



TOBY DOUGLAS
DIRECTOR

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



EDMUND G. BROWN JR.
GOVERNOR

SEP 28 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 94103-6707

STATE PLAN AMENDMENT 12-028

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 12-028 to incorporate a 10 percent payment reduction applicable to clinical laboratory or laboratory services, effective on and after July 1, 2012. This payment reduction was recently enacted in California Assembly Bill (AB) 1494 (Statutes of 2012), which amended Welfare & Institutions (W&I) Code Section 14105.22. This payment reduction is in addition to the payment reductions included in W&I Code Section 14105.192 (AB 97, Statutes of 2011). Laboratory services provided in connection with the Family, Planning, Access, Care and Treatment (Family PACT) program or by Hospital Outpatient Departments are exempt from both 10 percent payment reductions.

On August 21, 2012, the Centers for Medicare and Medicaid Services informed DHCS that tribal consultation is not required for this SPA. DHCS published the proposed payment reduction for clinical laboratory or laboratory services in the California Regulatory Notice Register on June 29, 2012. Up to now, no comments have been received.

Enclosed you will find the following for SPA 12-028:

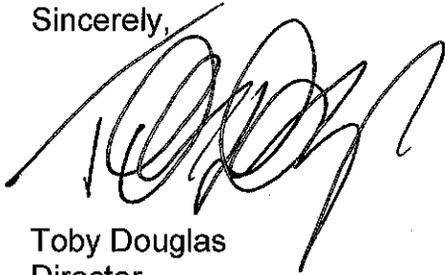
- Attachment 4.19-B, page 3h (page 3h is new).
- HCFA Form-179.

(Continue Next Page)

Gloria Nagle
Page 2

If you have any questions regarding this SPA, please contact John Mendoza, Acting Chief, Fee-For-Service Rates Development Division at (916) 552-9639.

Sincerely,

A handwritten signature in black ink, appearing to read 'Toby Douglas', written over a horizontal line.

Toby Douglas
Director

cc: John Mendoza, Acting Chief
Fee-For-Service Rates Development Division
1501 Capitol Avenue, Suite 71.4001
MS 4600
Sacramento, CA 95814

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

1. TRANSMITTAL NUMBER:
12-028

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, 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:
Welfare & Institutions Code, Section 14105.22 (b)(4)(A)

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 (3 months) \$1,925,000
b. FFY 2013 (12 months) \$7,700,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 3h

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

None

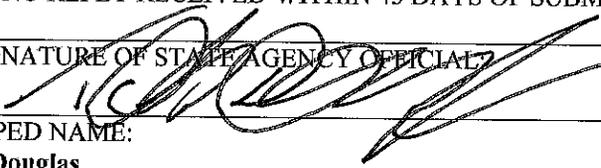
10. SUBJECT OF AMENDMENT:
10 percent payment reduction for clinical laboratory or laboratory services

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:



16. RETURN TO:

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

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: **SEP 28 2012**

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

REIMBURSEMENT FOR CLINICAL LABORATORY OR LABORATORY SERVICES

- (1) For dates of service on and after July 1, 2012, payments for “clinical laboratory or laboratory services,” as those services are defined in California Code of Regulations, Title 22, section 51137.2, will be reduced by 10 percent. This payment reduction is in addition to the 10 percent payment reductions included in 4.19B, page 3.1, paragraph (6).
- (2) The payment reduction specified in paragraph (1) set forth on this page 3h does not apply to the following:
 - Family planning services and supplies, as described in Attachment 3.1-A, item 4c, provided by the Family Planning, Access, Care, and Treatment (Family PACT) Program.
 - Hospital Outpatient Departments, as defined in California Code of Regulations, Title 22, section 51112.
- (3) References to State regulations on this page 3h are to those regulations in effect on July 1, 2012.

TN No 12-028
Supersedes
TN No None

Approval Date _____

Effective Date July 1, 2012

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

REIMBURSEMENT FOR CLINICAL LABORATORY OR LABORATORY SERVICES

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- (2) The payment reduction specified in paragraph (1) set forth on this page 3h does not apply to the following:
- Family planning services and supplies, as described in Attachment 3.1-A, item 4c, provided by the Family Planning, Access, Care, and Treatment (Family PACT) Program.
 - Hospital Outpatient Departments, as defined in California Code of Regulations, Title 22, section 51112.
- (3) References to State regulations on this page 3h are to those regulations in effect on July 1, 2012.

