

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

1. TRANSMITTAL NUMBER:  
09-022

2. STATE  
California

**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, 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:

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

Also see Attachment to this Transmittal Form

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19B—Amend pages 38 through 41

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  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

Attachment 4.19B, pages 38 through 41

10. SUBJECT OF AMENDMENT:

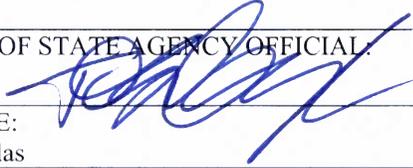
Description of Drug Medi-Cal Reimbursement Rate-Setting Methodology Changes Starting July 1, 2009

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:  
Governor's Office does not wish to Review  
State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:  
Toby Douglas

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:

**PLAN APPROVED – ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:



DAVID MAXWELL-JOLLY  
Director

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



ARNOLD SCHWARZENEGGER  
Governor

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Ms. Gloria Nagle  
Associate Regional Administrator  
Centers for Medicare & Medicaid Services  
Division of Medicaid and Children's Health  
90 7<sup>th</sup> Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6707

Dear Ms. Nagle:

STATE PLAN AMENDMENT TRANSMITTAL NUMBER 09-022

The Department of Health Care Services (DHCS) submits the enclosed State Plan Amendment (SPA) 09-022. This SPA amends Attachment 4.19B, pages 38 through 41 of the California Medicaid State Plan for the Drug Medi-Cal Services. The amendment is necessary to describe the Drug Medi-Cal reimbursement rate methodology changes mandated by the State Fiscal Year (FY) 2009-10 Budget Trailer Bill, Assembly Bill X4 4 (Statutes, Chapter 4, of 2009). This legislation added Welfare and Institutions Code Section 14021.9, which specifies the reimbursement rate limitations and methodologies described below.

The California State Department of Alcohol and Drug Programs (ADP) has developed Drug Medi-Cal reimbursement rates using the same rate-setting methodologies since FY 1997-98. The methodology change for FY 2009-10 comes from the enacted Budget Trailer Bill, which mandated a ten percent reduction applied to the rates that ADP developed using the normal reimbursement rate-setting methodologies.

ADP staff annually meets with stakeholders to discuss the rate-setting process. This year, the meeting was held June 23, 2009. On June 3, 2009, the proposed rates for FY 2009-10 were mailed to all county alcohol and drug program administrators and all service providers certified to provide substance abuse treatment services. The proposed rates were provided electronically on ADP's website and through the United States Postal Service.

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Assembly Bill X4 4 added Welfare and Institutions Code Section 14021.9 to require a ten percent rate reduction for FY 2009-10, effective July 1, 2009. For FY 2010-11 and subsequent fiscal years, Section 14021.9 requires the reimbursement rates to be set at the lower of the following:

- The reimbursement rates developed using the normal rate-setting methodologies; or
- The FY 2009-10 reimbursement rates adjusted for the cumulative growth in the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the California Department of Finance.

The enclosed SPA amends Attachment 4.19B, page 40, Section E to describe this reimbursement rate methodology change. It also updates references on pages 38 and 39 that have changed since these pages were last updated.

The following summarizes the SPA changes to Attachment 4.19B:

1. Page 38, first paragraph: Deleted the "monthly" reimbursement rate reference. Assembly Bill 1279 (Chapter 759, Statutes of 2008) revised Health and Safety Code Section 11758.42(c) to delete the "monthly" reference.
2. Page 38, Section A, third paragraph: Replaced the HCFA (Health Care Financing Administration) with a reference to the Medicare Provider Reimbursement Manual of the Centers for Medicare & Medicaid Services (CMS) to reflect the Agency's name change.
3. Page 39, Section B(2)(b): Deleted the "monthly" reimbursement rate reference. (See #1 above.)
4. Page 40, Section D:
  - Same as page 39 above.
  - Replaced the reference to Section E with a reference to new Section F, since a new Section E was created (see next item).
5. Page 40, Section E: This new section describes the reimbursement rate-setting methodology change for FY 2009-10 and for FY 2010-11 and subsequent years. This is in accordance with Welfare and Institutions Code Section 14021.9.
6. Page 41, Section F: Re-titled the former Section E to Section F. This was necessary because of the creation of new Section E.

Ms. Gloria Nagle

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If you have questions regarding the enclosed changes, please contact Barbara Bailey, Chief, Medi-Cal Benefits, Waiver Analysis and Rates Division at (916) 552-9626.

