DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

MAR 27 2012

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) 11-039. SPA 11-039 was submitted to the Centers for Medicare and Medicaid Services (CMS) on December 28, 2011 to extend the ten percent payment reduction to Adult Day Health Care (ADHC) Centers through February 29, 2012. On February 27, 2012, the State requested to extend the reduction further, to March 31, 2012. The ten percent payment reduction for ADHC services was previously approved effective June 1, 2011 through November 30, 2011 via SPA 11-009.

However, with the approval of SPA 11-039, reimbursement for ADHC services will be reinstated at the reduced rate that was in place from June 1, 2011 – November 30, 2011. After March 31, 2012, ADHC will no longer be a Medicaid State Plan service. Instead, the State is seeking an amendment to its 1115 Waiver in order to provide ADHC-like services through a new Community-Based Adult Services (CBAS) program. The State's application for that amendment is currently pending before CMS.

While we review proposed SPAs to ensure their consistency with the relevant provisions of the Social Security Act (the Act), we conducted our review of your submittal with particular attention to the statutory requirements at section 1902(a)(30)(A) of the Act ("Section 30(A)"). Section 30(A) of the Medicaid Act requires that State plans contain "methods and procedures . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). As we explain in greater detail below, we find that the State's submission is consistent with the requirements of the Act, including those set forth in section 1902(a)(30)(A).

States must submit information sufficient to allow CMS to determine whether a proposed amendment to a State plan is consistent with the requirements of section 1902 of the Act. However, consistent with the statutory text, CMS does not require a State to submit any particular type of data, such as provider cost studies, to demonstrate compliance. *See* Proposed Rule, Dep't of Health & Human Servs., Ctrs. For Medicare & Medicaid Servs., 76 Fed. Reg. 26342, 26344 (May 6, 2011). Rather, as explained in more detail in the May 6, 2011 proposed rule, CMS

believes that the appropriate focus of Section 30(A) is on beneficiary access to quality care and services. CMS has followed this interpretation for many years when reviewing proposed SPAs.[1]

This interpretation – which declines to adopt a bright line rule requiring the submission of provider cost studies – is consistent with the text of Section 30(A) for several reasons. First, Section 30(A) does not mention the submission of any particular type of data or provider costs; the focus of the Section is instead on the availability of services generally. Second, the Medicaid Act defines the "medical assistance" provided under the Act to mean "payment of *part* or all of the cost" of the covered service. *See* 42 U.S.C. § 1396d(a) (emphasis added). Third, when Congress has intended to require states to base Medicaid payment rates on the costs incurred in providing a particular service, it has said so expressly in the text of the Act. For example, the now-repealed Boren Amendment to the Medicaid Act required states to make payments based on rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). By contrast, Section 30(A) does not set forth any requirement that a state consider costs in making payments. Finally, CMS observes that several federal courts of appeals have interpreted Section 30(A) to give States flexibility in demonstrating compliance with the provision's access requirement and have held that provider costs need not always be considered when evaluating a proposed SPA. *See Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 853 (3d Cir. 1999); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. Homecare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam). These decisions suggest that CMS's interpretation of Section 30(A) is a reasonable one. In this respect, CMS's interpretation differs from that first adopted by the Ninth Circuit in *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997), which established a bright line rule requiring a State to rely on "responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting."[2]

CMS has reviewed the proposed SPA and, applying our interpretation of Section 30(A), determined that the proposed rate cut is consistent with the requirements of that provision and the Medicaid Act. In reaching this conclusion, CMS relied on the following factors identified by the State in the document titled, "Proposed Reductions and Access to Adult Day Health Care Services" as justification for the proposed SPA's compliance with Section 30(A)'s access requirement:

- There are roughly 300 certified ADHC centers throughout California, the majority of which are facilities concentrated in Los Angeles County, San Diego County and the San Francisco Bay area.

- In State Fiscal Year 2010, 35,153 unique beneficiaries received ADHC services, 64% of whom resided in the Los Angeles County area and 93% of whom resided in the ten counties with the greatest utilization of ADHC services.

- In State Fiscal Year 2010, 69% of all ADHC expenditures were attributable to services rendered in Los Angeles County, San Diego County and the San Francisco

[1] *See, e.g.*, Br. of the United States as Amicus Curiae, *Douglas v. Independent Living Ctr.*, No. 09-958, at 9-10 (2010); Br. of United States as Amicus Curiae, *Belshe v. Orthopaedic Hosp.*, 1997 WL 33561790, at *6-*12 (1997).

[2] CMS's interpretation does not, of course, *prevent* states or CMS from considering provider costs. Indeed, for certain proposed SPAs, provider cost information may be useful to CMS as it evaluates proposed changes to payment methodologies. CMS also reserves the right to insist on cost studies to show compliance with Section 30(A) in certain limited circumstances – particularly when considering a SPA that involves reimbursement rates that are substantially higher than the cost of providing services, thus implicating concerns about efficiency and economy.

Bay area. Each of these areas contained multiple ADHC providers and afford ADHC users more than one option for care.

- As most other geographic regions of the State afford beneficiaries only a few ADHC centers, the State chose to make the ADHC reduction specific to geographic regions with a large number of ADHC providers. Those regions are:

Alameda County	Contra Costa County	Los Angeles County
Marin County	Orange County	Riverside County
San Bernardino County	San Diego County	San Francisco County
San Mateo County	Santa Cruz County	Santa Clara County
Ventura County		

- ADHC services are not generally covered by commercial health plans and are not generally available to the public.

