

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

December 10, 2015

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

We have reviewed the Department of Health Care Services' (DHCS) proposed state plan amendment (SPA) CA-15-021, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2015. This SPA is in response to the requirement from the Centers for Medicare and Medicaid Services (CMS) to update the payment methodology for the Local Educational Agency (LEA) Medi-Cal Billing Option Program. This SPA will add new assessment and treatment services; new practitioner types; and a Random Moment Time Survey (RMTS) methodology to the LEA Medi-Cal Billing Option Program. In addition, DHCS is implementing the guidelines in accordance with the letter to the State Medicaid Director (SMD-14-006), dated December 15, 2014.

We conducted our review of your submittal according to the federal statutory requirements at 1903(c) and 1905(a) of the Social Security Act. Section 1905(a) of the Act requires that states provide any medically necessary health care services to an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) recipient and section 1903(c) of the Act requires Medicaid to be the primary payer of health-related services provided under the Individuals with Disabilities Education Act (IDEA). We also looked at applicable regulations pertaining to additional services and providers to be included under item 23g, LEA services under ESPDT in the state plan, including therapies and personal care services.

The regulation at 42 CFR 430.10 requires that the state plan contain all information necessary for CMS to determine whether the plan can be approved to serve as a basis for federal financial participation (FFP). Since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Before we can continue processing this amendment, we are requesting additional information under provisions of Section 1915(f) of the Social Security Act (added by P.L. 97-35). The additional information that we request follows below.

A. HCFA 179

Please make the following pen and ink changes to the HCFA 179 and send the revised HCFA 179 to CMS:

1. **Box 6:** Please revise the Federal Statute/Regulation citations to sections 1905(a) and 1903(c) of the Social Security Act. Section 1905(a) of the Act requires that states provide any medically necessary health care services to an EPSDT recipient and section 1903(c) of the Act requires Medicaid to be the primary payer of health-related services provided under the Individuals with Disabilities Education Act (IDEA).
2. **Box 7:** The State projected federal budget impact amounts of \$57,397,085 and \$76,529,446 for FFYs 2015 and 2016, respectively. Please explain how the State computed these budget impact amounts.
3. **Box 8:** This box in the HCFA 179 lists all the specific state plan pages that are submitted under this SPA. Please make the following changes:
 - Revise Attachment 4.19-B, pages 1-11 to “Attachment 4.19-B, **Supplement 8**, pages 1-11.”

Add:

- Limitations to Attachment 3.1-A, pages 9 to 9o
 - Limitations to Attachment 3.1-B, pages 9 to 9o
4. **Box 9:** This box in the HCFA 179 lists all the specific, existing state plan pages that are superseded by the newly-submitted, newly-revised SPA pages. Pages 9i – 9o are not included in Box 9 because these pages are brand new to the state plan and do not supersede any existing pages. Please make the additions below to Box 9:
 - Limitations to Attachment 3.1-A, pages 9 to 9h
 - Limitations to Attachment 3.1-B, pages 9 to 9h
 - Attachment 4.19-B, Supplement 8, pages 1-8.
 5. **Box 11:** Please specify the level of Governor’s review for this SPA.

B. Limitations to Attachment 3.1-A, pages 9-9p (Item 4b, EPSDT) and pages 26-40 (item 24g, LEA Services) and Limitations to Attachment 3.1-B, pages 9-9p (item 4b, EPSDT) and pages 25-39 (item 23g, LEA Services): Comments and Questions

CMS has reviewed the Limitations for Attachments 3.1-A and 3.1-B and we believe the EPSDT LEA (item 4b) and stand-alone LEA services (items 24g and 23g, respectively) sections of the state plan need some reorganization.

First, we think that each 1905(a) state plan service should be listed separately and identified with the federal service regulatory citation. For the most part, the state has followed this format. However, if a service description is required or if it is incomplete or erroneous, then a service description should be added/corrected.