Sincerely,



Toby Douglas, Chief Deputy Director  
Health Care Programs

Enclosures

cc: Barbara Bailey, Chief  
Medi-Cal Benefits, Waiver Analysis and Rates Division  
1501 Capitol Avenue, MS 4601

Tim Matsumoto, Chief  
Rate Development Branch  
1501 Capitol Avenue, MS 4612

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## REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES

The policy of the State Agency is that reimbursement for Drug Medi-Cal (DMC) services shall be limited to the lowest of the county or contract provider's published or customary charge to the general public for providing the same or similar services, the provider's allowable costs of rendering these services, or the Statewide Maximum Allowances (SMA). For Narcotic Treatment Programs, reimbursement is limited to the lower of the provider's published or customary charge to the general public for the same or similar services, or the uniform statewide reimbursement rate established in Section D below, as defined by the State Department of Alcohol and Drug Programs (ADP) and approved by the Department of Health Care Services (DHCS). In no case shall payments exceed SMA.

### A. DEFINITIONS

"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 allowances" (SMA) are upper limit rates, established for each type of service, for a unit of service.

"Actual cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in the Medicare Provider Reimbursement Manual (Centers for Medicare & Medicaid Services, Publication 15-1.)

"Provider of Services" means any private or public agency that provides direct substance abuse treatment 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 Abuse Clinics.

"Unit of Service" (UOS) means a face-to-face contact on a calendar day for Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential Substance Abuse Services, and Naltrexone Treatment Program services. For these services, only one unit of 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

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record. For Narcotic Treatment Program services, “Unit of Service” means each calendar day a client receives services, including take-home dosing.

“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 ADP.

**B. REIMBURSEMENT METHODOLOGY**

1. The reimbursement methodology for providers of DMC Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential Substance Abuse Services, and Naltrexone Treatment program services, is based on the lowest of the following:

- a. The provider’s published or customary charge to the general public for providing the same or similar services;
- b. The provider’s allowable costs of rendering these services;
- c. The SMA established in Section C below, as defined by ADP and approved by DHCS.

The above reimbursement limits are applied at the time of settlement of the year-end cost reports. Reimbursement is based on comparisons to each provider’s total, aggregated allowable costs after application of SMA to total aggregated published charges, by legal entity.

2. The reimbursement methodology for providers of DMC Narcotic Treatment Program services is based on the lower of:

- a. The provider’s published or customary charge to the general public for the same or similar services, or
- b. The uniform statewide reimbursement rate established in Section D below, as defined by ADP and approved by DHCS

**C. SMA METHODOLOGY FOR DMC OUTPATIENT DRUG FREE TREATMENT, DAY CARE REHABILITATIVE TREATMENT, NALTREXONE TREATMENT, AND PERINATAL RESIDENTIAL SUBSTANCE ABUSE SERVICES**

“SMA” are based on the statewide median cost of each type of service as reported in the year-end cost reports submitted by providers for the fiscal year, which is two years preceding the year for which SMA are published.

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D. UNIFORM STATEWIDE REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS

The uniform statewide reimbursement rate is based on the averaged daily cost of dosing and ingredients and ancillary services described in Section F, based on the annual cost per patient and a 365-day year, using the most recent and accurate data available, and in consultation with DHCS, narcotic treatment providers, and county alcohol and drug program administrators.

E. ONGOING CHANGE TO SMA AND REIMBURSEMENT RATE METHODOLOGIES

Effective with the California State Fiscal Year (FY) 2009-10 rate development process, the rates established by the methodologies in Sections C and D, above shall be modified to comply with the provisions of the California Welfare and Institutions Code Section 14021.9 which specifies the following:

1. For FY 2009-10, the reimbursement rates for Drug Medi-Cal services developed by the State Department of Alcohol and Drug Programs will be reduced by 10 percent, effective July 1, 2009.
2. For FY 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 by the State Department of Alcohol and Drug Programs through the normal rate-setting methodologies as set forth in Sections C and D, above.
  - b. The 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.

F. ALLOWABLE SERVICES

Allowable services and units of service are as follows:

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<u>Service</u>	<u>Unit of Service</u>
Day Care Rehabilitative Treatment	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 Abuse Treatment	24-hour structured environment (excluding room and board).
Naltrexone Treatment	Face-to-face contact per calendar day for counseling and/or medication services.
Narcotic Treatment Programs (aggregate rate consisting of four (4) 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 LAAM patients.
3. Dosing	Ingredients and dosing fee for methadone and LAAM patients.
4. Counseling	Minimum of fifty (50) minutes to be provided and billed in ten (10) minute increments, up to a maximum of 200 minutes based on the medical needs of the patient.