TOBY DOUGLAS
Director

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

EDMUND G. BROWN, JR.
Governor

JUN 22 2012

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

Dear Ms. Nagle:

STATE PLAN AMENDMENT TRANSMITTAL NUMBER 09-022

The Department of Health Care Services (DHCS) is submitting a response to the Request for Additional Information letter dated December 23, 2009. The questions from the Centers for Medicare & Medicaid Services (CMS) were the result of its review of State Plan Amendment (SPA) 09-022 documents that the DHCS provided to CMS on September 30, 2009.

SPA 09-022 amends Attachment 4.19B, pages 38 through 42, for DMC Services. The amendment is necessary to describe the DMC reimbursement rate methodology changes that were mandated by Assembly Bill (AB) 4 of the 4th Extraordinary Session (Statutes of 2009).

AB 4 added Welfare and Institutions (W&I) Code Section 14021.9 that requires a 10 percent rate reduction for State Fiscal Year (SFY) 2009-10, effective July 1, 2009, for DMC Services. For SFY 2010-11 and subsequent fiscal years, this legislation requires the reimbursement rates to be set at the lower of the following:

- The reimbursement rates developed using the then applicable rate-setting methodology.
- The SFY 2009-10 reimbursement rates adjusted for the cumulative growth in the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies, as reported by the California Department of Finance.

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The additional information requested begins on page 3 of this letter. As requested, DHCS has revised various pages of the SPA and enclosed them as separate documents.

If there are questions regarding the Request for Additional Information responses or proposed changes to the SPA text, please contact John Mendoza, Acting Chief, Fee-For-Service Rates Development Division at (916) 552-9600.

Sincerely,

Toby Douglas
Director

Enclosures

cc: John Mendoza, Acting Chief
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Sacramento, CA 95899-7413

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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 (Payment Methods for other institutional & non institutional services) commencing with section 447.300

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

~~Also see Attachment to this Transmittal Form.~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B—Amend pages 38 through 41

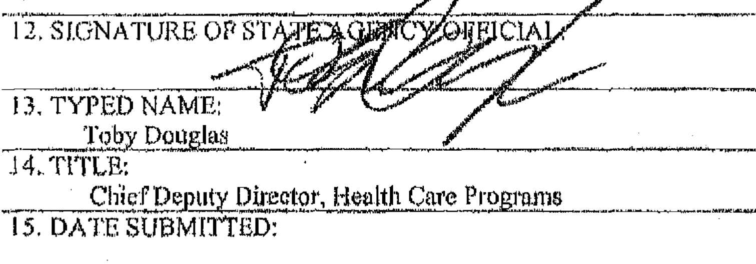
9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B, pages 38 through ~~41~~ 42B

10. SUBJECT OF AMENDMENT:

Description of Drug Medi-Cal Reimbursement Rate-Setting Methodology Changes Starting July 1, 2009

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:
Governor's Office does not wish to Review State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:
Toby Douglas

14. TITLE:
Chief Deputy Director, Health Care Programs

15. DATE SUBMITTED:

16. RETURN TO:

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)

Response to CMS Questions of December 23, 2009
Concerning Reimbursement for Drug Medi-Cal (DMC) Services
Revised May 8, 2012

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) $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 FY 2009-10 (after the 10 percent DMC rate reduction). The lower total cost due to the 10 percent rate reduction produced a federal cost savings of $12,873,000.

   ADP then took that federal savings and separated it into the partial Federal Fiscal Year (FFY) 2009 piece (July 1, 2009 through September 30, 2009) and the full-year FFY 2010 piece (October 1, 2009 through September 30, 2010). The FFY 2009 piece was three-twelfths of the $12,873,000 federal savings, and the FFY 2010 piece was the full-year $12,873,000 federal 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: State will address this comment in State Plan Amendment 12-005.

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.

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: State will address this comment in State Plan Amendment 12-005.

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: State will address this comment in State Plan Amendment 12-005.

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: State will address this comment in State Plan Amendment 12-005.

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: State will address this comment in State Plan Amendment 12-005.

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: State will address this comment in State Plan Amendment 12-005.

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: State will address this comment in State Plan Amendment 12-005.

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 revised as follows: "lowest of the provider's usual and customary charge." The State made same revision for page 39, sections B.1 and B.2. This is in accordance with the California Code of Regulations (CCR) Title 22, Section 51516.1(a) (1). The lower of cost principle applies to any Drug Medi-Cal (DMC) provider, whether county operated, direct contractor, or subcontractor. Provider of Services is also defined on page 38 to mean any private or public agency.

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: Page 38, first paragraph: The reference to the Statewide Maximum Allowances (SMA) in this paragraph refers to the same SMA in Section C of the same document. Section C briefly describes the methodology for determining the SMA. The non-Narcotic Treatment Programs use the term SMA. The Narcotic Treatment Program also uses an SMA but it is called the "uniform statewide reimbursement rate." Section D of the same document describes the methodology for determining the uniform statewide reimbursement rate.

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 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: "Provider of Services" is the legal entity certified pursuant to CCR, Title 22, Section 51200 to provide DMC substance abuse services to eligible beneficiaries at its certified location(s). "Legal Entity" is an organization that provides DMC services under contract with either the State or county. Providers of Services are Legal Entities only if they provide DMC services under a contract with the State or county. The contract is the basis for the "Legal Entity" providing these services.

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

Response: To receive reimbursement for services provided, a provider must have a contract with either the county or ADP.

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

Response: ADP has the authority to contract with either DMC-certified providers directly or counties to provide DMC services. All DMC services must be provided at sites that ADP has designated as being DMC certified clinics. Counties may provide DMC services through either a county-operated program that is DMC certified or under contract with a DMC-certified provider. ADP contracts with counties are for a three-year period and amendments are processed during the three-year period to increase funds, decrease funds, or modify requirements in response to requests for service.

As stated on revised Attachment 4.19B, page 39, providers billing for reimbursement of 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, 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.

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 as required by CCR, Title 22, section 51341.1, (b) (8) and (b) (9). 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: Allowable cost is defined in the SPA, Attachment 4.19B, 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). To minimize confusion, the State changed "Actual cost" to "Allowable cost" on page 38, Section A, third paragraph.

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

Response: Attachment 4.19B, page 40, item (E)(1) was revised to show effective date of the rates which is July 1st of each year and to show the published location of the rates which is the fiscal year's rates bulletin posted on the Department of Alcohol and Drug Programs' website at: http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml. Attachment 4.19B, page 40, Section C, has been revised 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 SMA is determined. This is consistent with the requirements of the California Welfare and Institutions Code, Section 14021.6(b) (1).

