



JENNIFER KENT  
DIRECTOR

State of California—Health and Human Services Agency  
Department of Health Care Services



EDMUND G. BROWN JR.  
GOVERNOR

APR 20 2015

Ms. Hye Sun Lee  
Acting Associate Regional Administrator  
Division of Medicaid and Children's Health Operations  
Centers for Medicare & Medicaid Services, Region IX  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 15-013

Dear Ms. <sup>Hye Sun</sup> Lee:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 15-013 to modify substance use disorder services in the Drug Medi-Cal Treatment Program by requiring the format of the final cost report to be in a format approved by the Centers for Medicare and Medicaid Services.

SPA 15-013 also rescinds the prohibition on receiving federal financial participation after June 30, 2015 imposed by SPA 09-022.

The enclosed SPA revises or adds language to the provisions set forth in the following pages:

- Attachment 4.19-B, page 41a
- Attachment 4.19-B, page 41c

In compliance with the American Recovery and Reinvestment Act of 2009, DHCS routinely notifies Indian Health Programs and Urban Indian Organizations of SPAs that have a direct impact on the programs and organizations. DHCS has confirmed no such notification is required for SPA 15-013.

There is no federal fiscal impact from this change to the substance use disorder services reimbursement procedures in Federal Fiscal year (FFY) 2015 and 2016 and that information is included on the HCFA-179 form.

Ms. Hye Sun Lee  
Page 2

If you have any questions regarding the information provided, please contact Don Braeger, Chief, Substance Use Disorder - Prevention, Treatment, and Recovery Services Division, at (916) 327-2754.

ORIGINAL SIGNED

Chief Deputy Director  
Health Care Programs

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**15-013**

2. STATE  
**CA**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

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, 2015

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 440.130

7. FEDERAL BUDGET IMPACT:  
a. FFY 15      \$0  
b. FFY 16      \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  
Attachment 4.19-B, page 41a  
Attachment 4.19-B, page 41c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):  
Attachment 4.19-B, page 41a  
Attachment 4.19-B, page 41c

10. SUBJECT OF AMENDMENT:

Amends Drug Medi-Cal cost report to be approved by the Centers for Medicare and Medicaid 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

OTHER, AS SPECIFIED:  
The Governor's Office does not  
wish to review the State Plan Amendment.

ORIGINAL SIGNED

14. TITLE:  
State Medicaid Director

APR 20 2015

15. DATE SUBMITTED:

16. RETURN TO:

Department of Health Care Services  
Nathaniel Emery  
State Plan Coordinator  
1501 Capitol Avenue, Suite 71.326  
P.O. Box 997417  
Sacramento, CA 95899-7417

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:

**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

State/Territory: California

a. SMA METHODOLOGY FOR NON-NTP SERVICES

“SMAs” are based on the statewide median cost of each type of service as reported in the most recent interim settled cost reports submitted by providers. The SMAs are updated annually with the rate effective July 1 of each State fiscal year.

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE  
METHODOLOGY FOR DMC NARCOTIC TREATMENT  
PROGRAMS

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators.

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under Section E.1.a above.

2. Cost Determination Protocol

The reasonable and allowable cost of providing each non-NTP service and NTP service will be determined in the CMS-approved cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined in accordance with Medicare cost 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 in providing the specific non- NTP and NTP service. Indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its net direct costs or allocated indirect costs based upon the allocation process in the legal entity’s approved cost allocation plan. If the legal entity does not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87, Medicare cost reimbursement principles (42 CFR 413 and Medicare Provider Reimbursement Manual Part 1 and 2), and Medicaid non-institutional reimbursement policy.

State/Territory: California

a. SMA METHODOLOGY FOR NON-NTP SERVICES

“SMAs” are based on the statewide median cost of each type of service as reported in the most recent interim settled cost reports submitted by providers. The SMAs are updated annually with the rate effective July 1 of each State fiscal year.

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators.

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under Section E.1.a above.

2. Cost Determination Protocol

The reasonable and allowable cost of providing each non-NTP service and NTP service will be determined in the ~~State-developed~~ **CMS-approved** cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined in accordance with Medicare cost 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 in providing the specific non- NTP and NTP service. Indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its net direct costs or allocated indirect costs based upon the allocation process in the legal entity’s approved cost allocation plan. If the legal entity does not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87, Medicare cost reimbursement principles (42 CFR 413 and Medicare Provider Reimbursement Manual Part 1 and 2), and Medicaid non-institutional reimbursement policy.

TN No. ~~15-013 09-022~~

Supersedes

TN No. ~~09-022 00-046~~ Approval Date: August 27, 2014 Effective Date: July 1, 2015 July 1, 2009

State/Territory: California

No later than eighteen months after the close of the State fiscal year, DHCS will complete the interim settlement of the county operated legal entities or legal entities that direct contract with DHCS cost report. The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the State-developed cost report for the reporting period. Total reimbursable costs are specified under Section B.1 for non-NTP services and county operated NTP service, and Section B.2 for NTP services. 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.

#### 1. Final Settlement Process

The State will complete the final settlement process within three years from the date of the interim settlement. The State will perform financial compliance audit to determine data reported in the provider's State-developed cost report represents the allowable cost of providing non-NTP or NTP services in accordance with Medicare cost reimbursement principles (42 CFR 413), OMB A-87, and Medicaid non-institutional reimbursement principle; and the statistical data used to determine the unit of service rate reconciled with the State's record. If the total audited reimbursable cost based on the methodology as described under Section B(1) is less than the total interim payment and the interim settlement payments, 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 cost is greater than the total interim and interim settlement payments, the State will pay the provider the difference.

State/Territory: California

No later than eighteen months after the close of the State fiscal year, DHCS will complete the interim settlement of the county operated legal entities or legal entities that direct contract with DHCS cost report. The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the State-developed cost report for the reporting period. Total reimbursable costs are specified under Section B.1 for non-NTP services and county operated NTP service, and Section B.2 for NTP services. 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.

#### 1. Final Settlement Process

The State will complete the final settlement process within three years from the date of the interim settlement. The State will perform financial compliance audit to determine data reported in the provider's State-developed cost report represents the allowable cost of providing non-NTP or NTP services in accordance with Medicare cost reimbursement principles (42 CFR 413), OMB A-87, and Medicaid non-institutional reimbursement principle; and the statistical data used to determine the unit of service rate reconciled with the State's record. If the total audited reimbursable cost based on the methodology as described under Section B(1) is less than the total interim payment and the interim settlement payments, 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 cost is greater than the total interim and interim settlement payments, the State will pay the provider the difference.

#### ~~B. Termination Date~~

~~The reimbursement methodologies described herein for the Drug Medi-Cal Program will sunset on June 30, 2015.~~

TN No. ~~15-013 09-022~~

Supersedes

TN No. ~~09-022 00-016~~ Approval Date: ~~August 27, 2014~~ Effective Date: ~~July 1, 2015 July 1, 2009~~