Second, the state should add the practitioners and their qualifications (if required), and any “soft” limitations on amount, duration and scope of services. We are suggesting this approach because we saw that some proposed practitioners do not belong under a particular service (e.g., nurse practitioners are a separate benefit from nursing services and should be listed under their own benefit). In at least in one instance, such as under LEA services, the state listed a benefit where there is no federal equivalent service category – specifically, "school health aide services." Since there is no federal “school health aide services” benefit, this practitioner type should be moved under the Personal Care Services (PCS) category.

With this general guidance in mind, CMS has the following questions and comments for the state as follows:

1. **Limitations Attachment 3.1-A and 3.1-B, items 24g and 23g, respectively (LEA Services) and Coordination with Managed Care:** Please describe how LEA services will be integrated with or otherwise coordinated with services provided by managed care plans.
2. **Limitations Attachment 3.1-A and 3.1-B, item 4b (EPSDT), Format:**
 - a. Please explain why the state separates out LEA services from EPSDT services, instead of placing them within item 4b.
 - b. Please also explain why the state doesn’t combine all the LEA treatment services in one list.
3. **Limitations Attachment 3.1-A and 3.1-B, item 4b (EPSDT):** Please consider repagination so that LEA services provided under EPSDT begin on a separate page from the description of other EPSDT services. Please update any page changes accordingly in the HCFA 179.
4. **Limitations Attachment 3.1-A and 3.1-B, item 4b (EPSDT):**
 - a. Please add the following statement to the first page of Limitations Attachment 3.1-A and 3.1-B, item 4b, EPSDT, before “Covered for Medicaid eligible under 21 years of age:” “All medically necessary services coverable under 1905(a) of the Social Security Act are provided to EPSDT-eligible population individuals.”

- b. Please remove language from the EPSDT section of the state plan indicating that services can be provided to individuals under age 22. EPSDT services may only be provided to individuals under age 21.
 - c. Please remove the sentence “LEA providers may provide services to all eligible Medicaid beneficiaries.” The qualifications of LEA providers are listed elsewhere in this section of the state plan.
 - d. Is the language defining the LEA in the state plan the same language as is used to define LEA in state law? Where is the term LEA defined in California state law?
 - e. Please explain how many California State University campuses or University of California campuses participate in the school-based services claiming program? Does the state anticipate that this participation rate will change in the future?
5. **Limitations Attachment 3.1-A and 3.1-B, items 24g and 23g, respectively (LEA Services), pages 26 and 25:**
- a. Please confirm if the state is proposing to cover any beneficiary under age 21 for all listed medical services provided by a LEA, regardless of whether there is an Individualized Education Plan (IEP) or an Individualized Family Services Plan (IFSP).
- If not, please clarify if the state is only covering services to all beneficiaries under age 21 provided by an LEA when the service is part of the IEP/IFSP.
6. **Limitations Attachment 3.1-A and 3.1-B, items 24g and 23g, respectively (LEA Services), pages 26 and 25:**
- a. Please reword language in the state plan to say that the state covers all medically necessary services.
7. **Limitations to Attachment 3.1-A and 3.1-B, items 24g and 23g, pages 26 and 25 respectively (LEA Services), Assessment and Treatment:** The SPA says that LEA assessments and treatment services must be performed by providers who meet the applicable qualification requirements as defined in Title 42 CFR Part 440, who render services within their scope of practice, or as established in State law.
- a. Please revise this language to read “services within their scope of practice as defined by state law” and list the qualifications of each.

