DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: 08-009A

2. STATE: California

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

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

4. PROPOSED EFFECTIVE DATE: July 1, 2008

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 subpart C-Payment for InatientHospital and Long Term Caee

7. FEDERAL BUDGET IMPACT:
a. FFY 2007-08 $(-3.7M) 2009-10 $(-54.9M)
b. FFY 2008-09 $(-69.4M) 2010-11 $(-26.6M)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A amend pages 2 and 5 add pages 3.2-3.4 and 5.1-- 5.5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 2 and 5

10. SUBJECT OF AMENDMENT:
Payment Reductions for InpatientServicesof Non-contracted Hospitals

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL: [signature]

13. TYPED NAME: **Toby Douglas**

14. TITLE: **Director**

15. DATE SUBMITTED: 10/5/11

16. RETURN TO:
**Department of Health Care Services**
**Attn: State Plan Coordinator**
**1501 Capitol Avenue, Suite 71.3.26**
**P.O. Box 997417**
**Sacramento, CA 95899-7417**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: OCT 27 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL: [signature]

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 08-009 B1

2. STATE: California

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

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

4. PROPOSED EFFECTIVE DATE
July 1, 2008

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT: (SAVINGS)
a. FFY 07-08 (3 mos) ~~(-$107.4 million)~~ ~~(-$11 M)~~ ($-19.8M)
b. FFY 08-09 ~~(-$527.7 million)~~ ~~(-$235.6 M)~~ ($-88.5M)
FFY 09-10 ($-32.4M)
FFY 10-11 ($-39.5M)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ADD NEW ATTACHMENT 4.19-F
~~Attachment 4.19-A: amend pages 2 and 5 and add page 3.2~~
~~Attachment 4.19-B: amend page 3 and add page 3.1~~
~~Supplement 2 to Attachment 4.19-B: amend pages 1 and 2~~
~~Attachment 4.19-D: amend page 15.4 and add page 15.4a~~
Attachment 4.19-B: Add pages 3.1-3.4, 64
Add Supplement 15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Attachment 4.19-A, pages 2, and 5~~
~~Attachment 4.19-B, page 3~~
~~Supplement 2 to Attachment 4.19-B, pages 1 and 2~~
~~Attachment 4.19-D, page 15.4~~
AM. 4.19-B - 24 NEW PAGES
AM. 4.19-F - NEW

10. SUBJECT OF AMENDMENT:

IMPLEMENT 10% PROVIDER PAYMENT REDUCTION FOR SPECIFIED PROVIDERS AND SERVICES

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:
Governor's Office does not wish to Review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL: 9/30/08

13. TYPED NAME:
Stan Rosenstein

14. TITLE:
Chief Deputy Director, Health Care Programs

15. DATE SUBMITTED:

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 27 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

OMB NO. 0938-0193

# TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: **08-009D**

2. STATE: **California**

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

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

4. PROPOSED EFFECTIVE DATE: **July 1, 2008**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

**ABx3 5, ABx4 5, and AB 1183**

7. FEDERAL BUDGET IMPACT:

| | | |
|---|---|---|
| a. FFY | **2007-2008** | **$ 5,463,000** |
| b. FFY | **2008-2009** | **$ 21,646,000** |
| c. FFY | **2009-2010** | **$ 289,000** |
| d. FFY | **2010-2011** | **$ 5,746,250** |

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 4.19-D Page 15.4, 15.4a, 15.4b, 15.4c and 15.4d**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

**Attachment 4.19-D Page 15.4**

10. SUBJECT OF AMENDMENT:

**1) Reduced payment rates at 10 and 5 percent where specified, and**
**2) Freezes 2009-2010 rates and subsequent rates at the 2008-2009 levels as mandated by Health Trailer Bill ABx4 5**

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: The Governor's Office does not wish to review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: **Toby Douglas**

14. TITLE: **Director**

15. DATE SUBMITTED: 10/4/11

16. RETURN TO:

**Department of Health Care Services**
**Attn: State Plan Coordinator**
**1501 Capitol Avenue, Suite 71.4001**
**P.O. Box 997417**
**Sacramento, CA 95899-7417**

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED: OCT 27 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)