022) – the product of the Service Year 8 rate and 1.02. Stated as an equation: Services Year 8 rate x 1.02.

- Service Year 10 – (January 1, 2023 through December 31, 2023) – the product of the Service Year 9 rate and 1.02. Stated as an equation: Services Year 9 rate x 1.02.

- Service Year 11 – (January 1, 2024 through December 31, 2024) – the product of the Service Year 10 rate and 1.025. Stated as an equation: Services Year 10 rate x 1.025.

- Service Year 12 – (January 1, 2025 through December 31, 2025) – the product of the Service Year 11 rate and 1.025. Stated as an equation: Services Year 11 rate x 1.025.

- Service Year 13 – (January 1, 2026 through December 31, 2026) – the product of the Service Year 12 rate and 1.025. Stated as an equation: Services Year 12 rate x 1.025.

- Service Year 14 – (January 1, 2027 through December 31, 2027) – the product of the Service Year 13 rate and 1.025. Stated as an equation: Services Year 13 rate x 1.025.

Beginning January 1, 2018, administrative days shall be paid at a rate of three hundred seventy-five dollars ($375.00) per day. Beginning January 1, 2019, administrative days shall be paid at a rate of three hundred eighty-three dollars ($383.00) per day. Beginning January 1, 2020, administrative days shall be paid at a rate of three hundred ninety-one dollars ($391.00) per day. Beginning January 1, 2021, administrative days shall be paid at a rate of three hundred ninety-nine dollars ($399.00) per day. Beginning January 1, 2022, administrative days shall be paid at a rate of four hundred and seven dollars ($407.00) per day. Beginning January 1, 2023, administrative days shall be paid at a rate of four hundred and fifteen dollars ($415.00) per day. Beginning January 1, 2024, administrative days shall be paid at a rate of seven hundred and four dollars and eighty-six cents ($704.86) per day. Payment of such rate shall be limited and payable subject to requirements approved by the Board.

Subject to approval by the Board or its designated representative, the Administrator may enter into a contract with a hospital for the sole purpose of providing certain high-level procedures, such as organ transplant services, complex orthopedic surgeries, catastrophic burn care and similar complex tertiary services not otherwise available in the community. For such a specified tertiary hospital, the payment rates shall be based upon per diems for each hospital in accordance with the provisions set forth herein or as otherwise approved by the Board.

2. Inpatient Hospital Mental Health Services

The rate shall utilize a two-tiered (higher-level of care and lower-level of care), all-inclusive per diem structure that incorporates the following:

a. If the hospital has negotiated an all-inclusive per diem rate under Medi-Cal through a contract with the county where the hospital is located:

(i) Beginning January 1, 2009, the higher-level of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 114 (room and board – private, psychiatric), revenue code 124 (room and board – semi-private 2 bed psychiatric), and revenue code 204 (intensive care, psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning

January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

(ii) Beginning January 1, 2009, the lower-level rate of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 134 (room and board – semi-private 3 or 4 bed psychiatric) and revenue code 154 (room and board – ward (medical or general), psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

b. If the hospital has not negotiated an all-inclusive per diem rate under Medi-Cal through a contract with the county where the hospital is located, the rates referenced shall be the regional all-inclusive per diem rate established by the California Department of Mental Health for inpatient acute psychiatric care for the hospital:

(i) Beginning January 1, 2009, the higher-level of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 114 (room and board – private, psychiatric), revenue code 124 (room and board – semi-private 2 bed psychiatric), and revenue code 204 (intensive care, psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

(ii) Beginning January 1, 2009, the lower-level rate of care rate shall be based on the hospital's greater revenue code rate on file effective April 1, 2005, for revenue code 134 (room and board – semi-private 3 or 4 bed psychiatric) and revenue code 154 (room and board – ward (medical or general), psychiatric). Beginning January 1, 2014, the rate will be the higher of these revenue codes, less one percent (1%). Beginning January 1, 2015, the rate will be the higher of these revenue codes, plus one percent (1%). Beginning January 1, 2016, the rate will be the higher of these revenue codes plus three percent (3%). Beginning January 1, 2017, the rate will be the higher of these revenue codes plus five percent (5%).

This payment rate shall apply only to hospitals that maintain licensed acute psychiatric care beds.

B. Services Provided By Contracting Hospitals and Hospital Based Physicians and Other Providers in Non-CMSP California Counties or Contiguous Counties

1. Hospital Services

Subject to approval by the Board or its designated representative, the Administrator may enter into a contract with a California hospital that is not located in a CMSP County or a county contiguous to a CMSP County for the provision of medically necessary health care services to CMSP members.