TN No 12-028
Supersedes
TN No None

Approval Date _____

Effective Date July 1, 2012

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

DEC 20 2012

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

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-B of your State Medicaid plan submitted to the Centers for Medicare & Medicaid Services (CMS) on September 28, 2012, under State Plan Amendment (SPA) 12-028. This SPA was submitted to incorporate a 10 percent payment reduction applicable to clinical laboratory and laboratory services, effective on or after July 1, 2012. Before we can continue processing this amendment, we need additional or clarifying information. Therefore, we are requesting the following additional information (RAI) pursuant to Section 1915(f)(2) of the Social Security Act (the Act).

General

1. HCFA 179, Box 7: Please provide support as to how the State computed the following fiscal impacts:

| | |
|----------|-------------|
| FFY 2012 | \$1,925,000 |
| FFY 2013 | \$7,700,000 |

Please also confirm that these amounts should be shown as negative to reflect the savings under the SPA.

2. HCFA 179, Box 6: Please confirm a pen and ink change to add 42 CFR 447 Subpart F.
3. Please clarify the specific services that will be impacted by this rate reduction. In other words, will all services covered under Item 3, "Other laboratory and X-ray services", on Attachment 3.1-A, page 1 be subject to this reduction (limitations described on page 4 of Limitations to Attachment 3.1-A)?
4. Please describe if/how this SPA interacts with pending SPA 10-020. What will the net reduction be for radiology services?

Public Notice

5. 42 CFR 447.205 requires that public notice: (1) Describe the proposed change in methods and standards; (2) Give an estimate of any expected increase or decrease in annual aggregate expenditures; (3) Explain why the agency is changing its methods and standards; (4) Identify a local agency in each county (such as the social services agency or health department) where copies of the proposed changes are available for public review; (5) Give an address where written comments may be sent and reviewed by the public; and (6) If there are public hearings, give the location, date and time for hearings or tell how this information

may be obtained. Please explain and provide documentation for how the state meets all 6 requirements of 42 CFR 447.205.

6. Please confirm that the 10% reduction applies to the current payment methodology as described in Attachment 4.19-B, page 3d, Item 4 - and not to the proposed new payment methodology as described in the public notice and in the AB 1494 legislation.

Reimbursement

7. Please confirm that the payment methodology for clinical laboratory and laboratory service is described on page 3d, item 4 of Attachment 4.19-B. If so, please confirm whether providers of clinical laboratory or laboratory service can receive between 1% to 80% of the lowest maximum allowance for California established by the federal Medicare program for the same similar services. Section 1902(a) of the Social Security Act requires that State Plan language be clear, auditable and unambiguous. The referenced language, as currently structured, does not comport with the above referenced regulation and statute as it allows for a wide fluctuations in payment. The current language on page 3d, item 4 of Attachment 4.19-B needs to be revised to create a fixed amount of reimbursement for this service. According to the state's public notice, DHCS proposes to develop a new reimbursement methodology that will be based on the lowest amounts paid to other payers or similar clinical laboratory services. Please explain whether the state is planning to include the referenced new methodology in the proposed SPA – and provide an anticipated submission date.
8. Attachment 4.19-B, page 3h, item (1), last paragraph: Please clarify whether this proposed payment reduction is in addition to the 10% payment reductions included in 4.19-B, page 3.1, paragraph (6). CMS believes the reference should be to Attachment 4.19-B, page 3.3, paragraph (13), because the reduction described on page 3.1, paragraph (6) is only for services on or after July 1, 2008 through February 28, 2009.
9. Attachment 4.19-B, page 3h, item (3): Please clarify the intent/need for the language, "References to State regulations on this page 3h are to those regulations in effect on July 1, 2012."

Access Questions

Section 1902(a)(30) of the Social Security Act requires 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." Please reply to the following questions regarding access to care:

10. How will the reduction in rates allow the State to comply with requirements of 1902(a)(30)?
11. How did the State determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?
12. What types of studies or surveys were conducted or used by the State to assure that access would not be negatively impacted (e.g. comparison with commercial access/reimbursement rates, comparison with Medicare rates, comparison with surrounding State Medicaid rates, comparison with national averages for Medicaid or Medicare, other)?
The reductions proposed via SPA 12-028 are in addition to previous payment reductions implemented via SPA 08-009B1 and SPA 11-009. Has the State conducted any additional access analyses pertaining to the previous reductions for clinical laboratory or laboratory services? If so, please provide that analysis and any conclusions made regarding access to Medicaid services.

