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Director

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



ARNOLD SCHWARZENEGGER
Governor

MAR 26 2010

Ms. Gloria Nagle
Associate Regional Administrator
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 09-022 (Drug Medi-Cal Reimbursement Rate Reduction)

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) requests to stop the 90-day clock for State Plan Amendment (SPA) 09-022. SPA 09-022 describes the Drug Medi-Cal reimbursement rate methodology changes that were mandated by the State Fiscal year (FY) 2009-10 California State Budget, Assembly Bill 4 of the 4th Extraordinary Session, (Chapter 4, Statutes of 2009) and implemented on July 1, 2009. This SPA was submitted to CMS on September 30, 2009, and the Request for Additional Information (RAI) for the SPA was issued by Region IX on December 23, 2009.

Due to the complexity of the RAI questions and items for the SPA, DHCS will need additional time to provide comprehensive responses.

If you have questions or concerns regarding this request, please contact Ms. Barbara Bailey, Chief, Medi-Cal Benefits, Waiver Analysis and Rates Division, at (916) 552-9400.

Sincerely,

Toby Douglas
Chief Deputy Director
Health Care Programs

cc: See Next Page

cc: Ms. Beverly Binkier
Division of Medicaid & Children's Health Operations
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Region IX

Division of Medicaid & Children's Health Operations

90 Seventh Street, Suite 5-300 (5W)

San Francisco, CA 94103-6706

DEC 23 2009

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

Dear Mr. Douglas:

We have reviewed the proposed amendment to pages 38 through 41 of Attachment 4.19B of your State Medicaid plan submitted to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2009 under State plan amendment (SPA) 09-022. This SPA, with a proposed effective date of July 1, 2009, proposes to amend the Drug Medi-Cal reimbursement rate methodology to implement a ten percent rate reduction. Our review has indicated that the proposed SPA is not approvable as currently drafted. Additional information is needed before this amendment can be approved. Therefore, we are requesting additional information (RAI) pursuant to Section 1915(f)(2) of the Social Security Act (the Act).

A. General

1. HCFA-179, Federal Statute/Regulation Citation, Box 6 – Please request a pen and ink change to include 42 CFR 447 Subpart F.
2. HCFA 179, Federal Budget Impact, Box 7 – Please explain how the Federal budget impact was determined.
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 to Attachment 3.1B. Additionally, please request a pen and ink change to reflect these additional pages under review.
4. Please include the effective date on all State plan pages under review.

B. Coverage – Attachment 3.1A and B

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.

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 Postpartum Women.
3. Supplement 3 to Attachment 3.1A "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."
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.
5. Supplement 3 to Attachment 3.1A – Please elaborate on the qualifications of the individual(s) supervising the qualified substance abuse treatment professional.
6. Limitations to Attachment 3.1A and B, 13d.3, Outpatient Heroin Detoxification Services – Please explain whether providers of outpatient heroin detoxification are subject to the 10 percent payment reduction.

C. Reimbursement – Attachment 4.19B

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

3. Page 38, “Provider of Services” 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 services 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.
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.
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”.
6. Page 39, Section B.1.c. - Please include the effective date of the SMA and the published location.
7. Page 39, Section B.1., second paragraph – It appears that a legal entity is the only provider category that is required to submit a cost report. Please explain if there are other provider categories that are not legal entities and if they are required to submit a cost report. How do the lower of charges, allowable cost and SMA methodology apply?

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 first sentence indicates that the reimbursement limits (i.e. lower of charges, allowable cost, or SMA) only apply to the year-end settlement. Is there an interim payment process or are providers only paid after the year-end cost reports are submitted?

If providers receive interim payments, the State needs to describe in detail the interim payment methodology in the State plan. Further, the State plan needs to include details of the reconciliation and settlement process, including time frames for the submission of the cost report, auditing of the cost report, adjustment as a result of any audit findings, and settlement to audited cost. Specifically, the State plan should include a description of the process and data used to reconcile the total interim payments to the final audited actual cost, the process and the data used to validate the cost and statistical data used in the determining the actual allowable cost and who is responsible for the process.

8. Page 40, Section D – CMS suggests amending the title of this section to read, “UNIFORM STATEWIDE AND REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS”.
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”.
10. Page 40, E., 1st paragraph – Please remove the reference to California’s Welfare & Institutions Code. We suggest that this sentence be revised to state “Effective with the California State Fiscal Year (FY) 2009-10 rate development process, the rates established by the methodologies in Sections C and D above shall be modified as follows”.
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 rate(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.xxxxx.xxx.”
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.
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.
14. Page 40, Section E.2.b. – Please include the effective date and published site of the SFY 2009 -2010 rates. How often will the FY 2009-2010 rates be adjusted by the Price Deflator?
15. Page 41, Section F – Please elaborate on the following units of service descriptions:
 - a. Day Care Rehabilitation Treatment – daily rate?
 - b. Outpatient Drug Free Treatment - by minute?
 - c. Perinatal Residential Substance Abuse Treatment – daily rate?
 - d. Natltrexone Treatment – encounter/visit or daily rate?
 - e. Narcotic Treatment Programs – daily rate which covers all four components?

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 for the ingredient and the dispensing fee. Please explain what is meant by a “dosing fee”.
17. Page 41, Section F – Please identify what provider(s) dispenses methadone.
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. Please explain how the reduction in rates allow the State to comply with requirements of Section 1902(a)(30) of the Act?
 - 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?
 - c. Please 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 other State Medicaid rates, comparison with national averages for Medicaid or Medicare, other).
 - d. Please explain how providers, advocates, and beneficiaries were engaged in discussions about the rate modifications. What were their concerns and how did the State address these concerns?
 - e. Please 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).
 - f. Please 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. Please 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.
 - g. Please 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.

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. 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.).

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either 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).

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

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.
5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

We are requesting this additional clarifying information under provisions of section 1915(f) of the Social Security Act (added by P.L. 97-35). This has the effect of stopping the 90-day clock with respect to CMS taking further action on this State plan submittal. A new 90-day clock will not begin until we receive your response to this request for additional information. In accordance with our guidelines to all State Medicaid Directors dated January 1, 2001, we request that you provide a formal response to this request for additional information within ninety (90) days of receipt. Thank you in advance for your continued cooperation in processing this SPA.

If you have any questions, please contact Michelle Baldi at (415) 744-3656.

Sincerely,



for

Gloria Nagle, Ph.D., M.P.A.

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Cc: Barbara Bailey, California Department of Health Care Services
Kathryn Waje, California Department of Health Care Services
Kenya Cantwell, Centers for Medicaid and State Operations
Adrienne Delozier, Centers for Medicaid and State Operations
Christopher Thompson, Centers for Medicaid and State Operations