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 non-NTP DMC providers to which ADP has paid DMC claims are required to submit cost reports to ADP, either via the county with which they contract or directly to ADP. 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 must submit a report that contains the units of service provided and the reimbursement rate claimed to ADP. ADP instructs the NTP providers that their DMC claims must claim reimbursement at the lower of the uniform statewide daily reimbursement rate or the provider's usual and customary charge. This approach is consistent with the NTP reimbursement methodology detailed in the California State Medicaid Plan, Attachment 4.19B, page 39. Unlike non-NTP providers which are reimbursed at a median rate calculated from cost report data, reimbursement of DMC NTP services is calculated using a fixed formula created in 1997 with extensive provider input. The NTP reimbursement formula is based on the last year that NTP cost report data was available, State Fiscal Year 1996-97.

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 running total for the cumulative UOS per provider is calculated.
4. The total cumulative UOS is divided in half 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 reimbursement rate.

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 reimbursement rate of $4.00 is selected because this cost is related to the cumulative UOS (60).

A	B	C	D	E
Provider	**Total Cost**	**Units of Service (UOS)**	**Cost Per UOS**	**Cumulative UOS**
			B / C	**Previous Col E + Current Col C**
Provider 1	$60	30	$2	30
Provider 2	$120	30	$4	60
Provider 3	$180	20	$9	80

Description of Rate Setting Methodology for NTP Daily Dosing Reimbursement Rate

The rate setting methodology adds the component costs of the Narcotic Treatment Program together to get a total annual cost for delivering the daily dose to a patient, and then converts that total annual cost to a daily reimbursement rate.

The total cost includes allowances for administrative overhead to cover the indirect non-personnel costs (e.g., rent, utilities), indirect personnel costs (e.g., Accounting, Human Resources), and county administration cost related to delivering the daily dose to the patient.

There are three main cost components to determine the reimbursement rate for the Narcotic Treatment Program dosing modality.

- The first is the Core Component. That covers the cost of the first physical exam and first drug test, the intake assessment of patient's treatment needs, and the labor cost and administrative overhead cost for the physician's supervision of the patient NTP services.
- The second component is the Lab Work component. That covers the costs of up to 11 other drug tests that occur during the year for regular patients and up to 38 other tests for perinatal patients. This component also includes the cost of the tuberculosis and syphilis tests.
- The third component is the Dosing component. That covers the methadone ingredients cost, labor cost and administrative overhead cost for the two minutes of one and one-half (1-1/2) Licensed Vocational Nurses' and one Registered Nurse's time to administer the dose to the patient.

The State conducts post service and post payment reviews to confirm that the service providers billed correctly for the services provided. The State also conducts financial compliance audits of DMC providers to provide reasonable assurance that reimbursements are made for their intended purpose in accordance with applicable Medicaid requirements and that costs are allowable based on a determination of reasonable costs related to activities provided.

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 State determines the Medi-Cal cost by following The Provider Reimbursement Manual, Part 1 (CMS-Publication #15-1) available on the website of the Centers for Medicare and Medicaid Services, and the Government Auditing Standards. ADP also determines that costs are allocated to the DMC programs on a fair and equitable basis by following the Office of Management and Budget (OMB) Circular A-87, Cost Principles for State, Local and Indian Tribal Governments. The methodology used to apportion costs to the Medicaid program consists of using direct treatment staff hours to prorate costs between the Medi-Cal and Non Medi-Cal programs. Per contractual agreement, accurate fiscal records and supporting documentation are required of the DMC contractor and subcontractors to support all claims for reimbursement. All records must be capable of verification by auditors.

The Cost Report Attachment is an example of the cost report instructions and forms a county must complete to create its cost report. The example is for the Outpatient Drug Free Group service for the FY 2010-11 cost report. The first two pages of the Attachment contain the instructions and remaining pages contain the forms. There are separate instructions and forms for each Drug Medi-Cal service.

The following is the timeline for cost report submission and completion using Fiscal Year 2007-08 as an example. After FY 2007-08 ended on June 30, 2008, counties were required to submit their cost report for FY 2007-08 by November 1, 2008. By December 2009, ADP had completed the interim settlement of costs for FY 2007-08. "Interim Settlement" means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report. "Final Settlement" means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the State. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

The development of the Drug Medi-Cal reimbursement rates for the non-Narcotic Treatment Program modalities uses the most recently completed cost report. In August of 2010, when ADP determined the proposed FY 2011-12 Drug Medi-Cal reimbursement rates, the most recently completed cost report data available was for FY 2007-08.

Counties are paid throughout the year for the cost of providing Drug Medi-Cal Services based on approved services amount not to exceed the reimbursement rate. 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. Based on the cost report settlement amount, counties adjust reimbursements to their contracted service providers accordingly.

For NTP services, within the direct cost, counties are permitted to withhold up to ten percent of the reimbursement amounts to their contracted service providers to cover the county's administrative, indirect cost of providing services. For non-NTP services, counties are permitted to do nearly the same, except that instead of the ten percent of direct cost limitation, the indirect cost must simply be reasonable.

Reimbursement During the Year: As Drug Medi-Cal services are provided, a county enters the claim information into an automated claim processing system. Starting in FY 2011-12, the non-federal share of cost was funded by county funds. Counties pay their contracted service provider the lower of the provider's: 1) usual and customary charge, 2) actual costs of providing the service, or 3) the Statewide Maximum Allowance. Counties then submit a signed Certified Public Expenditure form to the Department of Alcohol and Drug Programs (ADP) certifying the total expenditure paid to contracted service providers for Drug Medi-Cal services provided and requesting the federal share of cost. For claims that are adjudicated as approved by the claim processing system, ADP invoices the Department of Health Care Services for the federal share of cost. ADP then pays counties for their federal share of cost.

Completed Cost Report: After the November 1 cost report submission, ADP analyzes each county's cost report to determine whether DMC claims have been paid at the appropriate level. This requires that ADP reexamine the Drug Medi-Cal claims processed during the year (both approved and denied claims) to determine if the claims were properly paid at the lowest of the provider's usual and customary charge to the general public for providing the same or similar services, the provider's allowable costs of providing these services, or the Statewide Maximum Allowances. Based on that analysis, the ADP compares what it should have reimbursed for claims to what it actually reimbursed for claims during the year. If ADP reimbursed too much, an invoice is sent to the county requesting the return of funds. If ADP reimbursed too little, the ADP pays the county an additional amount. This analysis process establishes the interim settlement of claim payments for the fiscal year and makes the cost report "completed".

As described in the answer to the previous question, the State conducts post service, post payment reviews to confirm that service providers billed correctly for the services provided. In this review process, the state visits service providers to review the file documentation for Drug Medi-Cal claims submitted to a county or to the state for payment. The State also conducts financial compliance audits of DMC providers to provide reasonable assurance that reimbursements are made for their intended purpose in accordance with applicable Medicaid requirements and that costs are allowable based on a determination of reasonable costs related to activities provided. These review and audit processes help ensure that counties and service providers are paid for allowable cost.

c. ***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?