8. **Limitations to Attachment 3.1-A and 3.1-B, items 24g and 23g, pages 26 and 25 respectively (LEA Services), Other Health Coverage (OHC):**
 - a. Please define in the state plan the term “Other Health Coverage.”
9. **Limitations to Attachment 3.1-A and 3.1-B, items 24g and 23g, pages 27 and 26 respectively (LEA Services), Nutritional Education Assessment and Nutritional Status Assessment:**
 - a. What is a nutritional educational assessment? How does it differ from nutritional status assessment? Please define.
10. **Limitations to Attachment 3.1-A and 3.1-B, items 24g and 23g, pages 27 and 26 respectively (LEA Services), Individuals with Disabilities Education Act (IDEA):**
 - a. The phrase “For Medicaid eligible individuals, including Medicaid eligible individuals with an IEP/IFSP under the IDEA” appears duplicative in intent to the second paragraph of Section 23g/24g. Please either remove this phrase from the state plan or re-draft the language to clarify the state’s intent.
11. **Limitations to Attachment 3.1-A and 3.1-B, items 24g and 23g, pages 27 and 26 respectively (LEA Services), Assessment Services:**
 - a. Under “Assessment Services”, please clarify why the state cited item 13d, the rehabilitative services benefit, if all of the listed assessments are being completed pursuant to the required EPSDT periodic or inter-periodic schedule.
12. **Limitations to Attachment 3.1-A and 3.1-B, items 24g and 23g, pages 29 and 28 respectively (LEA Services), Treatment Services:**
 - a. As written under “Treatment Services,” personal care services, orientation and mobility services and respiratory therapy treatment services appear to be a subset of nursing services. Please reformat this section of the state plan by giving these services their own bullet points.
13. **Limitations to Attachment 3.1-A and 3.1-B, items 24g and 23g, pages 29 and 28 respectively (LEA Services), Other LEA Covered Services:**
 - a. Targeted case management services are currently described in California’s approved Medicaid State Plan in Supplement 1c to Attachment 3.1-A. What is the state’s intent in including a reference to TCM services in this SPA? Why is the state calling the service “LEA” Targeted Case Management? It should not be a different service just because it is furnished in the LEAs.

- 14. Limitations to Attachment 3.1-A, item 24g, pages 27-40 and Limitations to Attachment 3.1-B, and 23g, pages 25-39 (LEA Services), Prior Authorization & Other Requirements Column:** As noted earlier, in general, the state plan must identify the federal benefit category for each service added under ESPDT, not the state coverage category. To qualify under a federal benefit category, a service must be delivered in a manner consistent with the regulatory definition of that service. For example, physical therapy services as defined in 42 CFR 400.100(a) do not include the rehabilitation of mental conditions of a person. Furthermore, the state plan must indicate the types of providers allowed to deliver the respective service and the providers' qualifications

For the following services identified below, please:

- a. Identify the service with the federal service regulatory citation if missing.
- b. Explain the differences for the following provider types: which -- if any -- are not licensed and, if not licensed, if they are under the supervision of a licensed practitioner who is qualified to provide the same services.
- c. Revise the SPA pages to reflect the information for each provider type.
- d. Respond to any additional questions noted for the service.

i. Audiology Services (42 CFR 440.110(c)):

- Credentialed Audiologists
- Credentialed Speech-Language Pathologists
- Licensed Audiologists
- Licensed Physicians
- Licensed Speech-Language Pathologists
- Registered School Audiometrists

ii. Nursing Services (42 CFR 440.60(a), 440.166 and 440.167):

- Certified Nurse Practitioners
- Certified Public Health Nurses
- Licensed Registered Nurses
- Licensed Vocational Nurses
- Registered Credentialed School Nurses

- a. School Health Aide Services:** The state includes “school health aide services” as covered in “items 13(d) and 24(a) in the Program Coverage column and also under the Limitations and Other Requirements column. School health aide does not have a federal equivalent service category. This category is considered to be a practitioner type should be moved under the Personal Care Services (PCS) category; furthermore, these services are not a coverable rehabilitative or transportation service. Please add the providers' qualifications (if required), and

any “soft” limitations on amount, duration and scope of services. Please describe the specific activities performed by school health aides as well as activities performed by personal health attendants.

iii. Nutritional Services (B&P Code 2585):

