



Region IX

Division of Medicaid & Children's Health Operations

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San Francisco, CA 94103-6706

OCT 27 2011

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Avenue
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

This letter is being sent as a companion to our approval of California State Plan Amendment (SPA) 11-009. This SPA was originally submitted to reduce payment to providers. As you are aware, 42 CFR 430.10 requires that the State plan be a comprehensive written statement that describes the nature and scope of the State's Medicaid program and that contains all information necessary for CMS to determine whether the plan can be approved to serve as the basis for Federal financial participation (FFP) in the State program.

Please note that CMS reviews SPAs in the context of the overall State plan for consistency with the requirements of section 1902(a) of the Social Security Act. In reviewing reimbursement provisions, CMS must also independently review the corresponding State plan coverage and any other same page State plan reimbursement provisions to determine whether coverage and payment methodologies comport with current regulation and statute. Our review of SPA 11-009 included a same page reimbursement review of the submitted pages, as well as a review of the coverage provisions for each of the rates being reduced.

Based on our review, CMS has identified additional issues that we would like to bring to your attention as they are not in compliance with current regulations, statute, and CMS guidance. We welcome the opportunity to work with you and your staff to discuss options for resolving the concerns outlined below.

Coverage - Attachments 3.1-A and B

1. Limitations on Attachments 3.1-A and B, page 3 (chart), item 2.b, Rural Health Clinic (RHC) services: Please confirm and add language that home nursing services are provided only to individuals who are established patients of the RHC. Please confirm that services are provided to ensure continuity of care.
2. Limitations on Attachments 3.1-A and B, page 3 (chart), items 2.c and 2.d, Federally Qualified Health Center (FQHC) Services: Program coverage for FQHC/RHC lists only physician services and home nursing services. Please confirm that the services of the other six allowable FQHC providers – physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or visiting nurse – also are covered.
3. Limitations on Attachment 3.1A page 25, item 24b and 3.1B page 24.1 item 23b: Please update Type of Service text to reflect "Services furnished in Religious Nonmedical Health Care Institutions." Under Program Coverage show "Not Provided" and delete language in last column.

4. Limitations on Attachment 3.1A page 25, item 24c and 3.1B page 24.1 item 23c: Please update Type of Service text to reflect “reserved.” Delete “See 4a” in columns two and three.

Reimbursement

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that procedures related to payments include a comprehensive description of the methods and standards used to set payment rates. Attachment 4.19-B illustrates how non-institutional providers will be reimbursed and must contain comprehensive State plan language. To make State plan language comprehensive, a dated reference to any item not directly listed in the State plan is required. In addition, since the State plan is the basis for Federal financial participation, it is important that payment methodologies documented in the State plan are understandable and auditable. Absent the descriptions of these criteria, CMS will not be able to determine that the State plan language meets the requirements set forth in 42 CFR 447.252(b), 42 CFR 447.10, and Section 1902(a)(30)(A) of the Act. Based on our review, CMS identified additional issues and we would like to work with the State to resolve the concern outlined below.

1. Page 3, Item (4) is only a general blanket statement regarding adjustments and modifications to the method or amount of payment; it is inadequate and does not provide sufficient information to understand the reimbursement methodology for non-institutional services. Accordingly, we suggest that the State delete the first sentence. In addition, if the State changes the reimbursement methodology in the future, the State will need to submit a State plan amendment to revise and comprehensively describe the reimbursement methodology that results from the adjustments/modifications.
2. State Plan page 1 describes the general reimbursement methodology, i.e. the lesser of usual charges or the fee schedules specified in Title 22 and Title 17, for “each of the other types of care or services listed in Section 1905(a) of the Act.”
 - a. Currently, Attachment 3.1-A of the State plan lists twenty-seven 1905(a) service categories. Please confirm if every one of the twenty-seven service categories listed is reimbursed using this general reimbursement methodology. If not, please revise this section to include an itemized listing of the 1905(a) services (as described in Attachment 3.1-A) that are reimbursed using this methodology. We believe this information will make the State plan more straightforward and comprehensive.
 - b. Please include the effective date of the fee schedule and where it is posted. Some suggested language follows:

The agency’s rates were set as of (Month/Day/Year) and are effective for services on or after that date. All rates are published on the agency’s website at www.XXXXXXX.XXX.