<u>Response to "c"</u>: Once the State adjudicates and approves the claim, the State makes an interim payment to pay the claim at lowest of the provider's: 1) usual and customary charge, 2) allowable costs of providing the service, or 3) the Statewide Maximum Allowance if the claim is from a non-NTP service provider, or the lower of the provider's: 1) usual and customary charge, or 2) the Uniform Statewide Reimbursement Rate if the claim is from an NTP service provider.

d. ***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 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.***

<u>Response to "d"</u>: Providers are reimbursed for approved claims before cost reports are submitted. During the course of the year, providers submit claims for services provided. The claims are adjudicated through the Short-Doyle Medi-Cal system maintained by the California Department of Health Care Services (DHCS). Payments are made to providers after adjudicated claims are approved. The amount reimbursed is based on the amount submitted on the claim but not to exceed the SMA. For example, if the SMA for the DMC claim is $10.00 per unit of service, and the provider's allowable cost on the claim is only $9.00, then the DMC reimbursement is the lower amount, $9.00.

During the State's annual cost report settlement process, ADP determines if the non-NTP claims were properly paid at the lowest of the provider's usual and customary charge to the general public for providing the same or similar services, the provider's allowable costs of providing these services, or the Statewide Maximum Allowances. Based on that comparison, the ADP determines how much it should have reimbursed for claims compared to what it actually reimbursed for claims. If ADP reimbursed too much, an invoice is sent to the county requesting the return of funds. If ADP reimbursed too little, the ADP pays the county an additional amount. This analysis establishes the final settlement of claim payments for the fiscal year and makes the cost report "completed". The State does this analysis for direct providers and for counties. Counties then make similar final adjustments to the treatment providers with which they contract.

As explained in the response to Reimbursement Question #7a above, NTP providers submit a report identifying the units of service provided and the reimbursement rate at which the services are billed. The reimbursement rate is the lower of the Uniform Statewide

Reimbursement Rate or the provider's usual and customary charge to the general public for the same or similar service. The report multiplies the units of service by the reimbursement rate to determine total reimbursement. The total reimbursement amount becomes the final annual settlement. The State instructs NTP treatment providers that if their cost is lower than either the Statewide Maximum Allowance or the provider's customary and usual charge, then they must change their report to state the lower cost as the reimbursement rate. The State samples selected NTPs annually for financial auditing to confirm that providers are billing for reimbursement consistent with the State's reimbursement billing requirements.

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".**

   The States response: The State is unsure why CMS is proposing this change to add the word "AND" between the words STATEWIDE and REIMBURSEMENT. We request clarification from CMS on the importance of this proposed change.

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, we revised title to "ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE REIMBURSEMENT RATE METHODOLOGIES."

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 (FY) 2009-10 rate development process, the rates established by the methodologies in Sections C and D above all shall be modified as follows".**

    Response: We agree and have made the changes requested by CMS.

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 SPA has been revised to show effective date and published location of the rates following section E.2.

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 SPA has been revised to show effective date and published location of the rates following section E.2.

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 fee schedule. The methodologies to update the SMA for the non-Narcotic Treatment Program and the uniform statewide reimbursement rate 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 Department of Alcohol and Drug Programs' website at: http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml.

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 FY 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 FY 2010-11 and subsequent fiscal years, the cumulative growth in the Implicit Price Deflator is applied annually to the FY 2009-10 rates to determine adjusted rates for each treatment modality. Then, in accordance with the Welfare and Institutions Code, Section 14021.9, the adjusted rate for each treatment modality is 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, California does not further adjust the rates if the deflator changes.

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. **Natltrexone Treatment-encounter/visit or daily rate?**
    e. **Narcotic Treatment Programs–daily rate which covers all four components?**

Response:

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) (6) and (b) (22).

b. Outpatient Drug Free Treatment—The daily 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)(15) and (b)(22). 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 considered to be 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) allows the Statewide Maximum Allowance 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 Statewide Maximum Allowance 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)(17) and (b) (22).
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) (b)(13) and (b)(22).
e. Narcotic Treatment Programs
    - Dosing-One unit of service covers the daily methadone dosing.
    - Counseling—One unit of service is one 10-minute increment of counseling. Clients must be provided a minimum of 50 minutes of counseling per month. The State reimburses up to a maximum of 200 minutes of counseling per month. Counseling can be individual and/or group. (Reference is CCR, Title 22, Section 51516.1(h)

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 uniform statewide reimbursement rate for Methadone Dosing service 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 daily uniform statewide reimbursement rate.

- The Core Component contains the cost of the physical exam, initial drug test and intake

assessment by a counselor given to the client; physician supervision of the core component; and administrative overhead to cover indirect and program administration costs.

- The Lab Work Component contains the cost of the ongoing monthly drug tests given to the client, and the tuberculosis and syphilis test given to the client; and administrative overhead to cover indirect and program administration costs.
- The Dosing Component contains the methadone ingredient cost, the cost in time to administer the dose, and administrative overhead to cover indirect and program administration costs.

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 approval from the Center for Substance Abuse Treatment and the Drug Enforcement Agency, and 3) obtain a license from ADP.

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 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 compiles and tracks data for both service providers and beneficiaries receiving services throughout the State. Quarterly, ADP examines 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 compares the data against the previous quarter's data looking for indicators of change in access to care. ADP also examines 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 FY 2009-10 (see Table 1). In FY 2008-09, the number of certified DMC providers decreased by 380. This decrease was primarily due to the loss of $86.8 million in 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 FY 2009-10, certified DMC providers increased by 6.4 percent demonstrating expanded access to DMC services.

Table #1, Number of Certified Drug Medi-Cal Providers

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%

Table 2 shows that the DMC unduplicated client count remained relatively stable from FY 2008-09 through 2010-11 which indicates that access to care was not negatively impacted by the 10 percent rate reduction. The one percent decrease in client count that occurred in FY 2009-10 was due to a decrease in the number of client referrals from the SACPA program. However, in FY 2010-11, the trend was reversed and the client count increased.

Table #2 Number of DMC Clients

Fiscal Year	DMC Unduplicated Client Count	Change From Prior Year	Percent Change from Prior Year
FY 2006-07	102,288	5,838	6.05%
FY 2007-08	110,627	8,338	8.15%
FY 2008-09	114,561	3,934	3.56%
FY 2009-10	113,133	-1,428	-1.25%
FY 2010-11	113,829	696	0.62%

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

The average number of days that clients waited for DMC treatment did not change from FY 2008-09 through 2010-11, indicating that access was not negatively impacted.

Table #3, Mean Days Waited for Treatment for Clients That Began Treatment

Fiscal Year	Outpatient Mean Days Waited	Narcotic Treatment Mean Days Waited	Day Care Rehabilitative Mean Days Waited	Perinatal Residential Mean Days Waited
2008-09	1.7	0.8	0.3	7.1
2009-10	1.6	0.5	0.3	7.6
2010-11	1.6	0.7	0.3	7.1

Collectively, this data demonstrates that the 10 percent rate reductions did not negatively impact access to DMC services. In addition, the DMC program is not aware of access to care complaints from beneficiaries or providers due to the 10 percent provider rate reductions.