- Certified Nurse Practitioners
- Certified Public Health Nurses
- Licensed Physician Assistants
- Licensed Physicians/Psychiatrists
- Licensed Registered Nurses
- Registered Credentialed School Nurses
- Registered Dietitians

iv. Orientation & Mobility Services (42 CFR 440.110(b)):

- a. Please describe in the state plan activities conducted as part of orientation and mobility services.

v. Physical Therapy Services (42 CFR 400.110(a)):

- a. Therapy services should be defined consistent to federal regulations. Please remove “or mental” from the definition of PT services.

vi. Optometry Services (B&P Code, Section 3041.2(a)):

- Licensed Optometrists
- Licensed Physician Assistants
- Licensed Physicians/Psychiatrists
- Registered Credentialed School Nurses

- a. Please clarify the state intent with respect to the B&P code. For example, does the state intend to use professional credentialing standards established by an accrediting organization for these provider groups?
- b. Does the scope of practice as licensed by the state permit all of the above providers to provide Optometry services?

vii. Respiratory Services (B&P Codes 3740-3742):

- Licensed Respiratory Therapists
- a. Who does the billing for this practitioner?
 - b. What respiratory services does the state anticipate would be provided by an LEA?

- c. Please revise the reference to “B&P” code in the state plan to clarify that the state intent with respect to this code. For example, does the state intend to use professional credentialing standards established by the Commission on Accreditation for Respiratory Care?

viii. Psychological Services (42 CFR 440.60(a)):

- Credentialed School Counselors
 - Credentialed School Psychologists
 - Credentialed School Social Workers
 - Licensed Clinical Social Workers
 - Licensed Educational Psychologists
 - Licensed Marriage and Family Therapists
 - Licensed Physicians/Psychiatrists
 - Licensed Psychologists
 - Registered Associate Clinical Social Workers
 - Registered Credentialed School Nurses
 - Registered Marriage and Family Therapist Interns
- a. For the above providers which are under the supervision of a licensed practitioner who can provide the services and who bills for these services?

C. Attachment 4.19-B, Supplement 8

1. Page 1 – The opening paragraph states that school-based services, provided by LEAs, including specialized transportation services, will be paid on a cost basis. Please revise this paragraph as follows:

“Reimbursement for school-based services, including specialized transportation services, will be based upon each LEA’s reasonable and allowable cost as determined based on the LEA’s annual cost report and Medicare principles of reimbursement as described at 42 CFR Part 413, the Medicare Provider Reimbursement Manual (Centers for Medicare & Medicaid Services, Publication 15-1), OMB Super-Circular (2 CFR 200) and Medicaid non-institutional reimbursement principles.”

2. Page 2, I. A – Please explain how the methodologies described on pages 2-6 represent a reasonable approximation of the provider’s costs. Since cost data is readily available via LEAs’ annual cost reports, we like to know why the state is not using the prior year’s costs reports as the mechanism of setting interim payment rates for these school providers. CMS is not particularly comfortable with the state’s use of the Medi-Cal fee schedule rates as the interim payment rates because California’s fee schedule rates likely do not provide a reasonable approximation of each LEAs’ cost of providing covered Medicaid services. Further, it is common practice in other state programs, where CPE is the funding source, to use the prior year’s cost report to set the provider’s

interim payment rates. We urge the state to consider using prior year's cost report as the basis for determining LEAs' interim payment rates.