You supplied a geographically based analysis of the potential effects a proposed rate reduction would have on beneficiary access. Your analysis divided the State into medical study service areas (MSSAs), and determined the number of ADHC providers and users in each area. This analysis showed that ADHC providers were concentrated in certain MSSAs. The payment rate reduction in this SPA only applies to those providers in high concentration MSSAs. We agree that given the concentration of providers and the historical trends, the proposed SPA will not compromise access in those areas and is consistent with Section 30(A).

We also conclude that the proposed SPA is consistent with the efficiency and economy requirements in section 1902(a)(30)(A) of the Act. We have generally considered a proposed payment rate as being inefficient or uneconomical if it was substantially above the cost of providing covered services. *See Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 537 (3d Cir. 2002) ("What sort of payments would make a program inefficient and uneconomical? Payments that are *too high*."). For this reason we do not believe that it is appropriate for States to address potential access concerns by setting rates unreasonably high in relation to costs – such rates would necessarily be neither efficient nor economical. Consistent with this view, HHS has promulgated Upper Payment Limit ("UPL") regulations that "place an upper limit on overall aggregate payments" for certain types of services, 65 Fed. Reg. 60151-01. As these provisions reflect, we believe that States must balance access concerns with efficiency and economy concerns. Applying our interpretation of the statute to the proposed SPA at issue here, we believe that the proposed rates are consistent with efficiency and economy.

As we have explained elsewhere, CMS does not interpret section 1902(a)(30)(A) of the Act as requiring a State plan by itself to ensure quality of care. As the text of the statute reflects, payments must be consistent with quality of care, but they do not need to directly assure quality of care by themselves. CMS therefore believes that Section 30(A) leaves room to rely on factors external to a State plan to ensure quality of care. In this particular instance, CMS relies on applicable State licensure and regulatory activities applicable to ADHCs. While one could argue that higher payments would result in care above and beyond State licensure standards, the focus is on ensuring the regulatory standard of quality. CMS believes that it is reasonable to assume that ADHC providers will continue to meet licensure standards.

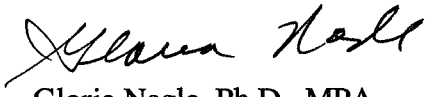
The effective date of this SPA is December 1, 2011. Enclosed is the following approved SPA page that should be incorporated into your approved State Plan:

- Attachment 4.19B, page 64

The approval of this State Plan Amendment relates solely to the availability of Federal Financial Participation (FFP) for Medicaid covered services. This action does not in any way address the State's independent obligations under the Americans with Disabilities Act or the Supreme Court's *Olmstead* decision.

If you have any questions, please contact Jeanie Chan by phone at (415) 744-3596 or by email at Jeanie.Chan@cms.hhs.gov.

Sincerely,



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

Enclosure

cc: Jean Close, Centers for Medicare and Medicaid Services
Elizabeth Garbarczyk, Centers for Medicare and Medicaid Services
Stephen Halley, California Department of Health Care Services
Christopher Thompson, Centers for Medicare and Medicaid Services
Janice Spitzer, California Department of Health Care Services
Kathyryn Waje, 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: 11-039

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: December 1, 2011

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:
a. FFY 2012 ~~-$4.71 million (savings)~~ $-6.5m
b. FFY

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B: amend page 64

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B: page 64

10. SUBJECT OF AMENDMENT:

EXTENDING THE 10% PROVIDER PAYMENT REDUCTION END-DATE FOR ADULT DAY HEALTH CARE CENTERS

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:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: ~~12/23/11~~ 12/28/11

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: MAR 27 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

ITEM# 7: Pen and ink change requested by the State on 2/27/12

ITEM# 15: Pen and ink change confirmed on 2/27/12

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

REIMBURSEMENT FOR ADULT DAY HEALTH CARE CENTERS

(1) Reimbursement for services provided in an Adult Day Health Care (ADHC) Center shall be equal to 90 percent of the rate established for Nursing Facilities – Level A for the corresponding rate year, pursuant to the methodology described in Attachment 4.19-D, beginning on page 10.

(2) For dates of service on or after March 1, 2009, through and including March 8, 2009, payments for services provided in an ADHC Center shall be the rate as calculated in paragraph (1), less 5 percent

(3) For dates of service March 1, 2011, through and including May 31, 2011, payments for services provided in ADHC Centers located within specified Medical Service Study Areas (MSSAs) in Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz and Ventura counties shall be the rate as calculated in paragraph (1), less 5 percent.

MSSAs are the defined geographic analysis unit for the California Office of Statewide Health Planning and Development (OSHPD). They are composed of one or more complete U.S. Census Bureau census tracts and are reproduced on the decadal census. The boundaries are approved by the Health Manpower Policy Commission and the U.S. Department of Health and Human Services, Health Resources Service and Administration (HRSA), formally recognizes California MSSAs as the Rational Service Area for medical service for California. MSSAs are published on the OSHPD website at: http://www.oshpd.ca.gov/General_Info/MSSA/AtoC.html.

(4) For dates of service June 1, 2011, through and including March 31, 2012, payments for services provided in ADHC Centers located within specified Medical Service Study Areas (MSSAs) in Alameda, Contra Costa, Los Angeles, Marin, Orange, Riverside, San Bernardino, San Diego, San Francisco, San Mateo, Santa Clara, Santa Cruz and Ventura counties shall be the rate as calculated in paragraph (1), less 10 percent.

ENCLOSURE

Revised Pages for:

CALIFORNIA MEDICAID STATE PLAN

Under Transmittal of

STATE PLAN AMENDMENT (SPA)

11-039*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	**Insert Page (s)**
Attachment 4.19-B, page 64 (TN 11-009)	Attachment 4.19-B, page 64