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 ADP's certified DMC providers is increasing and not decreasing, even after the 10 percent rate reduction for FY 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 Drug Medi-Cal (DMC) rates annually. This process included hosting a DMC Rates Workgroup meeting where the proposed rates are introduced and comments are solicited. This workgroup was 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.

Additionally, the Legislature acted after hearing public comments from DMC providers during the legislative budget hearing process.

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: The State has the ability to request that counties utilize the Substance Abuse Prevention and Treatment Block Grant, county realigned DMC 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. If Medicaid utilization data falls below the benchmarks described in the response to question 18f (above), the State plans to encourage counties to use their available funds to supplement services for DMC clients.

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 <u>clinic or outpatient hospital services</u> or for <u>enhanced or supplemental payments to physician or other practitioners,</u> 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.)**

   <u>Response</u>: See the response to Reimbursement question 7b. 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 Uniform Statewide Reimbursement Rate. Counties then enter their claim information into an automated claim processing system, and submit a signed Certified Public Expenditure form to the Department of Alcohol and Drug Programs (ADP) 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, ADP invoices the Department of Health Care Services for the federal share of cost. ADP 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 ADP reimbursed too much, an invoice is sent to the county requesting the return of funds and any excess federal matching funds are returned. If ADP reimbursed too little, the ADP 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, the California Legislature realigned funds from the State to counties to cover the non-federal share of cost of Drug Medi-Cal 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 Department of Health Care Services. IGT's are not applicable.

Beginning September 1, 2011, ADP implemented CPEs for Drug Medi-Cal services. Under the CPE process, the county submits a signed form certifying the total expenditure paid its contracted service providers for Drug Medi-Cal 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 Department of Health Care Services 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: California does not believe any reimbursements for Drug Medi-Cal services are subject to the UPL. This belief is based upon the fact that DMC services are only available on an outpatient basis, and must be provided at site specific certified DMC clinics. No DMC services are reimbursable by Medicare.

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. Current rates for outpatient services, including outpatient Drug Medi-Cal rates to be reduced/revised by SPA 09-022, are approximately 60 percent of the Medicare rate in the aggregate. Therefore, recoupment of payments exceeding the cost of services would not occur.

INSTRUCTIONS FOR COMPLETING DMC FORMS FOR ODF GROUP – ALCOHOL AND DRUG

The EXCEL filename on the FY 2010-11 Cost Report Forms is **"ODF Group - Alcohol and Drug".** A separate worksheet has been created for each document within the Excel file. The worksheets are "Comparison", "ODFGFUND-AD" aka [OK Fundsheet], "7990ODFG-AD", "7895ODFG-AD" and the "Data Entry Sheet". Information is **only** entered in the **yellow shaded areas** on both the "Data Entry Sheet" and "Comparison" worksheets.

These forms must be completed to provide adequate cost data analysis (refer to 42 CFR 413.24 and 45 CFR 96.30). The detail of the service provider's costs must be identified on the forms in the appropriate cost categories.

BRIEF ON UPDATES:
Funding lines established for Drug Medi-Cal, ARRA and State's Match to DMC have been combined. The two new funding lines are:

- 71a for regular Drug Medi-Cal
- 71b for Perinatal Drug Medi-Cal

WORKSHEET "DATA ENTRY SHEET"

Heading: Enter the County Name, name of Contractor/Provider being reported, Contract Period, Drug Medi-Cal 4-digit Provider Number, and the 6-digit Provider Number. This information will be automatically transferred to the other worksheets.

Cost Information: Enter the specific categorical cost information for the following areas: Private Pay, Drug Medi-Cal, and NNA/Public Funded Program.

Unit Information: Enter the specific unit information for the following areas: Private Pay, Drug Medi-Cal, and NNA/Public Funded Program.

Prorated and/or Usual and Customary Charges: enter the amount of the prorated rate that is used to determine the appropriate rate for services offered. The Drug Medi-Cal requirement for Group Sessions is based upon the annual average of all group sessions. The reimbursement rate is set to a 90 minute session. If the annual average is less than 90 minutes the rate for DMC Group Sessions can be prorated accordingly. Additional information can be found in Exhibit U, Unit Definitions. No entry is required in the box if there is no change to Prorated or UCC rate.

NOTE: There are various edits programmed into the form to check for erroneous or inconsistent entries, and to identify cost shifts necessary to assure that NNA and DMC programs have like costs for like services. If these edits detect entries that require changes, the areas in need of review or correction will be highlighted on the Data Entry Sheet. Additionally, notes on correcting the inconsistency will be shown in the "**EDITS**" panel on the ODFGFUND-AD worksheet and on the Data Entry Sheet.

NOTE: Food costs are not allowed in Drug Medi-Cal programs. Costs of **employee** meals are allowable Drug Medi-Cal costs under specific conditions as identified in the *Provider Reimbursement Manual*, Part 1 (CMS Publication 15-1). These costs must meet the test for reasonableness and necessity of the expense and be defined as either salary or a fringe benefit specifically identified in the employee manual; such costs should be reported in either "Salary and Wages" or "Employee Benefits".

WORKSHEETS "7895ODFG-AD" and "7990ODFG-AD" – NO DATA ENTRY REQUIRED

All information is derived by formulas contained in the workbook and transferred accordingly.

WORKSHEET "ODFGFUND-AD" [OK Worksheet] – NO DATA ENTRY REQUIRED

Based on the data entered on the "Data Entry Sheet" and programmed calculations within the other worksheets; error messages may appear under the heading "EDITS". The entries beside each edit will identify changes that must be made to the entries on the Data Entry Sheet. **NOTE:** Correct all other errors before making any cost shift between NNA and DMC programs.

Once all the entries on the "EDITS" panel show "OKAY" and all three "OKAY" messages appear under the NNA Amount, DMC Amount, and Total columns (if the total amounts match the Funding Needed amounts for each column and an "Error" message appears, this is due to rounding and this is acceptable), then the funding and unit information is to be placed in the Paradox cost report. On this worksheet, amounts for funding lines other than the Drug Medi-Cal reimbursable and state matching to Drug Medi-Cal funding lines (71a and 71b), Fee/DMC Share of Cost (Funding Line 84) and Insurance/3rd Party Fees (Funding Line 85), are combined under "*various*". On the Paradox cost report, you will need to identify these "*various*" funding lines separately.

