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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

JUL 29 2014

7/29/2014

Hye Sun Lee
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RESPONSE TO THE REQUEST FOR ADDITIONAL INFORMATION FOR STATE PLAN AMENDMENT 09-022

Dear Ms. Lee:

The Department of Health Care Services (DHCS) is submitting its response to the Request for Additional Information (RAI) for State Plan Amendment (SPA) 09-022. DHCS responses to the RAI and the Centers for Medicare and Medicaid Services (CMS) formal comments are included with this letter, as well as the following updated State Plan pages.

- Attachment 4.19-B, Page 38
- Attachment 4.19-B, Page 39
- Attachment 4.19-B, Page 40
- Attachment 4.19-B, Page 41
- Attachment 4.19-B, Page 42 (new)
- Attachment 4.19-B, Page 42a (new)
- Attachment 4.19-B, Page 42b (new)

I want to thank your staff for the open dialogue, technical assistance and helpful guidance during the SPA review process. We look forward to continuing the collaborative work in this upcoming year on the various cost report forms if you have

any questions regarding the information provided, please contact Mr. Don Braeger, Chief, Substance Use Disorder – Prevention, Treatment and Recovery Services Division, at (916) 322-7012 or by e-mail at Don.Braeger@dhcs.ca.gov

Sincerely,

ORIGINAL SIGNED

Director

Enclosures (5)

cc: Tyler Sadwith
Division of Medicaid and Children's Health Operations
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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: **09-022**

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
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:
42 CFR 447 Subpart F, commencing with 447.300

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

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 38
Attachment 4.19-B, Page 39
Attachment 4.19-B, Page 40
Attachment 4.19-B, Page 41
Attachment 4.19-B, Page 42 (new)
Attachment 4.19-B, Page 42a (new)
Attachment 4.19-B, Page 42b (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Page 38
Attachment 4.19-B, Page 39
Attachment 4.19-B, Page 40
Attachment 4.19-B, Page 41

10. SUBJECT OF AMENDMENT:

Drug Medi-Cal Rate Setting and Reimbursement

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.

Original Signed

Toby Douglas

14. TITLE:
Director, Department of Health Care Services

15. DATE SUBMITTED:

16. RETURN TO:

Department of Health Care Services
Nathaniel Emery
1501 Capitol Avenue, MS 4600
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:

FORM HCFA-179 (07-92)

State/Territory: California

REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES

Effective July 1, 2012, the administration of the Drug Medi-Cal Program (DMC) is transferred from the State Department of Alcohol and Drug Programs (ADP) to the Department of Health Care Services (DHCS), authorized by Assembly Bill 106 (Chapter 32, Statutes of 2011).

A. DEFINITIONS

"Drug Medi-Cal" services are substance use disorder treatment services as described under the Attachment 3.1A. These services can be categorized into Narcotic Treatment Programs (NTP) and non-Narcotic Treatment Programs (non-NTP).

"Non-NTP services" include Outpatient Drug Free Treatment, Day Care Rehabilitative (to be renamed as Intensive Outpatient Treatment effective January 1, 2014), Perinatal Residential Substance Use Disorder Services, and Naltrexone Treatment.

"NTP services" include Daily Dosing services and Counseling Individual and/or Group services.

"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 allowance" (SMA) is established for each type of non-NTP service, for a unit of service.

"Allowable cost" is reasonable and allowable cost, determined based on year-end cost reports 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 A-87 and Medicaid non-institutional reimbursement principles.

"Provider of Services" means any private or public agency that provides direct substance use disorder 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 Use Disorder Clinics.

"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 DHCS.

"Unit of Service" (UOS) means a face-to-face contact on a calendar day (for non-NPT services). Only one unit of each non-NTP 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 record. For NTP services, "Unit of Service" means each calendar day a client receives services, including take-home dosing.

B. REIMBURSEMENT METHODOLOGY

1. The reimbursement methodology for county and non-county operated providers of non-NTP services is the lowest of the following:

   a. The provider's usual and customary charge to the general public for providing the same or similar services;
   b. The provider's allowable costs of providing these services;
   c. For legal entities not directly contracted with DHCS, until June 30, 2014, the SMA, established in Section E.1.a below, is reduced by the portion related to the "County administrative" component, and effective July 1, 2014, the full SMA will apply.
      For legal entities directly contracted with DHCS, the SMA, established in Section E.1.a below, applies.

2. The reimbursement methodology for non-county operated NTP providers is the lower of:

   a. The provider's usual and customary charge to the general public for the same or similar services, or
   b. Through June 30, 2014, the uniform statewide daily reimbursement rate (USDR) established in Section E.1.b below, is reduced by the amount related to "County administrative" component. Effective July 1, 2014, except for NTP daily dosing service, the USDR will apply.

3. Reimbursement for county-operated NTP providers is at the lowest of:

   a. the provider's usual and customary charge to the general public for providing the same or similar services;
   b. the provider's allowable costs of providing these services as described in Section E below; or
   c. the USDR established in Section E.1.b below, less the amount related to "County administrative" component. Effective July 1, 2014, except for NTP-daily dosing service, USDR will apply.

C. ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGIES

1. Effective with the California State Fiscal Year (FY) 2009-10 rate development process, the rates established by the methodologies in Sections E.1.a and E.1.b, below shall be modified as follows:

   For State Fiscal Year (SFY) 2009-10, effective from July 1, 2009 through June 30, 2010, the SFY 2009-10 SMA and USDR rates, for non-NTP and NTP services, developed using the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below will be reduced by 10 percent.

2. For State 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 through the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below or,
   b. The State 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.

D. ALLOWABLE SERVICES AND UNITS OF SERVICE

Allowable services and units of service are as follows:

Service	Unit of Service
Day Care Rehabilitative Treatment (To be renamed Intensive Outpatient Treatment starting January 1, 2014)	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 Use Disorder Services	24-hour structured environment per day (excluding room and board).
Naltrexone Treatment	Face-to-face contact per calendar day for counseling and/or medication services.

Narcotic Treatment Programs (consist of two components):

a) Daily Dosing	Daily bundled service which includes the following 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 methadone/LAAM patients. 3. Dosing: Ingredients and labor cost for administering methadone /LAAM daily dose to patients.
b) Counseling Individual and/or Group	A patient must receive a minimum of fifty (50) minutes of face-to-face counseling sessions with a therapist or counselor up to a maximum of 200 minutes per calendar month, although additional services may be provided and reimbursed based on medical necessity.

E. COST DETERMINATION PROTOCOL FOR NON-NTP AND COUNTY-OPERATED NTP PROVIDERS

The following steps will be taken to determine the reasonable and allowable Medicaid costs for providing Non-NTP and NTP services.

1. Interim Payments

Interim payments for non-NTP and NTP services provided to Medi-Cal beneficiaries are reimbursed up to the SMA /USDR for the current year.

SMA METHODOLOGY FOR NON-NTP SERVICES

"SMAs" are based on the statewide median cost of each type of service as reported in the most recent interim settled cost reports submitted by providers. The SMAs are updated annually with the rate effective July 1 of each state fiscal year.

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in Section D. The daily cost is determined based on the annual cost per patient and a 365-day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators.

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under Section E.1.a above.