The rate for inpatient hospital services shall be determined pursuant to the criteria set forth in Part A, Section II.A(1). If there is insufficient data to use the methodology set forth in Part A, Section II.A(1), then the rate shall be the most recent average contract payment rate published by the California Medical Assistance Commission (CMAC) for the Standard Consolidated Statistical Area (SCSA) for the hospital plus two percent (2%). Rates for hospital outpatient services shall be set in accordance with Part A, Section I.B. Rates for inpatient mental health services shall be set in accordance with Part A, Section II.A(2).

2. Hospital Based Physicians and Other Providers

Subject to approval by the Board or its designated representative, the Administrator may enter into a contract with hospital based physicians and other providers for the provision of medically necessary health care services to CMSP members at a California hospital that has a contract to provide services and is not located in a CMSP County or a California county contiguous to a CMSP County. Rates of payment shall be those set forth in Part A, Sections I.A and IV, as appropriate to the service provided, or as otherwise approved by the Board or its designee.

III. Dental, and Home Infusion Services (Excluding FQHC/RHC and THP Providers)

A. Dental Services

Effective January 1, 2012, the CMSP rates shall be the CMSP rates in effect on December 31, 2011. Such rates shall be made available to all contracting providers through the Administrator. Such rates are comparable to the Medi-Cal rates for such services in effect on July 1, 2007.

For selected specialty providers, the Administrator may enter into a contract at an alternative rate to promote the availability of such provider, subject to approval by the Board or its designated representative.

B. Home Infusion Services

Effective January 1, 2012, the CMSP rate shall be comparable with the rate for such services in effect for CMSP on April 1, 2005. The payment structure is a "per-diem-plus" basis meaning that total payment for the service is composed of two components: the per-diem, which provides payment for services and supplies, plus payment for the medication. The payment rate for the medication is average wholesale price minus ten percent (AWP-10%).

The services and supplies that are included in the per-diem payment include: pharmacy compounding fees, therapy-related medical supplies (syringes, tubing, catheters, dressings, etc.), equipment rental (pump, pole, etc.), medication and supply delivery, clinical pharmacy services and kinetic dosing, and 24 hour on-call availability. Multiple per diems for services to individual CMSP members on a single day shall be discounted.

IV. All Other Services

These services include, but are not limited to: laboratory, home health, durable medical equipment, ground medical transportation, ambulatory surgery centers, vision and audiology services. These services do not include the services listed in I, II and III above or the prescription drug benefit services provided by MedImpact Health Systems, Inc. (MedImpact).

Effective January 1, 2012, the CMSP rates shall be equal to the CMSP rates in effect on December 31, 2011. Such rates shall be made available to all contracting providers through the Administrator. Such rates are comparable to the Medi-Cal rates for such services in effect on July 1, 2007.

The Administrator may enter into a contract with such providers at an alternative rate subject to approval by the Board or its designated representative.

PART B. NON-CONTRACTING "OUT OF NETWORK" PROVIDERS

For medically necessary emergency services provided to CMSP members by non-contracting providers, payment for these services shall be made as set forth below. These payment rates may be revised by the Board from time to time. Payment made for such services, net any share of cost collections, shall constitute payment in full to these providers.

The Board shall not pay for either (a) non-emergency services; or (b) emergency services that are not medically necessary.

I. Non-Contracting "Out of Network" Hospitals in California and Designated Border State Areas for Emergency Services

Effective January 1, 2014, the Board or its designated representative shall direct the Administrator to pay a non-contracting California hospital and a non-contracting hospital in the Designated Border State Areas (as defined below) the following rates for medically necessary emergency services provided to a CMSP member:

a. For inpatient hospital services, the rate shall be eighty-five percent (85%) of the average amount paid to California hospitals for non-contracted hospital emergency inpatient services based upon their service region and facility type, as published by the California Department of Health Care Services (DHCS) in 2012 ("base rate"). For dates of service on April 1, 2015, through December 31, 2023, these base rates shall be adjusted as follows:

- Partial Service Year 2[1] – (April 1, 2015, through December 31, 2015) – the product of the base rate and 1.02. Stated as an equation: Base rate x 1.02 ("Partial Service Year 2 rate")

- Service Year 3 – (January 1, 2016, through December 31, 2016) – the product of the Partial Service Year 2 rate and 1.02. Stated as an equation: Services Year 2 rate x 1.02 ("Service Year 3 rate")

- Service Year 4 – (January 1, 2017 through December 31, 2017) – the product of the Service Year 3 rate and 1.02. Stated as an equation: Services Year 3 rate x 1.02.

- Service Year 5 – (January 1, 2018 through December 31, 2018) – the product of the Service Year 4 rate and 1.02. Stated as an equation: Services Year 4 rate x 1.02.

- Service Year 6 – (January 1, 2019 through December 31, 2019) – the product of the Service Year 5 rate and 1.02. Stated as an equation: Services Year 5 rate x 1.02.