Additional information can be found regarding the allowable funding lines, based upon the combination of Service Code and Program Codes. This information may be found in the Excel Document 2009-10 Cost Fiscal Data Element Report (MS Excel) on ADP's webpage link, http://www.adp.ca.gov/NNA/nnamain.shtml

WORKSHEET "Comparison"

This document identifies the comparison between the DMC worksheets (7895, 7990, and the OKFund) and the Fiscal Detail Pages printed from the Paradox cost report. It is required of the county to identify and enter the appropriate information to identify the Service and Program from the DMC Settlement forms with the information entered into Paradox. . In some instances more than one NNA or DMC Program Code could be entered. For example; 92 for Minor Consent and 97 for DMC Regular.

In the “NNA Program Codes” field, list the program codes under which the NNA cost and unit information reflected on these DMC forms is entered in the Paradox cost report; leave blank if no NNA information is reported on the DMC forms. A new line was added to evaluate the number of group sessions entered.

In the “DMC Program Codes” field, list the program codes under which the DMC cost and unit information reflected on these DMC forms is entered in the Paradox cost report

In the “Paradox Fiscal Detail” column, record the totals for each type of information from Fiscal Detail Pages from the Paradox cost report for the listed NNA or DMC programs, as appropriate. One cannot be completed without the other. The Drug Medi-Cal Settlement Forms are considered incomplete without this information properly filled in by the user.

The information in **the OK Worksheet column should match the information entered on the cost report fiscal detail pages (in and printed from the Paradox program**). If the amounts entered in the Paradox Fiscal Detail column do not match the amount shown in the OK Worksheet column, the heading (in the “Type of Information” column) of the row in error will be highlighted.

FY 2010-11 Cost Report

Comparison Sheet

ODF Group Counseling - Alcohol/Drug

County:
Provider:
DMC Number:
6-Digit Provider Number:

NNA Funding Information

NNA Program Codes	

Type of Information	Form 7895	Form 7990	OK Worksheet	Paradox Fiscal Detail
NNA Staff Hours	0	NA	0	
NNA Total Costs	0	NA	0	
NNA Individuals	0	0	0	
NNA Direct Costs	0	0	0	
Group Sessions	0	NA	NA	

DMC Funding Information

DMC Program Codes	

Type of Information	Form 7895	Form 7990	OK Worksheet	Paradox Fiscal Detail
DMC Total Costs	0	0	0	
DMC Per Person (Individuals)	0	0	0	
DMC Direct Costs	0	0	0	
DMC County Administration **(REQUIRED)**	0	0	0	
Group Sessions	0	NA	NA	

IMPORTANT NOTE: The information in the OK Worksheet column should match the Cost Report Fiscal Detail Pages in Paradox

COST REPORT APPLICATION FUNDING WORKSHEET **FY 2010-11**

ODF Group Counseling - Alcohol/Drug

County: ______________________

Provider: ______________________ DMC # __________ 6-DIGIT PROVIDER # __________

NNA	DMC	
0	0	Total Cost
0	0	Less: Direct Cost
NA	0	Less: DMC Admin.
0	0	Subtotal
0	0	Units
NA	NA	Cost per unit

EDITS

NNA Staff Hours	OKAY	No correction needed
Total Units	OKAY	No correction needed
Denied/Adjusted Total	OKAY	No correction needed
Denied vs. Submitted	OKAY	No correction needed
SMA/Prorated Rate	OKAY	No correction needed
DMC County Admin	OKAY	No correction needed
Cost Shifting	OKAY	No correction needed

Line #	Funding Source	NNA Amount	DMC Amount	*Drug Medi-Cal Breakout* Title XIX	Minor Consent	Total
71a	DMC Regular, Combined Fed and State		0	0	0	0
71b	DMC Perinatal, Combined Fed and State		0	0	0	0
84	Fees / D/MC Share of Costs		0	0		0
85	Insurance		0	0		0
various	Various (funding lines displayed in Paradox Fiscal Detail)*	0	0	0	0	0
	Total:	*0*	*0*	*0*	*0*	*0*
	FUNDING NEEDED	**0**	**0**			**0**
		OKAY	**OKAY**			**OKAY**
	DIFFERENCE	0	0			0

Direct DMC Costs:	**0**	DMC Max. Rate:	**28.69**
Direct NNA Costs:	**0**	DMC Costs:	0
DMC County Administration:	**0**	DMC Max. Allowable:	0
Group Sessions:	**0**	DMC Excess Costs:	0
Combined Cost Per Unit:	0.00	NNA Costs:	0

Total Costs:	**0**	
NNA Staff Hours:	0	**Staff Hours**
DMC Units:	0	**Individuals**
NNA Units:	0	**Individuals**
DMC Cost Per Unit:	0.00	
NNA Cost Per Unit:	0.00	

REMINDER: FUNDING AND UNIT INFORMATION SHOWN ON THIS WORKSHEET SHOULD BE USED AS THE SUPPORTING DOCUMENTATION TO MAKE THE APPROPRIATE ENTRIES ON THE PARADOX COST REPORT.

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
DRUG MEDI-CAL PROGRAM COST SUMMARY
FY 2010-11

ODF Group Counseling - Alcohol/Drug

COUNTY ______________________ MEDI-CAL PROV. NUMBER ________

PROVIDER ______________________ 6-DIGIT PROVIDER NUMBER ________

ADJUSTMENT OF TOTAL COST

	CATEGORY	1 TOTAL NNA & DMC PROVIDER COSTS	2 LESS DIRECT NNA COSTS	3 LESS DIRECT DMC COSTS	4 ADJUSTED PROGRAM COSTS	5 DMC COUNTY ADMIN
	A. PERSONNEL SERVICES	0				
	B. DIRECT SERVICES	0				
	C. EQUIPMENT, MATERIAL, & SUPPLIES	0				
	D. OTHER OPERATION EXPENSES	0				
	E. PROFESSIONAL & SPECIAL SERVICES	0				
	F. TRANSPORTATION	0				
	G. INDIRECT COSTS	0				
	G1. DMC COUNTY ADMINISTRATION	0				
	H. TOTAL COSTS	0	0	0	0	0

MEDI-CAL PROVIDER COST CALCULATION

		TOTAL	
01	TOTAL NNA & DMC SERVICE COSTS	0	01
02	TOTAL NNA & DMC SERVICE UNITS	0	02
03	COMBINED COST PER UNIT OF SERVICE	0.00	03
04	STATEWIDE MAXIMUM ALLOWABLE RATE OR PRORATED RATE	28.69	04

DRUG MEDI-CAL (DMC) RECONCILIATION OF CLAIMS (UNITS)

		TOTAL UNITS SUBMITTED	DENIED UNITS	TOTAL ADJUSTED DMC UNITS	
04a	1st Reporting Period - July thru September	0	0	0	04a
04c4	Minor Consent - July thru June - Non-Title XIX Clients	0	0	0	04c4
	TOTAL	0	0	0	

