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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

August 7, 2012

Gloria Nagle, PhD, MPA
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

STATE PLAN AMENDMENT 12-001: REIMBURSEMENT FOR EMERGENCY AIR MEDICAL TRANSPORTATION SERVICES

Dear Ms. Nagle:

This letter and the enclosed State Plan Amendment (SPA) are the California Department of Health Care Services' (DHCS) responses to the Center for Medicare and Medicaid Services' (CMS) Request for Additional Information (RAI) letter dated, May 15, 2012, concerning SPA 12-001. This letter and the attached amendments address the questions and concerns expressed by CMS.

Additionally, during a May 9th conference call, CMS provided guidance to DHCS suggesting SPA 12-001 be split. Therefore, DHCS is requesting to split SPA 12-001 into two (2) SPAs: SPA 12-001A would describe the Supplemental Payment Methodology and SPA 12-001B would describe the Rate Augmentation Methodology. This split would allow CMS to approve 12-001A while DHCS works out the more complex issues of the Rate Augmentation Methodology with CMS.

The following are DHCS' responses to the RAI dates May 15, 2012:

General Questions

1. The effective date of the SPA may be no earlier than January 7, 2012 given the publishing date of the public notice. Therefore, please confirm a pen and ink change be made to Box 4 of the HCFA 179 to reflect a January 7, 2012 (or later) effective date.

State Response: See *Attachment 1* for a pen and ink change made to the HCFA 179, Box 4 to reflect a January 7, 2012, effective date.

2. Please confirm the budget impact numbers for Federal Fiscal Year 2012 and Federal Fiscal Year 2013 and confirm a pen and ink change be made to Box 7 of the HCFA 179.

State Response: See *Attachment 1*, Box 7 of the HCFA 179, for a pen and ink change made to the budget impact numbers that reflect the most recent fiscal impact estimate for Federal Fiscal Years 2012 and 2013.

Reimbursement Methodology

CMS and the State held several conference calls on this SPA during which CMS provided guidance on the level of specificity that needs to be outline in the SPA.

1. The State Plan must include the exact amounts for both the initial and final supplemental payments, as well as the pool amount on which the supplemental payment will be based. The SPA currently contains a "Phase 1 – Supplemental Payment Methodology" and a "Phase 2 – Emergency Air Medical Transportation Service Rate Adjustment Methodology." CMS understands that both the pool amount and the per transport supplemental payment may change in the future, but that the State cannot definitely project that change. During a May 9th conference call, CMS provided guidance to the State suggesting that SPA 12-001 be split. SPA 12-001A would describe the Supplemental Payment Methodology. CMS has provided some suggested language as an attachment to this RAI. SPA 12-001B would reference the future rate adjustments to be posted as part of the State's online fee schedule. Each time the rates are adjusted the State would need to submit a SPA to update the fee schedule effective date.

State Response: DHCS has placed the pool amount in the State Plan and is proposing to post the first and second supplemental payment amounts on the rates web site. DHCS is requesting to split SPA 12-001 into two SPAs: SPA 12-001A and SPA 12-001B.

2. In order for the State plan language to be understandable, auditable and unambiguous, the State will need to add more detail to the current description of the rate calculation methodology. The State should add additional language to the SPA to capture the description provided during the conference call held on April 11, 2012. CMS has provided suggested language in the documents attached to the RAI.

State Response: DHCS added language to the SPA to further describe in detail the supplemental payment calculation methodology.

Standard Funding Questions
The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal Matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

State Response: Providers receive and retain the total Medicaid expenditures claimed by DHCS.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditure (CPEs), provider taxes, or any other mechanism used by the State to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully described the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority; and,

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

State Response: Appropriation is made annually to DHCS through the Budget Act for the services provided. For the services that this SPA addresses, intergovernmental transfers, provider taxes, or any other mechanism used by states to provide the non-federal share, are not used. In addition to the rate of payment, public hospitals' uncompensated care costs associated with outpatient hospital services are used to claim federal reimbursement (FFP) based on certified public expenditures , as authorized under Assembly Bill (AB) 915 (2002). Therefore, the outpatient hospital services rendered by the public hospitals are considered fully reimbursed.

AB 2173 (Chapter 547, Statutes of 2010) authorizes the county courts to impose an additional $4 penalty to be levied upon every conviction for a violation of the Vehicle Code (except for specified parking offenses). Funds that are collected resulting from the $4 penalty are transferred to the Emergency Medical Air Transportation Act fund and are used to increase rates and/or payments for Medi-Cal emergency air medical transportation services.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhances payments are made, please provide the total amount for each type of supplemental or enhances payment made to each provider type.

State Response: California has implemented the following supplemental payment programs for services provided in an outpatient setting: Outpatient Disproportionate Share Hospitals, AB 915 Payments, and Outpatient Small and Rural Hospitals. Each is defined in California's State Plan.