2. Cost Determination Protocol

The reasonable and allowable cost of providing each non-NTP service and NTP service will be determined in the state-developed cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined in accordance with the reimbursement principles in Part 413 of Title 42 of the Code of Federal Regulations, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged in providing the specific non-NTP and NTP service. Indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its net direct costs or allocated indirect costs based upon the allocation process in the legal entity's approved cost allocation plan. If the legal entity does not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87, Medicare Cost Principle (42 CFR 413 and Medicare Provider Reimbursement manual Part 1 and 2), and Medicaid non-institutional reimbursement policy.

For the non-NTP Perinatal Residential Substance Use Disorder Services, allowable costs are determined in accordance to the reimbursement principle

in title 42 CFR 413, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are directly attributable to the provision of the medical services using a CMS approved allocation methodology. Specifically, indirect costs that are not directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes and would be incurred at the same level if the medical services did not occur are not allowed (e.g. room and board, allocated cost from other related organizations).

The total allowable cost for providing the specific non-NTP or NTP services by each legal entity is further reduced by any third parties payments received for the service provided. This netted amount is apportioned to the Medi-Cal program using a basis that must be in compliance with OMB A-87 and Medicare reimbursement principles, 42 CFR 413. The amount that is apportioned to the Medi-Cal program is further reduced by any provisions specified in the legal entity's contractual agreement in providing the non-NTP or NTP service to arrive to the Medi-Cal allowable cost for providing the specific non-NTP or NTP service.

The legal entity specific non-NTP or NTP service unit rate is calculated by dividing the Medi-Cal allowable cost for providing the specific non-NTP or NTP service by the total number of UOS for the specific non-NTP or NTP service for the applicable state fiscal year.

3. Cost Report Submission

Each legal entity that receives reimbursement for non-NTP or county operated NTP services is required to file a state-developed cost report by the November 1 following the end of each state fiscal year. An extension to submit the cost report may be granted by the State for good cause.

4. Interim Settlement

No later than eighteen months after the close of the state fiscal year, DHCS will complete the interim settlement of the county operated legal entities or legal entities that direct contract with DHCS cost report. The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the state-developed cost report for the reporting period. Total reimbursable costs are specified under Section B(1) for non-NTP services and county operated NTP service, and B(2) for NTP services. If the total reimbursable costs are greater than the total interim payments, the state will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the state will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR 433.316.

5. Final Settlement Process

The state will complete the final settlement process within three years from the date of the interim settlement. The state will perform financial compliance audit to determine data reported in the provider's state-developed cost report represents the allowable cost of providing non-NTP or NTP services in accordance with the Medicare reimbursement principle (42 CFR 413), OMB A-87, and Medicaid non-institutional reimbursement principle; and the statistical data used to determine the unit of service rate reconciled with the state's record. If the total audited reimbursable cost based on the methodology as described under Section B(1) is less than the total interim payment and the interim settlement payments, the state will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. If the total reimbursable cost is greater than the total interim and interim settlement payments, the state will pay the provider the difference.

F. Termination Date

The reimbursement methodologies described herein for the Drug Medi-Cal Program will sunset on June 30, 2015.

State/Territory: California

~~Citation~~ ~~Condition or Requirement~~

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 monthly 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 Services (DHS). In no case shall payments exceed SMA.~~ **Effective July 1, 2012, the administration of the Drug Medi-Cal Program (DMC) is transferred from the State Department of Alcohol and Drug Programs (ADP) to the Department of Health Care Services (DHCS), authorized by Assembly Bill 106 (Chapter 32, Statutes of 2011).**

A. DEFINITIONS

"Drug Medi-Cal" services are substance use disorder treatment services as described under the Attachment 3.1A. These services can be categorized into Narcotic Treatment Programs (NTP) and non-Narcotic Treatment Programs (non-NTP).

"Non-NTP services" include Outpatient Drug Free Treatment, Day Care Rehabilitative (to be renamed as Intensive Outpatient Treatment effective January 1, 2014), Perinatal Residential Substance Use Disorder Services, and Naltrexone Treatment.

"NTP services" include Daily Dosing services and Counseling Individual and/or Group services.

"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~~, **is** established for each type of **non-NTP** service, for a unit of service.

"~~Actual~~ Allowable cost" is reasonable and allowable cost, **determined** based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413**, the Medicare Provider Reimbursement**

Manual (Centers for Medicare & Medicaid Services ~~and in HCFA~~ Publication 15-1.)**, OMB A-87 and Medicaid non-institutional reimbursement principles.**

"Provider of Services" means any private or public agency that provides direct substance ~~abuse treatment~~ use disorder 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~~ **Use Disorder** 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~~ **non-NTP** 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 record. For ~~Narcotic Treatment Program~~ **NTP** 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~~ **DHCS**.

B. REIMBURSEMENT METHODOLOGY

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

   a. The provider's ~~published~~ **usual** ~~or~~ **and** customary charge to the general public for providing the same or similar services;

   b. The provider's allowable costs of ~~rendering~~ **providing** these services; ~~or~~

   c. **For legal entities not directly contracted with DHCS, until June 30, 2014,** the SMA established in Section ~~C~~ **E.1a** below, ~~as defined by ADP and approved by DHS. The above reimbursement limits are~~

~~Citation~~ ~~Condition or Requirement~~

~~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.~~ **is reduced by the portion related to the "County administrative" component, and effective July 1, 2014, the full SMA will apply. For legal entities directly contracted with DHCS, the SMA, established in Section E.1.a below, applies.**

2. The reimbursement methodology for ~~providers of DMC Narcotic Treatment Program services~~ **non-county operated NTP providers** is ~~based on~~ the lower of:

   a. The provider's ~~published~~ **usual** ~~or~~ **and** customary charge to the general public for the same or similar services, or

   b. **Through June 30, 2014,** the uniform statewide ~~monthly~~ **daily** reimbursement rate established in Section ~~D~~ E.1.b below, ~~as defined by ADP and approved by DHS~~ is reduced by the amount related to "County administrative" component. Effective July 1, 2014, except for NTP daily dosing service, the USDR will apply.

3. **Reimbursement for county-operated NTP providers is at the lowest of:**

   a. the provider's usual and customary charge to the general public for providing the same or similar services;
   b. the provider's allowable costs of providing these services as described in Section E below; or
   c. the USDR established in Section E.1.b below, less the amount related to "County administrative" component. Effective July 1, 2014, except for NTP-daily dosing service, USDR will apply.

C. ~~SMA METHODOLOGY FOR DMC OUTPATIENT DRUG FREE TREATMENT, DAY CARE REHABILITATIVE TREATMENT, NALTREXONE TREATMENT, PERINATAL RESIDENTIAL, SUBSTANCE ABUSE SERVICES~~ ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGIES

1. **Effective with the California State Fiscal Year (FY) 2009-10 rate development process, the rates established by the methodologies in Sections E.1.a and E.1.b, below shall be modified as follows:**

~~Citation~~ ~~Condition or Requirement~~

For State Fiscal Year (SFY) 2009-10, effective from July 1, 2009 through June 30, 2010, the SFY 2009-10 SMA and USDR rates, for non-NTP and NTP services, developed using the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below will be reduced by 10 percent.

