DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services**

March 30, 2012

Toby Douglas
Chief Deputy Director, Health Care Programs
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 99859

Dear Mr. Douglas:

The Centers for Medicare & Medicaid Services (CMS) has approved the State of California's request, submitted on January 1, 2012, to amend its Demonstration project authorized under section 1115 of the Social Security Act (Act) entitled the "Bridge to Health Care Reform (Waiver number 11-W-00193/9)," to incorporate the Community Based Adult Services (CBAS) program, effective April 1, 2012.

This letter summarizes CMS' review and approval of this request, and encloses revised Special Terms and Conditions (STCs) and expenditure authorities for the Demonstration to reflect the approval of this amendment. Approval of this amendment is limited to approval of the enclosed revision to the Demonstration expenditure authorities. The revised expenditure authorities may be implemented only in accordance with the revised STCs. Pursuant to those expenditure authorities and STCs, all requirements of the Medicaid program apply to the CBAS program except as expressly waived or specifically listed as not applicable under the Demonstration.

It is our understanding and intent that the CBAS program contained in this amendment provides benefits that are consistent with a settlement agreement related to California's termination of Adult Day Health Care (ADHC) services as an optional benefit under its state plan effective March 31, 2012. In the settlement agreement, California agreed to request an amendment to its 1115 demonstration to provide CBAS benefits that would be similar to those previously provided under the ADHC benefit.

This amendment will assure continuation of the services being received by current ADHC recipients until such time as they receive a face-to face assessment to determine whether they meet the needs-based criteria for CBAS benefits. With that exception, the CBAS center benefits will be delivered initially on a fee-for-service basis using a per diem rate, and ultimately through managed care plans, to Medi-Cal beneficiaries who are found to meet a Nursing Facility level of care, including individuals with mental illness, traumatic brain injury, developmental disabilities, in areas that have CBAS centers. Component parts of the CBAS center benefit will also be available through managed care organizations as unbundled services outside of CBAS centers on a fee-for-service basis for individuals who reside in areas that had ADHC centers as of December 1, 2011, but where CBAS center capacity has been reached.

Through this fee-for-service coverage, the State is expanding services for individuals not previously served by the ADHC benefit who have a high level of need.

All individuals who had been receiving ADHC but do not qualify for CBAS center services or CBAS component services will receive Enhanced Case Management (ECM). ECM is a service that provides person centered planning including coordination of medical, social, and education supports. The goal of ECM will be to develop individualized care plans that focus on an individual's abilities, preferences, and needs. By providing systematic coordination and assessment of care and service, individuals will be provided assistance in obtaining and facilitating the delivery of needed care. Individuals receiving the ECM benefit are also provided with the added safeguard of being able to receive CBAS benefits if their level of care changes. ECM coverage will serve the coverage objectives of the Medicaid statute to increase access to care and improve quality of care for Medi-Cal beneficiaries.

In an effort to further the access and quality of care objectives of the Medicaid program, the State will research and test the different effects of the provision of CBAS center services and CBAS unbundled services delivered outside of CBAS centers, thereby determining the impact of each on access, providers and delivery systems, and outcomes. The State and CMS will test impacts on populations by comparing the level of services, delivery mechanisms, and health outcomes. This evaluation will inform future policy regarding how to achieve the access and quality of care objectives of the Medicaid program. The evaluation design plan will describe how California will assess the impact of unbundling and ECM based on parameters and hypotheses developed during the evaluation design process.

As part of our review, we have determined that the CBAS program, operated in accordance with the Special Terms and Conditions, will be consistent with the requirements of section 1902(a)(30)(A) of the Act which 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).

In determining whether proposed State Plan Amendments are consistent with Section 30(A) 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, and we believe that it is appropriate to apply that interpretation in evaluating this Demonstration. 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."

CMS has determined that the CBAS program is consistent with the access requirements of section 1902(a)(30)(A) of the Act, for the following reasons: 1) the payment rates specified by the State on a fee-for-service basis initially for adult day health benefits provided in centers will be the same as the rates for ADHC services and are supported by the access study submitted with SPA 11-039 and SPA 11-009; 2) provision of the CBAS services through managed care entities is not subject to 1902(a)(30)(A) and access to services is ensured through network sufficiency standards; 3) fee-for-service payment rates for CBAS component services are based on existing state plan rates for similar services; and 4) the State will be monitoring access on an ongoing basis in accordance with an approved monitoring plan. Such a monitoring plan is an important protection for beneficiary access to services on an ongoing basis and can provide greater assurance of access than may be possible through a one-time review at the time of approval, depending on the circumstances and available data. CMS interprets the broad language of Section 30(A) to accommodate the use of such prospective monitoring plans as appropriate. Nothing in Section 30(A) requires that all access problems be identified and resolved before they occur. Rather, the statutory language requires that a state plan achieve the substantive goal of access without specifying by what means. In implementing that statutory command, CMS has determined that a prospective monitoring plan coupled with a method for promptly addressing access issues can be an effective "method and procedure" to ensure consistency with the statutory access requirement.

We also conclude that the proposed Demonstration is consistent with the efficiency and economy requirements of Section 30(A). 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 establish rates that both assure access and are consistent with efficiency and economy. Applying our interpretation of the statute to the proposed Demonstration, which adopts payment rates for CBAS identical to that which were approved for Adult Day Health Care services under the State plan, we believe that the proposed rates are consistent with efficiency and economy.

We also believe that the proposed Demonstration satisfies the quality of care requirement of Section 30(A). 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 various strategies, such as quality reporting and incentive payments as well as State regulation and licensure requirements to ensure that the services provided through this Demonstration are of high quality. In addition, the Special Terms and Conditions of the Demonstration provide detailed provider standards that will ensure the high quality of CBAS services.

The Department of Health and Human Services' approval of the amended Demonstration, including the waivers and the expenditure authorities that are described in the enclosed list, are conditioned on the State's acceptance of the revised STCs within 30 days of the date of this letter. The STCs will be effective April 1, 2012, unless otherwise specified. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the Demonstration.

Your project officer is Ms. Alexis Gibson. She is available to answer any questions concerning your section 1115 Demonstration. Ms. Gibson's contact information is as follows:

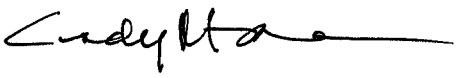
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
Mailstop S2-01-06
Baltimore, MD 21244-1850
Telephone: (410) 786-2813
Facsimile: (410) 786-8534
E-mail: alexis.gibson@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Gibson and to Ms. Gloria Nagle, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Nagle's contact information is as follows:

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103 -6706

If you have questions regarding this approval, please contact Ms. Victoria A. Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

Sincerely,



Cindy Mann

Enclosures
cc: Gloria Nagle, Associate Regional Administrator, Region IX
Vikki Wachino, CAHPG
Alexis E. Gibson, CAHPG