Outpatient Disproportionate Share Hospitals is defined in Attachment 4.19-A, beginning on page 18, entitled "Increase in Medicaid Payment Amounts for California Disproportionate Share Hospitals." Assembly Bill 915 Payments are defined in Attachment 4.19-B, beginning on page 46, entitled "Supplemental Reimbursement for Public Outpatient Hospital Services." Supplemental Reimbursement for Outpatient Small and Rural Hospitals is specified in California Code of Regulations, Title 21, Section 51509.

The total amounts paid for Outpatient Disproportionate Share Hospitals, Assembly Bill 915 Payments, and Outpatient Small and Rural Hospitals for State Fiscal Year 2009-2010 is as follows:

- Outpatient Disproportionate Share Hospitals.....$ 10,000,000
- Assembly Bill 915 Payments.....$ 329,227,356*
- Outpatient Small and Rural Hospitals.....$ 8,000,000

* Total funds expenditures by the counties on which the claim for FFP is based.

4. For clinic or outpatient hospital services please provided a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current year) UPL demonstration.

State Response: A rate study performed in 2007 comparing 2006 Medi-Cal and Medicare reimbursement rates revealed that Medi-Cal rates for outpatient services in the aggregate are approximately 60 percent of the Medicare rate. There have been no rate increases for outpatient services since 2006. Reimbursement rates for clinic or outpatient hospital services addressed in this SPA are the same for all classes of providers (i.e., State owned or operated, non-state government owned or operated, and privately owned or operated). Being that this SPA references enhanced payments to outpatient emergency air medical transportation services, compliance with the UPL would not be affected.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

State Response: No. Current rates for outpatient services in the aggregate are approximately 60 percent of the Medicare rate and include emergency air medical transportation rates covered under this SPA. Therefore, recoupment of payments exceeding the cost of services would not occur.

Sincerely,

Toby Douglas
Director

Enclosures

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: **12-001B**

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
~~October 1, 2011~~ **January 7, 2012**

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 11-12 ~~$3,990,000~~ **$0**
b. FFY 12-13 ~~$2,520,000~~ **$7,714,914**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 16 to Attachment 4.19-B Pages ~~1-4~~ **4-5**

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

N/A

10. SUBJECT OF AMENDMENT:
Reimbursement for Air Medical Transportation 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.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED:

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:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
~~12c Prosthetic and orthotic appliances, and hearing aids (continued).~~	~~Beneficiaries who are receiving long-term care in a licensed skilled nursing facility or intermediate care facility (NF-A and NF-B).~~ • ~~Beneficiaries who are receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including ICF/DD Habilitative and ICF/DD Nursing.~~ • ~~Beneficiaries in the Program for All-Inclusive Care for the Elderly (PACE).~~ • ~~Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation~~.	
12d. Eyeglasses and other eye appliances	Covered as medically necessary on the written prescription of a physician or an optometrist under this state plan only for the following beneficiaries: 1. Pregnant women, if eyeglasses or other eye appliances are part of their pregnancy-related services or for services to treat a condition that might complicate their pregnancy. 2. Individual who is an eligible beneficiary ~~under~~ of the Early and Periodic Screening Diagnosis and Treatment Program. ~~3. Individual who is receiving long term care in a licensed skilled or intermediate care facility (NF-A and NF-B). Services would be provided in an FQHC or RHC if an NF-A or NF-B resident is a patient of the clinic.~~ ~~4. Individual who is receiving long term care in a licensed intermediate care facility for the developmentally disabled (ICF-DD) including ICF-DD Habilitative and ICF-DD Nursing.~~	Prior authorization is required for low vision devices when the billed amounts are over $100 and for contact lenses when medically indicated for conditions such as aphakia, keratoconus, anisometropia, or when facial pathology or deformity preclude the use of eyeglasses. Prior authorization is required for ophthalmic lenses and frames that cannot be supplied by the fabricating optical laboratory.
13a Diagnostic services	Covered under this state plan only for EPSDT program	
13b Screening services	Covered under this state plan only for EPSDT program	
13c Preventive services	Covered for all preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). Preventive services are provided and covered by a physician or other licensed practitioner of the healing arts within the scope of	Prior authorization is not required and services are exempt from cost sharing in accordance with ACA Section 4106. The State assures the availability of documentation to support the claiming of federal reimbursement for these services.

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

		his/her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan. ~~under this state plan only for EPSDT program and for pregnant/postpartum Medi-Cal recipient~~	The State assures that the benefit package will be updated as changes are made to USPSTF and ACIP recommendations, and that the State will update the coverage and billing codes to comply with these revisions.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
~~12c Prosthetic and orthotic appliances, and hearing aids (continued).~~	~~Beneficiaries who are receiving long-term care in a licensed skilled nursing facility or intermediate care facility (NF-A and NF-B).~~ • ~~Beneficiaries who are receiving long-term care in a licensed intermediate care facility for the developmentally disabled (ICF/DD), including ICF/DD Habilitative and ICF/DD Nursing.~~ • ~~Beneficiaries in the Program for All-Inclusive Care for the Elderly (PACE).~~ • ~~Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) and AIDS Healthcare Foundation~~.	
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**Coverage is limited to medically necessary services

his/her practice under State law and are reimbursed according to the methodologies for those services in that portion of the state plan.