2. **For State 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 through the normal rate-setting methodologies as set forth in Sections E.1.a and E.1.b, below or,**
   b. **The State 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.**

~~"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.~~

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

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

D. ALLOWABLE SERVICES **AND UNITS OF SERVICE**

Allowable services and units of service are as follows:

Service	Unit of Service
Day Care Rehabilitative Treatment **(To be renamed Intensive Outpatient Treatment starting January 1, 2014)**	Minimum of three hours per day, three days per week.
Outpatient Drug Free Treatment	Individual (50-minute minimum session) or group

~~Citation~~	~~Condition or Requirement~~
	(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~~ consist of ~~four (4)~~ **two** Components)**:**	
a) Daily Dosing	**Daily bundled service which includes the following 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.~~**b)** Counseling **Individual and/or Group**	**A patient must receive a** minimum of fifty (50 minutes **of face-to-face counseling sessions with a therapist or counselor** ~~to be provided and billed in ten (10) minute in increments,~~

~~Citation~~ ~~Condition or Requirement~~

up to a maximum of 200 minutes **per calendar month, although additional services may be provided and reimbursed** based on ~~the~~ medical ~~needs of the patient.~~ necessity.

E. COST DETERMINATION PROTOCOL FOR NON-NTP AND COUNTY-OPERATED NTP PROVIDERS

The following steps will be taken to determine the reasonable and allowable Medicaid costs for providing Non-NTP and NTP services.

1. Interim Payments

Interim payments for non-NTP and NTP services provided to Medi-Cal beneficiaries are reimbursed up to the SMA /USDR for the current year.

SMA METHODOLOGY FOR NON-NTP SERVICES

"SMAs" are based on the statewide median cost of each type of service as reported in the most recent interim settled cost reports submitted by providers. The SMAs are updated annually with the rate effective July 1 of each state fiscal year.

b. UNIFORM STATEWIDE DAILY REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in Section D. The daily cost is determined based on the annual cost per patient and a 365-day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators.

The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under Section E.1.a above.

2. Cost Determination Protocol

The reasonable and allowable cost of providing each non-NTP service and NTP service will be determined in the state-developed cost report pursuant to the following methodology. Total allowable costs include direct and indirect costs that are determined in accordance with the reimbursement principles in Part 413 of Title 42 of the Code of Federal Regulations, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged in providing the specific non-NTP and NTP service. Indirect costs may be determined by either applying the cognizant agency specific approved indirect cost rate to its net direct costs or allocated indirect costs based upon the allocation process in the legal entity's approved cost allocation plan. If the legal entity does not have a cognizant agency approved indirect cost rate or approved cost allocation plan, the costs and related basis used to determine the allocated indirect costs must be in compliance with OMB Circular A-87, Medicare Cost Principle (42 CFR 413 and Medicare Provider Reimbursement manual Part 1 and 2), and Medicaid non-institutional reimbursement policy.

For the non-NTP Perinatal Residential Substance Use Disorder Services, allowable costs are determined in accordance to the reimbursement principle in title 42 CFR 413, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy. Allowable direct costs are costs related to direct practitioners, medical equipment, and medical supplies for providing the service. Indirect costs are determined by applying the cognizant agency approved indirect cost rate to the total direct costs or derived from the provider's approved cost allocation plan. When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are directly attributable to the provision of the medical services using a CMS approved allocation methodology. Specifically, indirect costs that are not directly attributable to the provision of medical services but would generally be incurred at the same level if the medical service did not occur will not be allowable. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes and would be incurred at

the same level if the medical services did not occur are not allowed (e.g. room and board, allocated cost from other related organizations).

The total allowable cost for providing the specific non-NTP or NTP services by each legal entity is further reduced by any third parties payments received for the service provided. This netted amount is apportioned to the Medi-Cal program using a basis that must be in compliance with OMB A-87 and Medicare reimbursement principles, 42 CFR 413. The amount that is apportioned to the Medi-Cal program is further reduced by any provisions specified in the legal entity's contractual agreement in providing the non-NTP or NTP service to arrive to the Medi-Cal allowable cost for providing the specific non-NTP or NTP service.

The legal entity specific non-NTP or NTP service unit rate is calculated by dividing the Medi-Cal allowable cost for providing the specific non-NTP or NTP service by the total number of UOS for the specific non-NTP or NTP service for the applicable state fiscal year.

3. Cost Report Submission

Each legal entity that receives reimbursement for non-NTP or county operated NTP services is required to file a state-developed cost report by the November 1 following the end of each state fiscal year. An extension to submit the cost report may be granted by the State for good cause.

4. Interim Settlement

No later than eighteen months after the close of the state fiscal year, DHCS will complete the interim settlement of the county operated legal entities or legal entities that direct contract with DHCS cost report. The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the state-developed cost report for the reporting period. Total reimbursable costs are specified under Section B(1) for non-NTP services and county operated NTP service, and B(2) for NTP services. If the total reimbursable costs are greater than the total interim payments, the state will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the state will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR 433.316.

~~Citation~~ ~~Condition or Requirement~~

5. Final Settlement Process

The state will complete the final settlement process within three years from the date of the interim settlement. The state will perform financial compliance audit to determine data reported in the provider's state-developed cost report represents the allowable cost of providing non-NTP or NTP services in accordance with the Medicare reimbursement principle (42 CFR 413), OMB A-87, and Medicaid non-institutional reimbursement principle; and the statistical data used to determine the unit of service rate reconciled with the state's record. If the total audited reimbursable cost based on the methodology as described under Section B(1) is less than the total interim payment and the interim settlement payments, the state will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. If the total reimbursable cost is greater than the total interim and interim settlement payments, the state will pay the provider the difference.

F. Termination Date

The reimbursement methodologies described herein for the Drug Medi-Cal Program will sunset on June 30, 2015.

State/Territory: California

State/Territory: California

State/Territory: California

State/Territory: California

State/Territory: California

SPA 09-022
Drug Medi-Cal Reimbursement Rate-Setting Methodology Changes Starting July 1, 2009
Response to CMS Questions of December 23, 2009
Revised September 17, 2012; April 23, 2013; October 22, 2013; June 2014

A. General Questions

1. **HCFA-179, Federal Statute/Regulation Citation, Box 6- Please request a pen and ink change to include 42 CFR 447 Subpart F.**

   Response: As requested, the State added 42 CFR 447 Subpart F (Payment Methods for Other Institutional and Non-Institutional Services) commencing with section 447.300.

2. **HCFA-179, Federal Budget Impact, Box 7- Please explain how the Federal budget impact was determined.**

   Response: The Federal Budget impact was the result of comparing the Department of Alcohol and Drug Programs' (ADP's) $128,410,000 federal share of cost of administering Drug Medi-Cal (DMC) services in State Fiscal Year (SFY) 2009-10 (before the 10 percent DMC rate reduction) with ADP's $115,537,000 federal share of cost of administering DMC services in SFY 2009-10 (after the 10 percent DMC rate reduction). The lower total cost due to the 10 percent rate reduction produced a full-year, federal cost savings of $12,873,000.

   ADP took the full-year, federal cost savings of $12,873,000 and extrapolated it to cover the 15 months from the July 1, 2009 start of the rate reduction in federal fiscal year (FFY) 2009 to the September 30, 2010, end of FFY 2010. The $12,873,000 full-year federal cost savings was extrapolated to cover the full FFY 2010 (from October 1, 2009 to September 30, 2010). Three-twelfths of that full-year savings (i.e., $3,218,250 or three-twelfths of $12,873,000) was extrapolated to cover the three months in FFY 2009 from the July 1, 2009 start of the rate reduction to the September 30, 2009 end of FFY 2009. Therefore, the total federal cost savings over the 15 months was $16,091,250, comprised of the $12,873,000 full year federal cost savings plus another $3,218,250; i.e., three-twelfths of that full-year cost savings.

