DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 27, 2014

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

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 09-022. SPA 09-022 was submitted to my office on September 30, 2009 to update the rate setting and reimbursement methodologies for Drug Medi-Cal services. The effective date of this SPA is July 1, 2009.

Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Limitations to Attachment 4.19-B, page 38
- Limitations to Attachment 4.19-B, page 39
- Limitations to Attachment 4.19-B, page 40
- Limitations to Attachment 4.19-B, page 41
- Limitations to Attachment 4.19-B, page 41a
- Limitations to Attachment 4.19-B, page 41b
- Limitations to Attachment 4.19-B, page 41c

If you have any questions, please contact Tyler Sadwith by phone at (415) 744-3563 or by email at tyler.sadwith@cms.hhs.gov.

Sincerely,

/s/

Hye Sun Lee, M.P.H.
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Laurie Weaver, California Department of Health Care Services
Marjorie McKisson, California Department of Health Care Services
Nathaniel Emery, California Department of Health Care Service
Karen Baylor, California Department of Health Care Services
Connie Florez, California Department of Health Care Services
Don Braeger, California Department of Health Care Services

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: **09-022**

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, 2009

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 F, commencing with 447.300

7. FEDERAL BUDGET IMPACT:
a. FFY 2008-09 (3mos): -$3,218,250
b. FFY 2009-10 (12mos): -12,873,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 38
Attachment 4.19-B, Page 39
Attachment 4.19-B, Page 40
Attachment 4.19-B, Page 41
Attachment 4.19-B, Page 41a (new)
Attachment 4.19-B, Page 41b (new)
Attachment 4.19-B, Page 41c (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 38
Attachment 4.19-B, Page 39
Attachment 4.19-B, Page 40
Attachment 4.19-B, Page 41

10. SUBJECT OF AMENDMENT:

Drug Medi-Cal Rate Setting and Reimbursement

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

Toby Douglas

14. TITLE:
Director, Department of Health Care Services

15. DATE SUBMITTED: September 30, 2009

16. RETURN TO:

Department of Health Care Services
Nathaniel Emery
1501 Capitol Avenue, MS 4600
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: September 30, 2009

18. DATE APPROVED: August 27, 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2009

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Hye Sun Lee, MPH

22. TITLE: Acting Associate Regional Administrator

23. REMARKS:

REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES

Effective July 1, 2012, the administration of the Drug Medi-Cal Program (DMC) is transferred from the State Department of Alcohol and Drug Programs (ADP) to the Department of Health Care Services (DHCS), authorized by Assembly Bill 106 (Chapter 32, Statutes of 2011).

A. DEFINITIONS

"Drug Medi-Cal" services are substance use disorder treatment services as described under the Attachment 3.1A. These services can be categorized into Narcotic Treatment Programs (NTP) and non-Narcotic Treatment Programs (non-NTP).

"Non-NTP services" include Outpatient Drug Free Treatment, Day Care Rehabilitative (to be renamed as Intensive Outpatient Treatment effective January 1, 2014), Perinatal Residential Substance Use Disorder Services, and Naltrexone Treatment.

"NTP services" include Daily Dosing services and Counseling Individual and/or Group services.

"Published charges" are usual and customary charges prevalent in the alcohol and drug treatment services sector that are used to bill the general public, insurers, and other non-Title XIX payers. (42 CFR 447.271, and 405.503(a)).

"Statewide maximum allowance" (SMA) is established for each type of non-NTP service, for a unit of service.

"Allowable cost" is reasonable and allowable cost, determined based on year-end cost reports and Medicare cost reimbursement principles as described at 42 CFR Part 413, the Medicare Provider Reimbursement Manual (Centers for Medicare and Medicaid Services, Publication 15-1), OMB A-87 and Medicaid non-institutional reimbursement principles.

"Provider of Services" means any private or public agency that provides direct substance use disorder services and is certified by the State as meeting applicable standards for participation in the DMC Program, as defined in the Drug Medi-Cal Certification Standards for Substance Use Disorder Clinics.

"Legal Entity" means each county alcohol and drug department or agency and each of the corporations, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with DHCS.

"Unit of Service" (UOS) means a face-to-face contact on a calendar day (for non-NTP services). Only one unit of each non-NTP service per day is covered by DMC except for emergencies when additional face-to-face contact may be covered for unplanned crisis intervention. To count as a unit of service, the second contact shall not duplicate the services provided on the first contact, and the contact shall clearly be documented in the beneficiary's patient record. For NTP services, "Unit of Service" means each calendar day a client receives services, including take-home dosing.