NEGOTIATED NET AMOUNT (NNA) UNITS OF SERVICE

		BEGINNING NNA UNITS	DMC UNALLOWABLE UNITS	FINAL NNA UNITS	FINAL DMC UNITS	
05	NNA and DMC Adjusted Units of Service	0	0	**0**	**0**	05
05a	TOTAL NNA AND DMC UNITS				**0**	05a

OKAY

COST OF DRUG MEDI-CAL UNITS OF SERVICE

09	COST (Line 3 × Total Adjusted Units Line)	0	09
10a	COUNTY MEDI-CAL ADMINISTRATION	0	10a
10b	DIRECT DMC COSTS	0	10b
11	TOTAL MEDI-CAL COSTS (Add Lines 9 + 10a + 10b)	0	11
12	TOTAL MEDI-CAL COST PER UNIT (line 11/ Total Adjusted Units Line)	0.00	12
13	MAXIMUM DMC ALLOWABLE (Line 4 × Total Adjusted Units Line)	0	13
14	DRUG MEDI-CAL ALLOWED (Lesser of Lines 11 or 13)	0	14
14a(1)	Allowed for July 01- June 30 (04a × the lesser line 12 or 4)	0	14a(1)
14d	Allowed for Minor Consent - Non-Title XIX (100% SGF)	0	14d
14f	Total of 14a(1) and 14d	0	14f

REVENUE FROM DRUG MEDI-CAL UNITS OF SERVICE

15	REVENUE/FEES (Share of Costs)	0	15
15a	INSURANCE / 3rd Party Fees	0	16

NET DRUG MEDI-CAL COSTS

16	NET COST (Line 14f minus Line 15 and 16)	0	17

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
REPORT OF EXPENDITURES AND REVENUES
FY 2010-11
ODF Group Counseling - Alcohol/Drug

COUNTY ______________

CONTRACTOR ______________ MEDI-CAL PROV. NO. ______________

CONTRACT PERIOD ______________ 6-DIGIT PROVIDER NO. ______________

SUMMARY

	A	B	C	D	E
CATEGORIES	TOTAL PROGRAM	PRIVATE PAY	MEDI-CAL	NNA/PUBLIC FUNDED	TOTAL MC/ NNA/PUBLIC
A. PERSONNEL SERVICES	0	0	0	0	0
B. DIRECT SERVICES	0	0	0	0	0
C. EQUIPMENT MATERIALS & SUPPLIES	0	0	0	0	0
D. OTHER OPERATING EXPENSES	0	0	0	0	0
E. PROFESSIONAL & SPECIAL SERVICES	0	0	0	0	0
F. TRANSPORTATION	0	0	0	0	0
G. INDIRECT COSTS	0	0	0	0	0
G1. COUNTY ADMINISTRATION	0		0		0
TOTAL GROSS COSTS	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
REVENUES					
H. PARTICIPANT FEES	0	0	0	0	0
I. INSURANCE, MEDICARE, & OTHER THIRD PARTY	0	0	0	0	0
NET COSTS (GROSS COSTS LESS LINES H,I)	0	0	0	0	0
UNITS OF SERVICE					
L. INDIVIDUAL FACE TO FACE VISITS	0	0	0	0	0
M. GROUP FACE TO FACE VISITS	0	0	0	0	0
N. DAYCARE DAY	0	0	0	0	0
O. RESIDENTIAL DAY	0	0	0	0	0
P. OTHER (Specify) - MINOR CONSENT 100% SGF	0		0	0	0
SUBTOTAL	**0**	**0**	**0**	**0**	**0**
Q1. ADJUSTMENT FOR DMC DENIED/UNALLOWABLE UNITS	0	0	0	0	0
Q2. ADJUSTED TOTAL	**0**	**0**	**0**	**0**	**0**
R. GROUP SESSIONS	0	0	0	0	0
S. STAFF HOURS (DIRECT SVCS - COUNSELING, MEDICAL, ETC.)	0	0		0	0
T. COST PER UNIT OF SERVICE (UNITS) (GROSS COSTS/LINE Q2)	$ -	$ -	$ -	$ -	$ -
U. COST PER STAFF HOUR (GROSS COSTS/LINE S)	$ -	$ -	$ -	$ -	$ -

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
DRUG MEDI-CAL FISCAL DETAIL
REPORT OF EXPENDITURES AND REVENUES
FY 2010-11
ODF Group Counseling - Alcohol/Drug

COUNTY ______________
CONTRACTOR ______________ MEDI-CAL PROV. NO. ______________
CONTRACT PERIOD ______________ 6-DIGIT PROVIDER NO. ______________

DETAIL

CATEGORIES	A TOTAL PROGRAM	B PRIVATE PAY	C MEDI-CAL	D NNA/PUBLIC FUNDED	E TOTAL MC/ NNA/PUBLIC
PERSONNEL SERVICES					
Salaries & Wages	0	0	0	0	0
Employee Benefits	0	0	0	0	0
TOTAL PERSONNEL SERVICES	**0**	**0**	**0**	**0**	**0**
DIRECT SERVICES					
Clothing & Personal Supplies	0	0	0	0	0
Food	0	0		0	0
Laundry Services & Supplies	0	0	0	0	0
Pharmaceutical	0	0	0	0	0
Other (Specify)	0	0	0	0	0
SUBTOTAL DIRECT SERVICES	**0**	**0**	**0**	**0**	**0**
EQUIPMENT, MATERIALS & SUPPLIES					
Depreciation-Equipment	0	0	0	0	0
Maintenance-Equipment	0	0	0	0	0
Medical, Dental, and Labratory Supplies	0	0	0	0	0
Membership Dues	0	0	0	0	0
Rents & Leases Equipment	0	0	0	0	0
Small Tools & Instruments	0	0	0	0	0
Training	0	0	0	0	0
Other (Specify)	0	0	0	0	0
SUBTOTAL EQUIPMENT, MATERIALS & SUPPLIES	**0**	**0**	**0**	**0**	**0**
OTHER OPERATING EXPENSES					
Communications	0	0	0	0	0
Depreciation-Structures & Improvements	0	0	0	0	0
Household Expenses	0	0	0	0	0
Insurance	0	0	0	0	0
Interest Expense	0	0	0	0	0
Leased Property Maintenance, Structures Improvements & Grounds	0	0	0	0	0
Maintenance-Structures, Improvements & Grounds	0	0	0	0	0
Miscellaneous Expense	0	0	0	0	0
Office Expense	0	0	0	0	0
Publications and Legal Notices	0	0	0	0	0
Rents & Leases-Land, Structures & Improvements	0	0	0	0	0
Taxes & Licenses	0	0	0	0	0
Drug Screenings & Other Testing	0	0	0	0	0
Utilities	0	0	0	0	0
Other (Specify)	0	0	0	0	0
SUBTOTAL OTHER OPERATING EXPENSES	**0**	**0**	**0**	**0**	**0**
PROFESSIONAL & SPECIAL SERVICES	**0**	0	0	0	**0**
TRANSPORTATION					
Transportation	0	0	0	0	0
Travel	0	0	0	0	0
Gas, Oil, & Maintenance - Vehicles	0	0	0	0	0
Rents & Leases-Vehicles	0	0	0	0	0
Depreciation-Vehicles	0	0	0	0	0
SUBTOTAL TRANSPORTATION	**0**	**0**	**0**	**0**	**0**
TOTAL NONPERSONNEL	**0**	**0**	**0**	**0**	**0**
Indirect Costs	0	0	0	0	0
PROVIDER TOTAL	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
DMC COUNTY ADMINISTRATION TOTAL	$ -		$ -		$ -
OVERALL TOTAL	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
DIRECT COSTS (Only if both NNA and D/MC funding is identified)			0	0	