3. **HCFA 179, Page Number of the Plan Section or Attachment, Box 8- Please submit the corresponding coverage pages for the Drug Medi-Cal program. The CMS review team will review pages 20 and 20a to the Limitations Section for Attachment 3.1A and B; pages 3 and 4 to Supplement 3 to Attachment 3.1A; and, pgs. 1 and 2 to Supplement 3 and 3.1B. Additionally, please request a pen and ink change to reflect these additional pages under review.**

   Response: The State has made the requested changes addressed in this comment in State Plan Amendment 12-005, which was approved in December 2012. Specifically, in Limitations on Attachment 3.1-A and B pages 20, 20a, and 20a.1 under 13.d.5 Substance Abuse Treatment Services, the State listed the services and referenced the appropriate Supplement sections for additional coverage information and detail. The reference is consistent with 13.d.4. Rehabilitative mental health services.

The State also revised Supplement 3 to Attachment 3.1-A pages 3 and 4, and Supplement 3 to Attachment 3.1-B pages 1 and 2. The State added language under Substance Abuse Treatment Services to describe Day Care Rehabilitative Treatment, Naltrexone Treatment, Narcotic Treatment Program, and Outpatient Drug Free Treatment.

For descriptions on Perinatal Residential Substance Abuse Services and Substance Abuse Treatment Services Provided to Pregnant Women and Postpartum Women, the State added reference to Supplement 2 to Attachment 3.1-A and Supplement 1 to Attachment 3.1-B, Extended Services For Pregnant Women. The descriptions in these sections are current; therefore, the State did not make any changes in Supplement 2 to Attachment 3.1-A and Supplement 1 to Attachment 3.1-B, Extended Services For Pregnant Women.

4. **Please include the effective date on all State plan pages under review.**

   Response: The effective date of July 1, 2009, is now included on all State Plan pages under review. The effective date for changes related to realignment of funding and the certified public expenditure process is July 1, 2011. The effective date of the administrative transfer of the Drug Medi-Cal program from the Department of Alcohol and Drug Programs to the Department of Health Care Services is July 1, 2012.

B. Coverage-Attachment 3.1A and B Questions:

1. **California SPA 09-022 overlaps with CA SPA 09-004 (Specialty Mental Health Services) currently in RAI status. To continue our review of CA SPA 09-022, a formal decision on the approval of SPA 09-004 will need to be taken by CMS prior to any final decision on this SPA. CMS's same page review policy requires that CMS analyze all information provided on a submitted State plan page. Because the coverage description of Substance Abuse Treatment Services currently resides on the same page (page 20, Limitations to Attachment 3.1A and B) as Rehabilitative Mental Health Services, CMS must include both service components in its review.**

   Response: The State addressed the overlapping page 20 in Limitations to Attachment 3.1-A and B in SPA 10-016 which CMS approved on March 31, 2011.

2. **In the Limitations Section to Attachment 3.1A and B, Supplement 3 to Attachment 3.1A, and Supplement 2 to Attachment 3.1B, please describe the various treatment services provided and the types of activities that constitute Day Care Rehabilitative Treatment, Naltrexone Treatment, Narcotic Treatment Program, Outpatient Drug Free Treatment, Perinatal Residential Substance Abuse Services, and Substance Abuse Treatment services Provided to Pregnant Women and Post partum Women.**

   Response: In Limitations on Attachment 3.1-A and B pages 20, 20a, and 20a.1 under 13.d.5 Substance Abuse Treatment Services, the State listed the services and referenced the appropriate Supplement sections for additional coverage information and detail. The reference is consistent with 13.d.4. Rehabilitative mental health services.

The State also revised Supplement 3 to Attachment 3.1-A pages 3 and 4, and Supplement 3 to Attachment 3.1-B pages 1 and 2. The State added language under Substance Abuse Treatment Services to describe Day Care Rehabilitative Treatment, Naltrexone Treatment, Narcotic Treatment Program, and Outpatient Drug Free Treatment.

For descriptions on Perinatal Residential Substance Abuse Services and Substance Abuse Treatment Services Provided to Pregnant Women and Postpartum Women, the State added reference to Supplement 2 to Attachment 3.1-A and Supplement 1 to Attachment 3.1-B, Extended Services For Pregnant Women. The descriptions in these sections are current; therefore, the State did not make any changes in Supplement 2 to Attachment 3.1-A and Supplement 1 to Attachment 3.1-B, Extended Services For Pregnant Women.

The State has addressed this comment in State Plan Amendment 12-005, which was approved in December 2012.

3. **Supplement 3 to Attachment 3.1-A "Provider Qualifications"- Please describe in detail the provider qualifications of a qualified substance abuse treatment professional. Please remove current State plan language which states that the individual is "qualified under the Medi-Cal program that has specialized training as required by State law and Medi-Cal regulations."**

   Response: The State added new pages and language in Supplement 3 to Attachment 3.1-A pages 5 and 6, and Supplement 3 to Attachment 3.1-B pages 3 and 4 to describe provider qualifications for substance abuse treatment professionals. The State also removed current State Plan language which states, "qualified under the Medi-Cal program that has specialized training as required by State law and Medi-Cal regulations."

   The State has addressed this comment in State Plan Amendment 12-005, which was approved in December 2012.

4. **Supplement 3 to Attachment 3.1A, "Provider Qualifications": Please describe in detail the provider qualifications for the individual(s) working under the supervision of a qualified substance abuse treatment professional.**

   Response: There are no individuals who work under the supervision of California's qualified substance abuse treatment professionals. Therefore, the State revised language in Supplement 3 to Attachment 3.1-A page 3, and Supplement 3 to Attachment 3.1-B page 1 to remove reference to services provided under the supervision of a qualified substance abuse treatment professional.

   The State has addressed this comment in State Plan Amendment 12-005, which was approved in December 2012.

5. **Supplement 3 to Attachment 3.1-A, Please elaborate on the qualifications of the individual(s) supervising the qualified substance abuse treatment professional.**

Response: The State has addressed this comment in State Plan Amendment 12-005, which was approved in December 2012.

6. **Limitations on Attachment 3.1-A and B, 13d.3, Outpatient Heroin Detoxification Services- Please explain whether providers of outpatient heroin detoxification are subject to the 10 percent payment reduction.**

   Response: Outpatient heroin detoxification was not subject to the 10-percent DMC rate reduction, and is not affected by the change in the rate-setting methodology. While it is a service reimbursed under the Department of Health Care Services (DHCS), Fee-for-Service Medi-Cal Program, it is not a DMC covered service.

C. Reimbursement – Attachment 4.19B:

1. **Page 38, first paragraph-The State indicates that the reimbursement for Drug Medi-Cal services is limited to the lowest of county or contract provider's published or customary charge. However, on page 39, only providers are referenced and the reimbursement methodology does not appear to be limited to county or contract providers only. Please clarify.**

   Response: The State has deleted the language on page 38 and placed revised text describing the Reimbursement Methodology on page 39 as follows: "lowest of the provider's usual and customary charge." The State made the same revision for page 39, sections B.1 and for B.3. This is in accordance with the California Code of Regulations (CCR) Title 22, Section 51516.1(a) (1). The lowest of cost principle applies to any non-NTP Drug Medi-Cal (DMC) provider, whether county operated, subcontractor, or direct contractor. "Provider of Services" is also defined on page 38 to mean any private or public agency.