- Service Year 7 – (January 1, 2020 through December 31, 2020) – the product of the Service Year 6 rate and 1.02. Stated as an equation: Services Year 6 rate x 1.02.

[1] For convenience purposes, Service Years correspond to the time periods described in Part A, Section II.A.1, above; Part A, Section II.A.1 shall not apply to Part B Non-Contracting "Out of Network" Providers.

- Service Year 8 – (January 1, 2021 through December 31, 2021) – the product of the Service Year 7 rate and 1.02. Stated as an equation: Services Year 7 rate x 1.02.

- Service Year 9 – (January 1, 2022 through December 31, 2022) – the product of the Service Year 8 rate and 1.02. Stated as an equation: Services Year 8 rate x 1.02.

- Service Year 10 – (January 1, 2023 through December 31, 2023) – the product of the Service Year 9 rate and 1.02. Stated as an equation: Services Year 9 rate x 1.02.

- Service Year 11 – (January 1, 2024 through December 31, 2024) – the product of the Service Year 10 rate and 1.025. Stated as an equation: Services Year 10 rate x 1.025.

- Service Year 12 – (January 1, 2025 through December 31, 2025) – the product of the Service Year 11 rate and 1.025. Stated as an equation: Services Year 11 rate x 1.025.

- Service Year 13 – (January 1, 2026 through December 31, 2026) – the product of the Service Year 12 rate and 1.025. Stated as an equation: Services Year 12 rate x 1.025.

- Service Year 14 – (January 1, 2027 through December 31, 2027) – the product of the Service Year 13 rate and 1.025. Stated as an equation: Services Year 13 rate x 1.025.

b. For outpatient hospital services, including but not limited to emergency department services and professional services delivered in the emergency department or other outpatient hospital setting, the rate shall be eighty-five percent (85%) of the CMSP rate for such services on December 31, 2011.

c. As a condition for receiving payment for services, the hospital provider must notify the Administrator within twenty-four (24) hours of admitting the CMSP member into the emergency department, and such services are determined to be medically necessary emergency services. Post-stabilization services require prior authorization.

For the purposes of this Policy, “Designated Border State Areas” is defined as the out-of-state areas of the states of Oregon, Nevada and Arizona that are within 30 miles of the California border.

II. Non-Contracting "Out of Network" Physicians and Other Providers for Emergency Services in California and Designated Border State Areas

Effective January 1, 2018, for all non-contracting providers in California and in the Designated Border State Areas, excluding non-contracting hospitals, the rate shall be eighty-five percent (85%) of the CMSP rate for such services in the year services are delivered.

As a condition for receiving payment for services, the hospital provider must notify the Administrator within twenty-four (24) hours of admitting the CMSP member into the emergency department, and such services are determined to be medically necessary emergency services. Post-stabilization services require prior authorization.

III. Non-Contracting "Out of Network" Hospital Based Physicians Providing Services During an Authorized Hospital Stay at a Contracting Hospital

Effective January 1, 2018, if a non-contracting hospital based physician renders medically necessary services to a CMSP member during a hospital stay approved in writing by the Administrator at a contracting hospital, the non-contracting hospital based physician shall be paid the CMSP rate for such services in effect in the year services are delivered.

IV. Non-Contracting "Out of Network" Providers Outside of California and Designated Border State Areas for Emergency Services

For any and all services provided to CMSP members by hospitals outside of California and the Designated Border State Areas, no payment shall be provided.

For any and all services provided to CMSP members by any physicians and other providers outside of California and the Designated Border State Areas, no payment shall be provided.

PART C. NON-CONTRACTING VISION AND AUDIOLOGY PROVIDERS (EXCLUDING FQHC/RHC AND THP PROVIDERS)

For covered vision and audiology services provided to CMSP members by an eligible non-contracting CMSP Provider, payment for these services shall be made as set forth below. These payment rates may be revised by the Board from time to time. Payment made for such services, net any share of cost collections, shall constitute payment in full to these providers.

For purposes of this Policy, an eligible non-contracting CMSP provider of vision or audiology services is defined as a licensed provider in California that maintains in good standing, all licenses, certifications, permits, accreditations and other prerequisites required by federal, California and local law to provide covered vision or audiology health care services, and agrees to accept CMSP's payment rate and terms for delivery of covered services prior to delivery of such services.

For any and all vision or audiology services provided to CMSP members by vision and audiology providers that do not meet either of these definitions, no payment shall be provided.

Effective January 1, 2012, the CMSP rates shall be the CMSP rates in effect on December 31, 2011. Such rates shall be made available to all contracting providers through the Administrator. Such rates are comparable to the Medi-Cal rates for such services in effect on July 1, 2007.

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