~~under this state plan only for EPSDT program and for pregnant/postpartum Medi-Cal recipient~~

The State assures that the benefit package will be updated as changes are made to USPSTF and ACIP recommendations, and that the State will update the coverage and billing codes to comply with these revisions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: California

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount of Basis for Determination
Physician			X	$1 per visit
Clinic/Outpatient			X	$1 per visit
Surgical center			X	$1 per visit
Optometric			X	$1 per outpatient visit
Chiropractic			X	$1 per outpatient visit
Psychology			X	$1 per outpatient visit
Podiatric			X	$1 per outpatient visit
Occupational therapy			X	$1 per outpatient visit
Physical therapy			X	$1 per outpatient visit
Speech therapy			X	$1 per outpatient visit
Audiology			X	$1 per outpatient visit
Acupuncture			X	$1 per outpatient visit
Drug Prescriptions			X	$1 per outpatient drug prescription
Dental			X	$1 per outpatient dental visit
Nonemergency services in an emergency room			X	$5 per visit (average payment for nonemergency services in an emergency room is greater than $50) All other amounts besides nonemergency services in an emergency room that meet the definition of nominal.

Exceptions:

1. Any service for which the State payment is $10 or less.
2. Any family planning service.
3. Any service provided to a person ~~age 18 or~~ under age 19.
4. ~~Any woman receiving perinatal care.~~Any service furnished to a pregnant women, if the service relates to the pregnancy or to any other medical condition which may complicate the pregnancy, including counseling and pharmacotherapy for cessation of tobacco use.
5. ~~Any person who is an inpatient in a health facility~~. Any service provided to an individual who is an inpatient in a hospital, long-term care facility or other medical institution who is required to spend all but a minimal amount of his income required for personal needs towards the cost of care. ~~.~~
6. Any children under 21 living in boarding homes or institutions for foster care.
7. Any individual who is currently or has previously used services provided by an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) in any state and any American Indian/Alaskan Native that have received services through referral under contract health services.
8. Any preventive services and vaccines in accordance with the Affordable Care Act Section 4106.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: California

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge Deduct. Coins. Copay.	Amount of Basis for Determination
Clinic	X	$1 per visit
Surgical center	X	$1 per visit
Optometric	X	$1 per outpatient visit
Chiropractic	X	$1 per outpatient visit
Psychology	X	$1 per outpatient visit
Podiatric	X	$1 per outpatient visit
Occupational therapy	X	$1 per outpatient visit
Physical therapy	X	$1 per outpatient visit
Speech therapy	X	$1 per outpatient visit
Audiology	X	$1 per outpatient visit
Acupuncture	X	$1 per outpatient visit
Drug Prescriptions	X	$1 per outpatient drug prescription
Dental	X	$1 per outpatient dental visit
Nonemergency services in an emergency room	X	$5 per visit (average payment for nonemergency services in an emergency room is greater than $50) All other amounts besides nonemergency services in an emergency room that meet the definition of nominal.

Exceptions:

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5. ~~Any person who is an inpatient in a health facility.~~ Any service provided to an individual who is an inpatient in a hospital, long-term care facility or other medical institution who is required to spend all but a minimal amount of his income required for personal needs towards the cost of care.
6. Any children under 21 living in boarding homes or institutions for foster care.
7. Any individual who is currently or has previously used services provided by an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) in any state and any American Indian/Alaskan Native that have received services through referral under contract health services.~~.~~
8. ~~7.~~ Any preventive services and vaccines in accordance with the Affordable Care Act Section 4106.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUPS

c. Prosthetic devices and hearing aids.

__X__ Provided _____ No limitations _X_ With limitations

d. Eye Glasses.

__X__ Provided _____ No limitations _X_ With limitations

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostics services

_____ Provided _____ No limitations ___ With limitations

b. Screening services

_____ Provided _____ No limitations ___ With limitations

c. Preventive services.

__X__ Provided _____ No limitations _X_ With limitations

d. Rehabilitative services; including rehabilitative mental health services and rehabilitative alcohol and drug treatment services for individuals diagnosed by physician as having a substance-related disorder. (See Supplements 1, 2, and 3 to Attachment 3.1-B)

__X__ Provided _____ No limitations ___ With limitations

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

__X__ Provided _____ No limitations _X_ With limitations

b. Skilled nursing facility services

__X__ Provided _____ No limitations _X_ With limitations

*Description provided on attachment.