   To help providers understand the various changes in the State Plan due to the transition of the administrating agency, the State has added the following text as the second paragraph on Attachment 4.19-B, page 38: "Effective July 1, 2012, the administration of the Drug Medi-Cal Program transferred from the Department of Alcohol and Drug Programs to the DHCS, as authorized by Assembly Bill 106 (Chapter 32, Statutes of 2011)."

2. **Page 38, 1st paragraph- Does the reference to the State Maximum Allowance (SMA) in this paragraph refer to the same State Maximum Allowances that are in Section C? If so, please clarify.**

   Response: The language on Page 38, first paragraph has been deleted and placed on page 39 with revisions. The reference to the Statewide Maximum Allowances (SMA) in this paragraph refers to the same SMA in Section C, Page 40, of the same document. Section E.1.a briefly describes the methodology for determining the SMA for the non-Narcotic Treatment Programs. The Narcotic Treatment Program also uses a statewide maximum

allowance, but it is called the "uniform statewide daily reimbursement (USDR)." Section E.1.b of the same document describes the methodology for determining the USDR.

3. **Page 38, "Provider of Service" and page 39 "Legal entity"- Please explain the relationship of these two definitions, if any. Are legal entities providers of services? Are all providers of serves legal entities? Do all providers have to be contracted with either a county or the State Department of Alcohol and Drug Programs (ADP)? Please specify the arrangement/relationship between each type of provider and the county, the ADP, and the State Medicaid Agency.**

The States response is in two parts.

a. ***Explain the relationship of these two definitions. Are legal entities providers of services? Are all providers of services legal entities?***

Response: Yes, all Legal Entities are Providers of Services. "Provider of Services" is an entity certified to provide DMC substance use disorder services to eligible beneficiaries at its certified location(s) pursuant to CCR, Title 22, Section 51200. A "Legal Entity" is a "Provider of Service" that has a contract with either the County or the State to provide DMC services. Providers of Services are Legal Entities only if they provide DMC services under a contract with the State or county. Without a contract, a "Provider of Service" is not a "Legal Entity".

b. ***Do all providers have to be contracted with either county or ADP?***

Response: Yes, to receive reimbursement for services provided, a provider must have a contract with either the county or with the State agency (ADP or DHCS). Without a contract, a provider cannot receive reimbursement for services.

Effective July 1, 2012 the administration of the DMC Program transferred from ADP to the DHCS; therefore, DHCS is now the State's contracting authority.

c. ***Please specify the arrangement/relationship between each type of provider and the county, ADP and the State Medicaid Agency.***

Response: DHCS has the authority to contract with counties to provide DMC services or to direct contract with DMC-certified providers. All DMC services must be provided at sites that the State has certified as DMC clinics. Counties may provide DMC services through either a county-operated program that is DMC certified or through a contract with a DMC-certified provider. DHCS contracts for DMC services are for a three-year period, and it may process amendments during the three-year period to increase funds, decrease funds, and/or modify requirements.

As stated on revised Attachment 4.19B, page 39, B.1, providers billing for reimbursement of non-NTP services (DMC Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential and Naltrexone Services) receive payment which is

the lowest of the provider's: 1) usual and customary charge, 2) allowable costs of providing the services, or 3) the Statewide Maximum Allowance.

As stated on revised Attachment 4.19B, page 39, B.2, non-county operated providers billing for reimbursement of DMC Narcotic Treatment Program (NTP) services receive payment which is the lower of the provider's: 1) usual and customary charge, or 2) the Statewide Maximum Allowance.

As stated on revised Attachment 4.19B, page 39, B.3, county-operated providers billing for reimbursement of DMC Narcotic Treatment Program (NTP) services receive payment which is the lowest of the provider's: 1) usual and customary charge, 2) the Statewide Maximum Allowance, or 3) the allowable cost of providing the services.

4. **Page 38, "Unit of Service"-Please explain whether a face-to-face contact can be with anyone within the certified agency/legal entity or with a specific healthcare professional.**

   Response: The face-to-face contact must be with a therapist or counselor, certified by the State to provide such services, as required by CCR, Title 22, section 51341.1, (b) (10) and (b)(11). The minimum requirements for certification of alcohol and other drug counselors are contained in CCR, Title 9, Section 13040.

5. **Page 39, The reimbursement methodology is the lower of customary charges, allowable costs or SMA. Are "allowable costs" the same as "actual cost" as defined on page 38, Section A? Please define "allowable costs".**

   Response: To minimize confusion, the State changed "Actual cost" to "Allowable cost" on page 38, Section A, third paragraph. Allowable cost is defined in the SPA, Attachment 4.19B, Section A, page 38, to mean the reasonable and allowable cost based on year-end cost reports and based on federal principles of cost reimbursement as described at 42 CFR Part 413 and in The Provider Reimbursement Manual, Part 1 (CMS-Publication #15-1).

6. **Page 39, Section B.1.c.- Please include the effective date of the SMA and the published location.**

   Response: The State has revised Attachment 4.19B, page 40, item (E)(1) to show the effective date of the annual rates, which is July 1st of each year. Section E.1 describes the SMA and USDR methodologies. The State has also revised Attachment 4.19B, page 40, Section E, to clarify that the median rate is from the most recently completed year-end cost reports instead of from the cost report two years preceding the year for which the State determines the SMA. This is consistent with the requirements of the California Welfare and Institutions Code, Section 14021.6(b) (1).

   As of July 2012 annual rates for DMC services are posted to the DHCS website at http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-InfoNotices.aspx.

7. **Page 39, B.1, second paragraph:**
   a. ***It appears the legal entity is the only provider category that requires submitting cost report. Explain if there are other provider categories that are not legal entities and if they are not required to submit a cost report, how does the lower of charges, allowable cost and SMA methodology apply?***

The States response for "a":

All DMC providers that have a contract with the state or county as a subcontractor for DMC services are legal entities. There is no other provider category.

   b. ***The cost report used by providers to determine actual allowable costs must be approved by CMS. Additionally, the State needs to detail how actual allowable costs are determined. This description must include, but is not limited to, the source of the data; the direct and indirect cost elements/factors/components; the cost principles and steps used to determine allowable medical costs; the methodologies (e.g. time study) used to apportion cost to the Medicaid program; and, the timeline for submitting the cost report.***

The States response for "b":

The DHCS will separately submit a cost report package to CMS which will include cost report forms, instructions and a complete description of direct and indirect cost elements, factors and components for the cost-reporting process, etc. Much of the information related to cost reports is already included below. DHCS will work with CMS to determine how and when to provide the complete package, as described above.

All non-NTP DMC providers to which DHCS has paid DMC claims must submit cost reports to DHCS, either via the county with which they contract or directly to DHCS if they are a direct contractor. The cost report that non-NTP providers submit is detailed and contains direct and indirect cost data on personnel services, equipment, materials, supplies, travel, transportation, and administrative overhead.