Data Entry Sheet - FY 2010-11

ODF Group Counseling - Alcohol/Drug

	County Name
	Contractor/Provider Name
	Contract Period
	4-digit DMC Number
	6-digit Provider Number

COST INFORMATION

This form must be completed to provide adequate cost data (refer to 42 CFR 413.24 and 45 CFR 96.30).
The detail of the service provider's costs must be identified on this form in the appropriate cost categories provided below.

Private Pay	Drug Medi-Cal	NNA/Public Funded	
			Personnel Services
			Salary and Wages
			Employee Benefits
			Direct Services
			Clothing and Personal Supplies
			Food
			Laundry Services and Supplies
			Pharmaceutical
			Other
			Equipment, Materials and Supplies
			Depreciation - Equipment
			Maintenance - Equipment
			Medical, Dental and Laboratory Supplies
			Membership Dues
			Rent and Lease Equipment
			Small Tools and Instruments
			Training
			Other
			Operating Expenses
			Communications
			Depreciation - Structures and Improvements
			Household Expenses
			Insurance
			Interest Expense
			Lease Property Maintenance, Structures, Improvements and Grounds
			Maintenance - Structures, Improvements, and Grounds
			Miscellaneous Expense
			Office Expense
			Publications and Legal Notices
			Rents & Leases - Land, Structure, and Improvements
			Taxes and Licenses
			Drug Screening and Other Testing
			Utilities
			Other
			Professional and Special Services
			Professional and Special Services
			Transportation
			Transportation
			Travel
			Gas, Oil, & Maintenance - Vehicles
			Rents & Leases - Vehicles
			Depreciation - Vehicles
			Other Costs
			Indirect Costs
			DMC County Administration
0	*0*	*0*	***Total Costs***
			Direct Costs (only if both NNA and DMC funds are identified)

Data Entry Sheet - FY 2010-11
ODF Group Counseling - Alcohol/Drug

	County Name
	Contractor/Provider Name
	Contract Period
	4-digit DMC Number
	6-digit Provider Number

FEES, INSURANCE, UNIT INFORMATION

Private Pay	Drug Medi-Cal	NNA/Public Funded	
			Participant Fees - Funding Line 84
			Insurance, Medicare and Other Third Party - Funding Line 85

	0		Group Face to Face Visits (Title XIX only in DMC)
	0		Non-Title XIX DMC Units (Group Face to Face Visits)
	0	0	Adjustment for DMC Denied/Adjusted Units
			Group Sessions
			Staff Hours

Drug Medi-Cal Reconciliation of Claims (Units)

Submitted Units	Denied Units	Adjusted Units	
		Utilize the **VOID** or **REPLACE** function in SDMC	Regular Title XIX - Jul 01 through June 30
			Minor Consent non-Title XIX - July 01 through June 30

Revenue from Drug Medi-Cal Units of Service

0	Revenue/Fees (Share of Costs)
0	Insurance

DMC Rate

	Prorated or Usual and Customary Rate
28.69	Statewide Maximum Allowable (SMA) Rate

State/Territory: California

REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES[1]

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~~ usual and customary charge to the general public for providing the same or similar services, the provider's allowable costs of providing ~~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~~ usual and customary charge to the general public for the same or similar services, or the uniform statewide 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 Care Services (DHCS). In no case shall payments exceed SMA.

A. DEFINITIONS

"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, established for each type of service, for a unit of service.

"~~Actual~~ Allowable cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in the Medicare Provider Reimbursement Manual (Centers for Medicare & Medicaid Services, Publication 15-1.)

"Provider of Services" means any private or public agency that provides direct substance abuse treatment 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 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 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

[1] As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services.

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 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.

B. REIMBURSEMENT METHODOLOGY

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

   a. The provider's ~~published or~~ usual and customary charge to the general public for providing the same or similar services;
   b. The provider's allowable costs of providing ~~rendering~~ these services;
   c. The SMA established in Section C below, as defined by ADP and approved by DHCS.

   The above reimbursement limits are 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.

2. The reimbursement methodology for providers of DMC Narcotic Treatment Program services is based on the lower of:

   a. The provider's ~~published or~~ usual and customary charge to the general public for the same or similar services, or
   b. The uniform statewide reimbursement rate established in Section D below, as defined by ADP and approved by DHCS

C. SMA METHODOLOGY FOR DMC OUTPATIENT DRUG FREE TREATMENT, DAY CARE REHABILITATIVE TREATMENT, NALTREXONE TREATMENT, AND PERINATAL RESIDENTIAL SUBSTANCE ABUSE SERVICES

[1] As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services.

"SMA" are based on the statewide median cost of each type of service as reported in the most recently completed 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 REIMBURSEMENT RATE METHODOLOGY FOR DMC NARCOTIC TREATMENT PROGRAMS

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

Dosing is the act of preparing the methadone dose for the client, administering the medication dose to the client, observing that the client has ingested the medication, and recording the amount of methadone administered as federally required of Schedule II substances.

The Dosing Component contains the methadone ingredient cost, the cost in time to administer the dose, and administrative overhead to cover indirect and program administration costs.

E. ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE REIMBURSEMENT RATE METHODOLOGIES

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 to comply with the provisions of the California Welfare and Institutions Code Section 14021.9 which specifies the following as follows:

1. For State FY 2009-10, the reimbursement rates for Drug Medi-Cal services developed by the State Department of Alcohol and Drug Programs will be reduced by 10 percent, effective July 1, 2009.

   For State FY 2009-10, the SMA/uniform statewide reimbursement rates were set as of July 1, 2009, and are effective for services on or after that date. All rates are published through bulletins posted once per year on ADP's website at http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml. The bulletins

[1]As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services.

are titled Drug Medi-Cal Rates for Fiscal Year 20XX-20XX. The bulletin for State FY 2009-10 was posted June 3, 2009.

For State FY 2010-11 and subsequent fiscal years, the reimbursement rates become effective on July 1 of each California State FY. The rate bulletins are posted once per year on ADP's website at least one month before the effective date of the rates. The bulletins are posted on the website location cited in the previous paragraph.