3. Page 2, I.A.3 – This paragraph states that the interim rates will be based on a methodology similar to that described in Sections I.B-F and based on Medi-Cal Fee Schedule Rates, when appropriate and necessary. Does the State intend to say that interim rates will be based on either the methodologies described in Sections I. B-F or the existing Medi-Cal Fee Schedule Rates for those covered services where interim rates have not been developed using the methodologies described in I.B-F (i.e., Specialized Transportation Services)? If so, please revise the language accordingly to reflect this intent. Please also consider removing the phrase, “when appropriate and necessary”, as it is vague and open for interpretation.
4. Page 3, I.C.3 (e) – Are the billing units for physician and optometrist services in 15-minute increments? If so, please revise your plan language accordingly.
5. Page 4, I.C.3 (i) – This paragraph states that interim rates for physical therapists, speech therapists, psychologists, nurses, audiologists and occupational therapists will be billed on a flat rate basis, regardless of service time spent. Please explain how nurses are paid a flat rate regardless of time spent and yet their hourly cost can be used as a proxy for other practitioners, such as physicians and optometrists. How does the state determine a reimbursement that is based on a flat rate is more reasonable than a reimbursement that is based on time spent?
6. Page 6, I.E.1 – This paragraph should clearly indicate the interim rates for TCM instead of the reimbursement of those services. Please revise the plan language accordingly. Please also explain whether or not the statewide prospective schedule rates differ from the state's Medi-Cal fee schedule rates.
7. Page 6, I.E.2 – This paragraph does not clearly explain how the interim rates for these providers will be computed. Please add clarifying language.
8. Page 6, I.F – Please provide information on the current Medi-Cal fee schedule rates for specialized transportation services and mileage and explain how those amounts compare to the estimated provider's cost for these services.
9. Page 6, II Payment Methodology – This paragraph states that on an interim basis, LEAs will be reimbursed an amount equal to the rate contained in the Medi-Cal fee schedule for covered services. This language appears to be inconsistent to the methodology for some of the practitioners previously listed in the SPA where interim rates will be based on the cost of certain practitioners and bill in service units of 15-minutes increments. Please clarify these conflicting language in the SPA.
10. Page 7, II.A. – Please provide copies of the cost report and related instructions, RMTS and all related training materials.

11. Page 7, II.B.2 – The second paragraph includes a statement that the Direct Medical Services Percentage will include the applicable relocated portion of General Administration time. How does the state determine the “applicable portion of General Administration time” to include in the computation of the Direct Medical Services Percentage?
12. Page 8, II.B.6 – This paragraph states that the numerator for the Medi-Cal Eligibility Ratio will be the number of Medicaid eligible students in the LEA. We believe it is not the number of Medicaid eligible students but rather the number of Medicaid “enrolled” students. As such, please revise the language accordingly.
13. Page 8, II.C. – Please explain why section II.C is broken out separately from the cost reimbursement process for all other school-based services. Aren’t the costs for Specialize Medical Transportation Services settled using the same cost report process as described in II.A?
14. Page 10, II.C.3 (c) - This paragraph states that the numerator for the Specialized Transportation Ratio will be the total number of Medicaid eligible IEP students receiving specialized transportation services. We believe it is not the number of Medicaid eligible IEP students but rather the number of Medicaid “enrolled” IEP students. As such, please revise the language accordingly.
15. Page 11, IV.1. – Please spell out “CRCS” in this paragraph.
16. Page 11, IV.2 – This paragraph should include a statement that the state will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. The state is responsible for returning overpayments to CMS regardless whether or not those overpayments are offset against future provider claims.

D. Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19B of your State plan.

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 payment 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.)

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 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 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 describe the matching arrangement including when the state agency receives the transferred amounts from the local government 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).
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 enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.
4. 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.
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?

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 letter has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to the State Medicaid Directors Letter 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 may initiate disapproval action on the amendment.

Please send your response to me via email at SPA_Waivers_SanFrancisco_R09@cms.hhs.gov:

Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
U.S. Department of Health & Human Services
Centers for Medicare & Medicaid Services
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at cheryl.young@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: John Mendoza, California Department of Health Care Services
Shelly Taunck, California Department of Health Care Services
Wendy Ly, California Department of Health Care Services
Michelle Kristoff, California Department of Health Care Services
Rick Record, California Department of Health Care Services
Nathaniel Emery, California Department of Health Care Services