NTP providers submit a report that contains the units of service provided and the reimbursement rate claimed to DHCS. DHCS instructs the NTP providers that their DMC claims must be at the lower of the USDR or the provider's usual and customary charge. This approach is consistent with the USDR rate-setting methodology for the NTP Dosing services detailed in the Attachment 4.19-B, page 39. Unlike non-NTP providers that the State reimburses at a median rate calculated from cost report data, reimbursement of DMC NTP Dosing services uses a fixed formula that was first created for SFY 1997-98 with extensive provider input. The NTP Dosing USDR rate-setting methodology is based on the last year that NTP cost report data was available, SFY 1994-95. The State develops rates for NTP counseling services separately from the rates for NTP Dosing services using the most recently completed cost report data.

Description of Rate Setting Methodology for non-NTP services
For each non-NTP modality, the rate setting methodology is as follows:

1. Cost report data is extracted for each treatment provider which includes the provider's total cost of providing the service, total units of service (UOS), and cost per UOS.
2. Providers' costs per UOS are sorted from lowest to highest.
3. The total cumulative UOS for all providers is calculated.
4. The total UOS is divided by 2 to determine the median (middle value) of the cumulative UOS.
5. The cost per UOS that relates to the median of the cumulative UOS value becomes the proposed SMA.

In the data example below, the total cumulative UOS of 80 is divided by 2 to equal the median cumulative UOS (40). Since 40 UOS is not present in the cumulative UOS data set, the established procedure is that the UOS is rounded upward to the next cumulative UOS (60). The proposed SMA of $4.00 is selected because this cost is related to the cumulative UOS (60).

A	B	C	D	E
Provider UOS	Total Cost	Units of Service (UOS)	Cost per UOS	Cumulative UOS
Provider 1	$60	30	$2	30
Provider 2	$120	30	$4	60
Provider 3	$180	20	$9	80

The SMA for the Naltrexone service is the same as it was when developed for use in SFY 1999-2000, with the ten-percent rate reduction applied for SFY 2009-10. The rate developed for SFY 1999-2000 was based on providers' cost report data for SFY 1997-98. Since SFY 1997-98, service providers have not submitted any claims for reimbursement, and have not reported any cost data for this service. It remains in the State Plan if providers decide to resume its use.

There is no limit for Day Care Rehabilitative (to be renamed as Intensive Outpatient Treatment) and Outpatient Drug Free counseling services.

Description of Rate Setting Methodology for NTP Counseling Services
The reimbursement rates for NTP Individual and Group Counseling are determined from service provider cost data for the Outpatient Drug Free Individual and Group Counseling services.

The NTP counseling rates are based on the Outpatient Drug Free counseling rates which are converted to ten-minute increment rates for billing purposes. For example, assume a reimbursement rate for non-perinatal, ODF Individual Counseling of $80. The normal length of an individual counseling session is 50 minutes. There are five 10-minute increments in a 50-minute session. The $80 rate is divided by 5 to determine a $16 NTP individual counseling, ten-minute incremental billing rate. NTP counseling services (both group and individual) are billed separately up to a maximum limit of 200 minutes per month. Beginning

January 1, 2014, additional counseling services may be provided and reimbursed based on medical necessity (as stated in Attachment 4.19-B, item D.

Additional informal questions from CMS have been satisfactorily answered.

8. **Page 40, Section D- CMS suggests amending the title of this section to read, "UNIFORM STATEWIDE REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS".**

   The States response: The State has made the change per final request from CMS (now in Section E.1.b).

9. **Page 40, Section E- CMS suggests amending the title of this section to read, "ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE REIMBURSEMENT RATE METHODOLOGIES"**

   Response: As requested, the State revised title to "ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE REIMBURSEMENT RATE METHODOLOGIES" (now in Section C).

10. **Page 40.E.1, 1st paragraph - Please remove the reference to California's Welfare and Institutions Code. We suggest that this sentence be revised to state "Effective with the California State Fiscal Year (SFY) 2009-10 rate development process, the rates established by the methodologies in Sections C and D above all shall be modified as follows".**

    Response: The State has made the change as requested by CMS, reflecting the citation of the final placement of the text (page 40, item C.1).

11. **Page 40, section E.1.- Please specify the effective date of the reimbursement rate (i.e. the SMA and the uniform statewide reimbursement rate) that is being reduced by ten percent. Also, please include the published location of these rates(s). We suggest the following language:**

    > **"The SMA/uniform statewide reimbursement rates were set as of (month/day/year) and are effective for services on or after that date. All rates are published on the agency's website at www.xxxx.xxx."**

    Response:

    The State has revised Attachment 4.19B, page 42, item E.1 to show the effective date of the annual rates, which is July 1st of each year, and to describe the SMA and USDR methodology

12. **Page 40. Section E.2.a- Please include the effective date of the SMA and uniform statewide reimbursement rate and where it is published. Please see suggested language in the above question.**

Response: The State has revised Attachment 4.19B, page 42, item E.1 to show the effective date of the annual rates, which is July 1st of each year, and to describe the SMA and USDR methodology

13. **If the State makes periodic updates to the fee schedule, it will need to submit a SPA to reflect the current effective date. Please indicate the frequency the State anticipates making updates to the fee schedule.**

Response: The rates covered by this SPA are not contained in the DHCS Medi-Cal fee schedule. The methodologies to update the SMA for the non-Narcotic Treatment Program and the USDR for the Narcotic Treatment Program are applied annually. The State then updates the rates effective on each July 1, the first date of the State Fiscal Year. In May of each year, the rates for the approaching fiscal year starting July 1 are posted in a rates bulletin on the website at: http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-InfoNotices.aspx

14. **Page 40.E.2.b- Please include the effective date and the published site of the SFY 2009-2010 rates. How often will the SFY 2009-2010 rates be adjusted by the Price deflator?**

Response: The SPA has been revised to show effective date and published location of the rates following section E.2. In applying the rate-setting methodology to determine rates for SFY 2010-11 and subsequent fiscal years, the cumulative growth in the Implicit Price Deflator is applied annually to the SFY 2009-10 rates to determine adjusted rates for each treatment modality. In accordance with the Welfare and Institutions Code, Section 14021.9, the adjusted rate for each treatment service is then compared to the rate developed using the normal rate-setting methodology, and the lower of the two rates becomes the proposed rate. Once the proposed rates are approved in the Budget Act, the rates are then promulgated into State regulations.