B. REIMBURSEMENT METHODOLOGY

1. The reimbursement methodology for county and non-county operated providers of non-NTP services is the lowest of the following:

   a. The provider's usual and customary charge to the general public for providing the same or similar services;
   b. The provider's allowable costs of providing these services;
   c. For legal entities not directly contracted with DHCS, until June 30, 2014, the SMA, established in Section E.1.a below, is reduced by the portion related to the "County administrative" component, and effective July 1, 2014, the full SMA will apply.
      For legal entities directly contracted with DHCS, the SMA, established in Section E.1.a below, applies.

2. The reimbursement methodology for non-county operated NTP providers is the lower of:

   a. The provider's usual and customary charge to the general public for the same or similar services, or
   b. Through June 30, 2014, the uniform statewide daily reimbursement rate (USDR) established in Section E.1.b below, is reduced by the amount related to "County administrative" component. Effective July 1, 2014, except for NTP daily dosing service, the USDR will apply.

3. Reimbursement for county-operated NTP providers is at the lowest of:

   a. The provider's usual and customary charge to the general public for providing the same or similar services;
   b. The provider's allowable costs of providing these services as described in Section E below; or
   c. The USDR established in Section E.1.b below, less the amount related to "County administrative" component. Effective July 1, 2014, except for NTP-daily dosing service, USDR will apply.

C. ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGIES

1. Effective with the California State Fiscal Year (SFY) 2009-10 rate development process, the rates established by the methodologies in Sections E.1.a and E.1.b, below shall be modified as follows:

   For SFY 2009-10, effective from July 1, 2009 through June 30, 2010, the SFY 2009-10 SMA and USDR rates, for non-NTP and NTP services, developed using the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below will be reduced by 10 percent.

2. For SFY 2010-11 and subsequent fiscal years, the reimbursement rates for Drug Medi-Cal services shall be the lower of the following:

   a. The rates developed through the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below or,
   b. The S FY 2009-10 rates adjusted for the cumulative growth in the California Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the Department of Finance.

D. ALLOWABLE SERVICES AND UNITS OF SERVICE

Allowable services and units of service are as follows:

Service	Unit of Service
Day Care Rehabilitative Treatment (To be renamed Intensive Outpatient Treatment starting January 1, 2014)	Minimum of three hours per day, three days per week.
Outpatient Drug Free Treatment	Individual (50-minute minimum session) or group (90-minute minimum session) counseling.
Perinatal Residential Substance Use Disorder Services	24-hour structured environment per day (excluding room and board).
Naltrexone Treatment	Face-to-face contact per calendar day for counseling and/or medication services.

Narcotic Treatment Programs (consist of two components):

a) Daily Dosing	Daily bundled service which includes the following components: 1. Core: Intake assessment, treatment planning, physical evaluation, drug screening, and physician supervision. 2. Laboratory Work: Tuberculin and syphilis tests, monthly drug screening, and monthly pregnancy tests of female methadone/LAAM patients. 3. Dosing: Ingredients and labor cost for administering methadone /LAAM daily dose to patients.
b) Counseling Individual and/or Group	A patient must receive a minimum of fifty (50) minutes of face-to-face counseling sessions with a therapist or counselor up to a maximum of 200 minutes per calendar month, although additional services may be provided and reimbursed based on medical necessity.

E. COST DETERMINATION PROTOCOL FOR NON-NTP AND COUNTY-OPERATED NTP PROVIDERS

The following steps will be taken to determine the reasonable and allowable Medicaid costs for providing Non-NTP and NTP services.

1. Interim Payments

Interim payments for non-NTP and NTP services provided to Medi-Cal beneficiaries are reimbursed up to the SMA /USDR for the current year.

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 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.

For the non-NTP Perinatal Residential Substance Use Disorder Services, allowable costs are determined in accordance with Medicare cost reimbursement principles in Title 42 CFR 413, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are directly attributable to the provision of the medical services using a CMS approved allocation methodology. Specifically, indirect costs that are not directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g. room and board, allocated cost from other related organizations).

The total allowable cost for providing the specific non-NTP or NTP services by each legal entity is further reduced by any third parties payments received for the service provided. This netted amount is apportioned to the Medi-Cal program using a basis that must be in compliance with OMB A-87 and Medicare cost reimbursement principles, 42 CFR 413. The amount that is apportioned to the Medi-Cal program is further reduced by any provisions specified in the legal entity's contractual agreement in providing the non-NTP or NTP service to arrive to the Medi-Cal allowable cost for providing the specific non-NTP or NTP service.

The legal entity specific non-NTP or NTP service unit rate is calculated by dividing the Medi-Cal allowable cost for providing the specific non-NTP or NTP service by the total number of UOS for the specific non-NTP or NTP service for the applicable State fiscal year.

3. Cost Report Submission

Each legal entity that receives reimbursement for non-NTP or county operated NTP services is required to file a State-developed cost report by the November 1 following the end of each State fiscal year. An extension to submit the cost report may be granted by the State for good cause. Interim Settlement

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.

4. 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.

F. Termination Date

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