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 by the State Department of Alcohol and Drug Programs through the normal rate-setting methodologies as set forth in Sections C and D, above.

   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.

F. ALLOWABLE SERVICES

Allowable services and units of service are as follows:

Service	Unit of Service
Day Care Rehabilitative Treatment	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 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.

[1]As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services.

Narcotic Treatment Programs
(aggregate rate consisting of four (4) 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. Counseling	Minimum of fifty (50) minutes to be provided and billed in ten (10) minute increments, up to a maximum of 200 minutes based on the medical needs of the patient.

G. REIMBURSEMENT SETTLEMENT PROCESS

1. Providers of DMC services are reimbursed throughout the year for costs of providing approved services, not to exceed the Statewide Maximum Allowance for each service.

2. After the end of the State FY, interim reimbursement adjustments for DMC services are determined from year-end cost reports. DMC providers that have received payments for claims are required to submit cost reports to ADP by November after the end of each State FY. From the cost report information, ADP determines the allowable costs, if the claims were properly paid, and the amount each claim should have been reimbursed. The provider is either invoiced for the amount due or paid

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State/Territory: California

an additional amount. This interim settlement process is completed by December of the following year.

3. On a continuous basis, ADP conducts financial compliance audits of DMC providers to assure that reimbursements are made as intended, are in accordance with applicable Medicaid requirements, and are for allowable costs. The final settlement, which is the permanent reimbursement settlement between ADP and the provider, is determined by ADP's financial compliance audit and is completed within three years from the date of ADP's interim settlement. If the audit is not completed within three years from the date of the interim settlement with ADP, then the interim settlement is considered as the final settlement.

[1]As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services.

REIMBURSEMENT FOR DRUG MEDI-CAL SERVICES[1]

The policy of the State Agency is that reimbursement for Drug Medi-Cal (DMC) services shall be limited to the lowest of the provider's usual and customary charge to the general public for providing the same or similar services, the provider's allowable costs of providing these services, or the Statewide Maximum Allowances (SMA). For Narcotic Treatment Programs, reimbursement is limited to the lower of the provider's usual and customary charge to the general public for the same or similar services, or the uniform statewide 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 Care Services (DHCS). In no case shall payments exceed SMA.

A. DEFINITIONS

"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, established for each type of service, for a unit of service.

"Allowable cost" is reasonable and allowable cost, based on year-end cost reports and Medicare principles of reimbursement as described at 42 CFR Part 413 and in the Medicare Provider Reimbursement Manual (Centers for Medicare & Medicaid Services, Publication 15-1.)

"Provider of Services" means any private or public agency that provides direct substance abuse treatment 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 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 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,

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and the contact shall clearly be documented in the beneficiary's patient record. For Narcotic Treatment Program 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.

B. REIMBURSEMENT METHODOLOGY

1. The reimbursement methodology for providers of DMC Outpatient Drug Free, Day Care Rehabilitative, Perinatal Residential Substance Abuse Services, and Naltrexone Treatment program services, is based on 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. The SMA established in Section C below, as defined by ADP and approved by DHCS.

   The above reimbursement limits are 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.

2. The reimbursement methodology for providers of DMC Narcotic Treatment Program services is based on the lower of:

   a. The provider's usual and customary charge to the general public for the same or similar services, or
   b. The uniform statewide reimbursement rate established in Section D below, as defined by ADP and approved by DHCS

C. SMA METHODOLOGY FOR DMC OUTPATIENT DRUG FREE TREATMENT, DAY CARE REHABILITATIVE TREATMENT, NALTREXONE TREATMENT, AND PERINATAL RESIDENTIAL SUBSTANCE ABUSE SERVICES

[1]As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services.

"SMA" are based on the statewide median cost of each type of service as reported in the most recently completed year-end cost reports submitted by providers.

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

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

Dosing is the act of preparing the methadone dose for the client, administering the medication dose to the client, observing that the client has ingested the medication, and recording the amount of methadone administered as federally required of Schedule II substances.

The Dosing Component contains the methadone ingredient cost, the cost in time to administer the dose, and administrative overhead to cover indirect and program administration costs.

E. ONGOING CHANGES TO SMA AND UNIFORM STATEWIDE REIMBURSEMENT RATE METHODOLOGIES

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:

1. For State FY 2009-10, the reimbursement rates for Drug Medi-Cal services developed by the State Department of Alcohol and Drug Programs will be reduced by 10 percent, effective July 1, 2009.

   For State FY 2009-10, the SMA/uniform statewide reimbursement rates were set as of July 1, 2009, and are effective for services on or after that date. All rates are published through bulletins posted once per year on ADP's website at http://www.adp.ca.gov/ADPLTRS/bulletin_letter.shtml. The bulletins are titled Drug Medi-Cal Rates for Fiscal Year 20XX-20XX. The bulletin for State FY 2009-10 was posted June 3, 2009.

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For State FY 2010-11 and subsequent fiscal years, the reimbursement rates become effective on July 1 of each California State FY. The rate bulletins are posted once per year on ADP's website at least one month before the effective date of the rates. The bulletins are posted on the website location cited in the previous paragraph.

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 by the State Department of Alcohol and Drug Programs through the normal rate-setting methodologies as set forth in Sections C and D, above.

   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.

F. ALLOWABLE SERVICES

Allowable services and units of service are as follows:

Service	Unit of Service
Day Care Rehabilitative Treatment	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 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.

[1]As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services.

State/Territory: California

Narcotic Treatment Programs
(aggregate rate consisting of four (4) 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. Counseling	Minimum of fifty (50) minutes to be provided and billed in ten (10) minute increments, up to a maximum of 200 minutes based on the medical needs of the patient.

G. REIMBURSEMENT SETTLEMENT PROCESS

1. Providers of DMC services are reimbursed throughout the year for costs of providing approved services, not to exceed the Statewide Maximum Allowance for each service.

2. After the end of the State FY, interim reimbursement adjustments for DMC services are determined from year-end cost reports. DMC providers that have received payments for claims are required to submit cost reports to ADP by November after the end of each State FY. From the cost report information, ADP determines the allowable costs, if the claims were properly paid, and the amount each claim should have been reimbursed. The provider is either invoiced for the amount due or paid

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an additional amount. This interim settlement process is completed by December of the following year.

3. On a continuous basis, ADP conducts financial compliance audits of DMC providers to assure that reimbursements are made as intended, are in accordance with applicable Medicaid requirements, and are for allowable costs. The final settlement, which is the permanent reimbursement settlement between ADP and the provider, is determined by ADP's financial compliance audit and is completed within three years from the date of ADP's interim settlement. If the audit is not completed within three years from the date of the interim settlement with ADP, then the interim settlement is considered as the final settlement.

[1]As of July 1, 2012, all references to the State Department of Alcohol and Drug Programs will change to the Department of Health Care Services