15. **Page 41.F, Elaborate on the following units of services descriptions:**

    a. **Day Care Rehabilitation Treatment-daily rate?**
    b. **Outpatient Drug Free Treatment-by minute?**
    c. **Perinatal Residential Substance Abuse Treatment-daily rate?**
    d. **Naltrexone Treatment-encounter/visit or daily rate?**
    e. **Narcotic Treatment Programs–daily rate which covers all four components?**

Response:

These services are addressed and more detail is provided on these services in the State's response to CMS' Informal Comments dated June 18, 2012 for SPA #12-005.

a. Day Care Rehabilitation—The daily reimbursement rate covers one unit of service which is one face-to-face contact of at least three hours in duration on a calendar day. The client must receive at least three of these sessions per week. (Reference is CCR, Title 22, Section 51341.1 (b)(8) and (b)(30).
b. Outpatient Drug Free Treatment—Thedaily reimbursement rate covers one unit of service which is one face-to-face contact on a calendar day. (Reference is CCR, Title 22, Section 51341.1 (b)(18) and (b)(30). A client must receive at least two group counseling sessions per month. (Reference is CCR Title 22, Section 51341.1(d)(2)(A).The typical face-to-face counseling session is 50 minutes in duration for individual counseling and 90 minutes in duration for group counseling. CCR Title 22, Section 51516.1(a)(3)(A)(1) and (2) allows the SMA for counseling sessions to be prorated annually using the percentage computed by dividing the total actual time for all counseling sessions by the total time which would have been spent if all counseling sessions were 50 minutes in duration (for individual counseling) or 90 minutes in duration (for group counseling). The percentage is then applied to the SMA to determine the maximum reimbursement rate.
c. Perinatal Residential Substance Abuse Treatment—The daily reimbursement rate covers one unit of service which is one face-to-face contact on a calendar day. Supervision and treatment services must be available day and night, seven days a week. (Reference is CCR, Title 22, Section 51341.1 (b)(20) and (b) (30).
d. Naltrexone Treatment—The daily reimbursement rate covers one unit of service which is one face-to-face counseling contact on a calendar day. This is an outpatient service that uses Naltrexone to block the euphoric effects of opiates. Patients must be detoxified and the service is only available to treat opiate addiction. (Reference is CCR, Title 22, Section 51341.1 (b)(16) and (b)(30).
e. Narcotic Treatment Programs
   - Dosing-One unit of service covers the daily methadone dosing.
   - Counseling—One unit of service is one ten-minute increment of counseling. Clients must be provided a minimum of 50 minutes of counseling per month. There is a maximum of 200 minutes of counseling per month, although additional services may be provided and reimbursed based on medical necessity. Counseling can be individual and/or group. (Reference is CCR, Title 22, Section 51516.1(h)

Additional informal questions from CMS have been satisfactorily answered.

16. Page 41, Section F- It is CMS's understanding that a pharmaceutical drug is reimbursed based on a two-part formula that consists of the cost of the ingredient and the dispensing fee. Please explain what is meant by a "dosing fee".

Response: In this State Plan Amendment, we are using the term "dosing" synonymously to mean "dispensing". For the context of the Item 3 dosing, "dosing fee" means the methadone ingredient cost, the cost in time in administering the dose, and the related administrative overhead as described below.

The Narcotic Treatment Program is comprised of three services: Methadone Dosing, Individual Counseling and Group Counseling.

The State's methodology for establishing the USDR for NTP Dosing services contains three component parts (Core, Lab Work and Dosing). The component costs are annualized to determine the total annual costs. The total costs are then divided by 365 days to determine the USDR.

- The Core Component covers the cost of the physical exam, initial drug test, intake assessment of the patient's treatment needs; and the labor cost of the physician's supervision of the patient's NTP services; and administrative overhead to cover county administration, indirect personnel cost (i.e., Program Administration) and indirect non-personnel cost (i.e., Program Administration).
- The Lab Work Component covers the cost of up to 11 additional drug tests that occur during the year for regular patients and up to 38 additional drug tests for perinatal patients; the cost of the tuberculosis and syphilis tests; and administrative overhead to cover county administration and indirect personnel cost (i.e., Program Administration).
- The Dosing Component contains the methadone ingredient cost, the two-minute labor cost of one Registered Nurse and 1.5 Licensed Vocational Nurses to administer the daily dose; and administrative overhead to cover county administration, indirect personnel cost (i.e., Program Administration) and indirect non-personnel cost (i.e., Program Administration).

17. Page 41, Section F- Please identify what provider(s) dispenses methadone.

Response: The only DMC providers authorized to dispense methadone in California are licensed narcotic treatment programs (NTPs). To be licensed to dispense methadone, an NTP must: 1) obtain accreditation from the Commission on Accreditation of Rehabilitation or the Joint Commission on Accreditation of Health Care Organizations, 2) obtain approvals from the federal Center for Substance Abuse Treatment and the federal Drug Enforcement Agency, and 3) obtain a State license from ADP/DHCS.

18. To assure compliance with access to care per 42 CFR 447.204 for payment rates as a result of a rate reduction, please address the following questions (a-g):

a. Explain how the reduction in rates allows the State to comply with requirements of Social Security Act (SSA) Title 19, Section 1902(a)(30).

Response: Section 1902(a)(30) conveys two requirements:1) safeguarding against unnecessary utilization of care and services, and 2) assuring 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 to the general population in the geographic area.

Safeguarding: The State audits both counties and DMC treatment providers, except for NTP service providers, that contract with the county. The audits include an assessment of whether the State has reimbursed any claims in excess of the county's or treatment provider's cost of providing the service in accordance with Section 11817.8(b) in the California Health and Safety Code. The State audits a sufficient number of counties,

direct contractors, and subcontractors to provide reasonable assurance that federal and State funds have been used for their intended purpose in accordance with applicable funding requirements and restrictions contained in statutes, regulations, and contracts. If payments exceed the cost of services as determined by a financial audit, the State recovers the overpayment in accordance with CCR, Title 22, Section 51047.

Assure Care and Services are Available: The State compiled and tracked data for both service providers and beneficiaries receiving services throughout the State. Quarterly, ADP examined data on the number of certified DMC clinics; the number of service providers providing DMC and non-DMC treatment modalities; the unduplicated count of clients served; the number of client admissions in treatment modalities; and mean days that a client waited to enter treatment. ADP compared the data against the previous quarter's data looking for indicators of change in access to care. ADP also examined California economic indicators such as employment rates that could lead to service provider expansion and closure. The answer to the next question presents some of the data analyzed and its minimal impact on care and services available.

b. 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?

Response: The number of certified DMC providers increased from September 30, 2006, through September 30, 2008, and in SFY 2009-10 (see Table 1). In SFY 2008-09, the number of certified DMC providers decreased by 380. This decrease was primarily due to the loss of $86,263,000 million in county local assistance funding for the State Substance Abuse and Crime Prevention Act (SACPA) in July 2009. The SACPA funding was used in part to sustain clinics that provided both SACPA and DMC program services and therefore, the loss of SACPA funding contributed toward the loss of certified DMC providers. However, in SFY 2009-10, certified DMC providers increased by 6.4 percent demonstrating expanded access to DMC services.

Table #1, Number of Certified Drug Medi-Cal Provider Site Locations

Year Ending on Date	No. of Certified DMC Providers[1]	Change From Prior Year	Percent Change
September 30, 2006	1,246	30	2.5%
September 30, 2007	1,388	142	11.4%
September 30, 2008	1,488	100	7.2%
September 30, 2009	1,108	(380)	(25.5)%
September 30, 2010	1,179	71	6.4%

[1] Although these providers are certified, some may be inactive meaning they are not providing services to clients.

Table #1, Number of Billing Drug Medi-Cal Provider site locations

DMC Billing Provider Counts

Service Type	FY 07/08	FY 08/09	FY 9/10 P1	FY 9/10 P2	FY 10/11	FY 11/12	FY 12/13
Day Care Rehabilitative	152	156	106	113	110	110	124
NTP-Methadone	125	123	118	119	121	123	122
ODF - (Group Counseling)	435	430	430	384	397	404	409
Perinatal Residential (RES)	24	19	19	16	16	17	13

**During FY 2009/10 the SD/MC2 system was implemented as of 1/1/2010; data reported is from each system.*

Additional informal questions from CMS have been satisfactorily answered.

c. **Describe 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).**

Response: See response to 18b. Data indicates that the number of certified DMC providers is increasing and not decreasing, even after the ten percent rate reduction for SFY 2009-10; and the median client wait for treatment is essentially unchanged since the reimbursement rate reductions; therefore, there is continued access to care and services.