13. How were providers, advocates and beneficiaries engaged in the discussion around this rate reduction? What were their concerns and how did the State address these concerns? Was there any direct communication (bulletins, town hall meetings, etc.) between the State and providers regarding the reductions proposed via this amendment?
14. Is the State modifying anything else in the State Plan which will counterbalance impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?
15. What is the current utilization volume of the services that will be affected by this amendment? Specifically please provide the following metrics for the services affected by this amendment:
 - a) Total number of providers by type and geographic location;
 - b) Total number of participating Medicaid providers by type and geographic area;
 - c) Total number of Medicaid Beneficiaries by eligibility type;
 - d) Utilization of services by eligibility type over time; and
 - e) Any analysis resulting from the above data
16. How does the State intend to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels? As part of the 08-009B1 and SPA 11-009 rate reduction approvals, the State implemented an access monitoring plan. What has been the result of the State's monitoring of clinic laboratory and laboratory services since the implementation of that reduction? Has there been any indication of access problems or vulnerabilities following the 08-009B1 and 11-009 reductions? Please share available data on provider availability and beneficiary utilization trends.
17. What action(s) does the State plan to implement after the rate modification(s) take place to counter any decrease to access if such a decrease is found to prevent sufficient access to care? For example, has the State contemplated temporarily lifting the reductions if access problems are identified?
18. Did the State receive any feedback or complaints from the public regarding this rate reduction? If so, how were the complaints addressed and resolved?
19. Does the State monitor the number of providers who have closed their practices to additional Medicaid patients (i.e., they no longer accept additional Medicaid patients)? If yes, please provide data on the number of providers by geographic service area and by quarter who have notified the State that they have closed their practices to additional Medicaid patients over the last year or as a result of the pending reductions. Does the State require providers to notify the State when they are no longer accepting additional Medicaid patients to their practice? If yes, please describe the notification process. How does the State consider the (enrolled providers who no longer accept additional Medicaid patients) in its access to care monitoring?
20. Recent Ninth Circuit Court of Appeals decisions (including, e.g., California Pharmacists Association, et al v. Maxwell-Jolly, No. 09-55532, March 3, 2010) have sustained district court injunctions placed on California's implementation of various Medicaid rate reductions. In these rulings, the Circuit court repeatedly has held that California improperly failed to assess whether the reduced payments would be sufficient to meet the patient access and quality of care requirements of 1902(a)(30)(A) of the Act. Federal regulations (42 CFR 430.12(c)(i)) require States to ensure that State plan materials are consistent with court decisions such as these. Please explain, with regards to the proposed service rate reductions in SPA 12-028, how California has satisfied the requirements as set forth by the Ninth Circuit Court in this line of cases.
21. Has the State received any legal challenge or other formal statement of opposition and/or concern from the providers on this proposed rate reduction?

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.

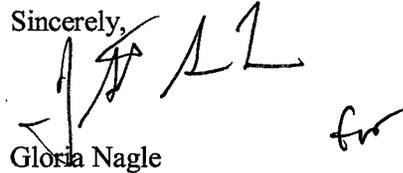
22. Section 1903(a) (1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, 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.)
23. 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 expenditures (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 shares is being provided using IGTs or CPEs, please fully describe 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).
24. 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 enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.
25. For clinic or outpatient hospital services please provide 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 rate year) UPL demonstration.
26. 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?

We are requesting this additional clarifying information under provisions of Section 1915(f) of the Social Security Act (added by P.L. 97-35). This has the effect of stopping the 90-day clock with respect to CMS taking further action on this State plan submittal. A new 90-day clock will not begin until we receive your response to this request for additional information.

In accordance with our guidelines to the State Medicaid Directors dated January 2, 2001, if the State does not respond to our request for additional information or communicate an alternate action plan within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

If you have any questions, please contact Kristin Dillon at (415) 744-3579 or via email at Kristin.Dillon@cms.hhs.gov.

Sincerely,

Handwritten signature of Gloria Nagle in black ink, consisting of stylized initials and a surname.

Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: John Mendoza, California Department of Health Care Services
Arlene Sakazaki, California Department of Health Care Services
Kathryn Waje, California Department of Health Care Services