In the subsequent quarter, if the State must make multiple updates to any fee schedules pertaining to the effective date language reference in the State Plan, California will need to submit a SPA that details these updates. When the State submits its SPA, it should use the following suggested language for those provisions:

The agency's fee schedule was revised with new fees for (insert service) effective:

For services on or after (Month/Day/Year). The fee schedule was posted on (insert date of posting).

For services on or after (Month/Day/Year). The fee schedule was posted on (insert date of posting).

For services on or after (Month/Day/Year). The fee schedule was posted (insert posting location) on (insert date of posting).

For services on or after (Month/Day/Year). The fee schedule was posted (insert posting location) on (insert date of posting).

Each fee schedule revision is effective for services provided on or after that date. Providers are notified of the rate changes through

(_____). All fee schedules are available through the agency's website at (insert URL).

3. State Plan page 2, Item (e), Rate adjustments: This item includes a blanket statement saying that rates may be adjusted by state statute provided that applicable requirements of 42 CFR Part 447 are met. This statement does not adequately and comprehensively describe the types of adjustments made to the reimbursement rates. When the State implements the adjustments, a State plan amendment will be needed to comprehensively describe the revised reimbursement methodology. Accordingly, we suggest that the State delete this item.
4. State Plan page 2, Item (f)(1), (2) & (3), Cost and funding: We request that the State delete these items from the State Plan. These items provide a description of how the State's cost and funding would impact the payments of services. At this time, the description of these situations should not be included as part of the State plan. When the State needs to make modifications to the reimbursement methodology, the State will need to submit a State Plan Amendment with State plan language that includes the details of the revised methodology.
5. State Plan page 20a, Payment for home health agencies: Please include the effective date of the fee schedule. Please see 2.b above for suggested language for dated references in the State Plan.

We would also like to remind you of the issues previously identified in the companion letter for SPA 11-012 issued on July 21, 2011. As indicated in that letter, CMS has identified additional issues that we would like to bring to your attention as they are not in compliance with current regulations, statute, and CMS guidance. We welcome the opportunity to work with you and your staff to discuss options for resolving the concerns outlined below.

1. The DME section that is listed on Attachment 3.1-A and 3.1-B indicates that DME is "covered when prescribed by a licensed practitioner". The regulations at 42 CFR §440.70(a)(2) require that home health services (including DME) be ordered by a physician as part of a written care plan. The State should amend the State Plan to indicate that only physicians can prescribe DME.

2. The coverage provisions for Hearing Aids and Enteral Formulae are listed in page 14 of Limitation to Attachment 3.1-A submitted under SPA 11-012. Please identify where in Attachment 4.19-B the reimbursement methodologies are described for these services. If the payment methodology is described on page 20a of Attachment 4.19-B of the current State Plan, please amend the State Plan to include the effective date of the fee schedule and the specific URL address for the fee schedule (instead of the DHCS Medi-Cal home page).
3. The payment methodology for durable medical equipment found in pages 3a – 3f of Attachment 4.19-B was last updated in June 2007. Please confirm whether this language is still accurate.

Additionally, we remind you of the issues previously identified in the companion letter for SPA 09-001 issued on July 1, 2011. We acknowledge that we are working with your staff on SPA 11-023 in attempt to resolve items identified as not in compliance with current regulations, statute, and CMS guidance outlined below.

The qualifications for physical therapy, occupational therapy, speech therapy and audiology providers are not described in the State plan. Section 1902(a)(23) of the Act provides that “any individual eligible for medical assistance...may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required...who undertakes to provide him such services.” Please specify in the State plan that all providers of physical therapy, occupational therapy, speech therapy and audiology services meet Federal provider qualifications as set forth in 42 CFR 440.

Please respond to this letter no later than 90 days from the date of this letter with a corrective action plan describing how the State will resolve the issues identified above. Failure to respond timely will result in our initiation of the formal compliance process. During the 90 days, we are willing to provide any required technical assistance. If you have any questions, please contact me directly at 415-744-3552 or via email at Gloria.Nagle@cms.hhs.gov.

Sincerely,



Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children’s Health Operations

cc: Vickie Orlich, California Department of Health Care Services
Janice Spitzer, California Department of Health Care Services
Kathryn Waje, California Department of Health Care Services
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