California also examined Medicaid reimbursement rates of adjoining states Oregon, Nevada, and Arizona. Unfortunately, there is a decided lack of uniformity in the substance abuse treatment services among the four states and a meaningful comparison was not possible.

d. **Explain how providers, advocates and beneficiaries were engaged in the discussion around rate modifications. What were their concerns and how did the State address these concerns?**

Response: The State's policy is to develop DMC SMAs and USDRs annually. This process includes hosting a DMC Rates Workgroup meeting where the proposed rates are introduced and comments are solicited. This workgroup is comprised of external stakeholders including county administrators, DMC providers, and advocates as well as ADP and DHCS departmental staff. Providers who were unable to attend were provided a toll free telephone number so their concerns could be heard.

The California Legislature acted after hearing public comments from DMC providers during the legislative budget hearing process. In the legislative budget development

process for SFY 2009-10, many State programs and services were proposed to be eliminated or reduced. This included Medi-Cal and DMC Program reimbursement rates. Providers were able to provide both written and oral testimony to the California State Assembly and Senate budget committees assigned responsibility for budgeting for Medi-Cal services, including DMC services, for State Fiscal Year 2009-10. The Legislature included the ten percent rate reduction for DMC services in the budget that was passed and the budget was signed by the Governor. No litigation has been filed over the ten percent rate reduction in DMC and no court-ordered injunctions have been issued.

e. **Explain whether the State intends to modify other pages or sections of the State Plan to counterbalance the 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).**

Response: California does not believe the decrease in provider reimbursement rates for DMC services created access to care issues for beneficiaries. As a result, California does not plan at this time to increase the scope of Medicaid substance abuse treatment services or to provide care in additional settings.

f. **Explain how the State intends to monitor the impact of the new rates and implement a remedy should rates be insufficient to guarantee required access levels. Provide specific details about the measures to be used, how these measures were developed, data sources, and plans for reporting, tracking and monitoring. The State should also provide the specific benchmarks for each measure which would trigger State action to remedy indicated access problems.**

Response: California intends to continue monitoring the California Outcomes and Measurement Systems (CalOMS) client treatment database as new data becomes available to determine whether clients experience increased waits to begin substance abuse treatment. Similarly, the State will track the number of Medi-Cal eligible beneficiaries beginning substance abuse treatment using CalOMS data. The State also will examine clients in the aggregate (which counts a client each time a service is received) and by unique clients (which counts a client receiving multiple services only once). The process will allow the State to identify, after the fact, any decline in the total volume of DMC claims and will also track DMC claims by specific modality and geographic region.

g. **Explain what action(s) the State plans to implement after the rate modification(s) take place to counter any negative impact on access to care?**

Response: As described above, DHCS intends to continue to monitor and analyze data on DMC program access. If Medicaid utilization data falls below the benchmarks described in the response to question 18f (above), the State will analyze data and discuss with impacted counties to ensure services for DMC patients. In addition, counties have the ability to utilize funding from the Substance Abuse Prevention and Treatment Block Grant, county realignment funds, and other county funds, as such funds are available, to

supplement the funding and services available to Medicaid-eligible beneficiaries needing substance abuse treatment services. This is possible because many substance abuse providers in California provide services to both DMC clients and non-Medicaid eligible clients, and receive Medicaid and non-Medicaid funding.

D. 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. **SSA, Title 19, 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.)**

   Response: No, the State does not receive or retain any portion of the total Medicaid expenditures. See the response to Reimbursement question 7(b). Counties pay their contracted non-NTP service providers the lower of the provider's: 1) usual and customary charge, 2) allowable costs of providing the service, or 3) the Statewide Maximum Allowance. Counties pay their contracted NTP service providers the lower of the provider's: 1) usual and customary charge, or 2) the USDR. Counties then enter their claim information into an automated claim processing system, and submit a signed CPE form to DHCS to certify the total expenditure and to request the federal share of cost. For claims that are adjudicated as approved by the claim processing system, DHCS draws down the federal share of cost, then pays counties for their federal share of cost. Once per year, counties submit a cost report. The completed cost report determines an interim total cost of providing services throughout the year. The difference between the amount that counties were paid throughout the year and the total cost in the completed cost report is the amount that is owed by the county to the State or vice versa. If DHCS reimbursed too much, an invoice is sent to the county requesting the return of funds. If DHCS reimbursed too little, the DHCS pays the county an additional amount. Based on the cost report settlement amount, counties adjust reimbursements to their contracted service providers accordingly.

The post service, post payment review process and financial audit process determine disallowed expenses and have procedures for recapturing payments made for such expenses.

2. **SSA 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 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 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).

   Response: Beginning July 1, 2011, California directs State revenues to counties to cover the non-federal share of cost of DMC services. The Legislature also provided budget authority to allow ADP to reimburse counties for the federal share of cost. ADP obtains the federal share of cost dollars by invoicing the DHCS. IGT's are not applicable.

   Beginning September 1, 2011, ADP implemented CPEs for DMC services. Under the CPE process, for each batch of DMC claims submitted into the automated claim processing system, the county submits a signed form certifying the total expenditure paid its contracted service providers for DMC services provided. For claims that are adjudicated as approved by the claim processing system and which have a corresponding signed CPE form, ADP invoices the DHCS for the federal share of cost. ADP then reimburses counties for their federal share of cost.

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.
Response: The DMC Program does not provide supplemental or enhanced payments.

4. **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.**

   Response: This question has been satisfactorily answered in a separate call with CMS representatives.

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?**

   Response: No payments to governmental providers exceed their reasonable costs as payments are limited to the SMA, USDR or actual costs. If at the time of the cost report settlement process, it is determined that the sum of initial payments during the year have exceeded allowable costs, then the State recoups the excess and returns the related federal share to the federal government.

   The DMC Program as structured provides assurance that service providers receive payments that do not exceed their reasonable cost of providing services. For these services DHCS annually collects cost data from service providers. As explained in the response to questions 7b through 7d, the annual cost settlement process compares service provider costs to DMC claim payments made to providers during the year. In that cost settlement process, payment adjustments are made so that providers seeking reimbursement are paid the lowest of the: 1) provider's usual and customary charge to the general public for providing the same or similar services; 2) the provider's allowable cost of providing these services; or 3) the Statewide Maximum Allowance.

SPA Impact Form

State/Title/Plan Number: California, Title XIX, Drug Medi-Cal Rate Setting and Reimbursement, SPA # 09-022

Federal Fiscal Impact:

Number of People Affected by Enhanced Coverage, Benefits or Retained Eligibility: _____

Number of Potential Newly Eligible People: _____
or
Eligibility Simplification: Yes/No No

Number of People Losing Medicaid Eligibility: __None_____

Reduces Benefits: Yes/No No

Provider Payment Increase: Yes/No No

Delivery System Innovation: Yes/No No
(Examples: adding new provider types to provide a covered service, managed care delivery systems or other similar type plans.)

Comments/Remarks:
This State Plan Amendment conforms the Plan with State law enacted in 2009 and provides clarity of the reimbursement processes and policies for all Drug Medi-Cal services.

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