



TOBY DOUGLAS  
Director

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



EDMUND G. BROWN JR.  
Governor

APR 18 2012

Gloria Nagle, Ph.D., M.P.A.  
Associate Regional Administrator  
Division of Medicaid & Children's Health Operations  
Centers for Medicare & Medicaid Services  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706

STATE PLAN AMENDMENT 10-020: MEDICAL REIMBURSEMENT FOR  
RADIOLOGY SERVICES

Dear Ms. Nagle:

This letter and the enclosed State Plan Amendment (SPA) are the California Department of Health Care Services' (DHCS) responses to the Request for Additional Information (RAI) dated March 4, 2011, concerning SPA 10-020. This letter and the attached amendments address the questions and concerns expressed by the Centers for Medicare and Medicaid Services (CMS).

The following are DHCS' responses to the RAI dated March 4, 2011:

**General Questions**

1) The fiscal budget impact in Box 7 of the HCFA 179 form (FFY 2011: - \$27.46 million, FFY 2012: -\$24.17 million) does not appear to agree with the State's February 24, 2011 response to CMS informal questions (FFY 2011: - \$28,327,657, FFY 2012: -\$24,931,930). Please clarify whether a pen and ink change is necessary to reflect the calculation in the February 24, 2011 response.

**State Response:** A pen and ink change is necessary to reflect the revised fiscal budget impact calculations. See pen and ink changes on the HCFA 179 form.

2) The February 24<sup>th</sup> response to the CMS informal comments includes the portion of the State's register that provided public notice for CA 10-020. It has been noted that the State register did not provided an estimate of the cost/savings that would result from implementation of this SPA. Were there

any documents on display which furnished the above referenced estimation of cost/savings resulting from implementation of this SPA? If so, please provide those documents.

**State Response:** DHCS' May 2010 Medi-Cal Estimates document references the estimation of cost/savings resulting from implementation of this SPA. A copy of the relevant page is enclosed.

**3) Page 3d of Attachment 4.19-B, Paragraph 5: Please change the state plan reference for "80% of the lowest maximum allowance for California established by the Federal Medicare Program" to "80% of the lowest maximum allowance for California established by the current Federal Medicare program."**

**State Response:** See Page 3d of Attachment 4.19-B, Paragraph 5, for change to language as requested.

**4) The February 24<sup>th</sup> response to the CMS informal comments indicates that providers of radiology services can receive between 1% and 80% of the lowest maximum allowance for California. 42 CFR 430.10 and section 1902(a) of the Social Security Act require that State plan language be clear, auditable and unambiguous. The referenced language, as currently structured, would not comport with the above referenced regulation and statute as it allows for a wide fluctuations in payment. Please revise this language to create a fixed amount of reimbursement for this service.**

**State Response:** This SPA will only reduce Radiology rates that are currently above 80% of the Medicare rate, to 80% of the current Medicare rate. This SPA will not make rate adjustments to those services that are currently at or below 80% of the Medicare rate. Rates for radiology services will be the same for all providers who render these services.

#### **Access Questions**

**The February 24<sup>th</sup> response to the CMS informal comments indicates that the State does not anticipate that the rate reduction to radiology services will have an impact on access to care, yet the State also indicates that it is in the process of conducting a study on access to care. Therefore, various questions regarding access to care have been restated below and should be addressed when the State has conclusive evidence regarding reductions proposed by this SPA and any impact to patient access and quality of care.**

**1) How will the proposed service rate reductions in SPA 10-020 allow the State to comply with requirements of Section 1902(a) (30) of the Act?**

**State Response:** SPA 10-020 reduces only those Radiology rates that are currently in excess of 80% of Medicare rates to 80% of the current

Medicare rates. The impact of these reductions is anticipated to be minimal because the amendment to the reimbursement methodology emulates the reimbursement methodology under Medicare for the same services.

It is also important to note that radiology services rates have not been updated for some time. Due to technological advances, it is likely that the actual costs to provide these services are much less today than when the rates were initially established. In some instances, the State may currently be overpaying for radiology services. Adjusting the rates to reflect 80% of Medicare rates will allow for these necessary adjustments and help to correct these reimbursement rate discrepancies.

For additional information, see Attachment 4.1B-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services."

**2) How did the State determine that the proposed service rate reductions in SPA 10-020 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?**

**State Response:** DHCS recently conducted a comprehensive analysis of services provided by physicians, outpatient clinics and hospital outpatient departments. The purpose of this analysis was to determine current physician participation in Medi-Cal, and establish a baseline utilization of physicians' services, including Radiology services, at various healthcare access points.

This analysis is published at:

<http://www.dhcs.ca.gov/Documents/Rate%20Reductions/Physician%20Clinic%20Medi-Cal%20Access%20Analysis.pdf>.

To ensure that the rate reductions comply with the requirements of Section 1902(a)(30) of the Act, DHCS will monitor the impact of the payment reductions as follows:

- Conduct annual audits of paid claims data for radiology services and compare the results with data from prior years when the rate reduction was not in effect to identify changes in provider participation, and
- Continue to monitor recipient and provider inquiries/complaints relating to the rate reductions. Data showing a negative change in utilization of services or provider participation will be evaluated as well as inquiries/complaints received by recipients where access is the stated issue to determine the best course of action.

For additional information, see Attachment 4.1B-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services."

**3) What data did the State rely on to assure that access would not be negatively impacted by the proposed service rate reductions in SPA 10-020 (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)?**

**State Response:** DHCS relied on the following data to assure that access would not be negatively impacted: comparison of Medi-Cal to Medicare rates; utilization of radiology services (total and per beneficiary) and radiology provider participation (by county) over the past 5 years.

DHCS analyzed the utilization of services per 1000 member months by geographic area and sub-population over a three-year period. The results of the study suggests that the utilization of radiology services for adults and children has showed a significant upward trend over time, both statewide and in the two county groups. There is nothing in the analysis to indicate there is any access issue for radiology services for adults and children in the Medi-Cal program.

For additional information, see Attachment 4.1B-F, entitled "Monitoring Access to Medi-Cal Covered Healthcare Services."

**4) How were providers, advocates and beneficiaries engaged in the discussion related to the proposed service rate reductions in SPA 10-020? What were their concerns, and how did the State address these concerns?**

**State Response:** Providers, advocates, and beneficiaries were informed of the proposed Radiology rate reductions through Provider Bulletins, a Public Notice published in the California Regulatory Notice Register, a Tribal Notification, and Legislative hearings.

DHCS received two Public Records Act requests and two contacts from the public. Concerns included requests for the list of codes subject to the rate reduction and the proposed rates, which were provided. Also requested was information on any studies that DHCS has conducted related to the proposed Radiology rate reduction. As noted above, these studies are now available to the public.

**5) The State's responses to access questions #13 and #14 on February 24, 2011 indicates that the payment reduction will not be implemented until the rate/access study is completed; however, the proposed effective date for the SPA is October 1, 2010. Please confirm if the State intended to apply the rate reduction to radiology services retroactively back to October 1, 2010 upon the completion of the rate/access study.**

**State Response:** Upon approval of the rate/access study and approval of SPA 10-020, DHCS intends to apply the rate reduction to radiology services retroactive to October 1, 2010. Overpayments made to providers will be recouped and the federal share of the recoupments will be returned.

### **Standard Funding Questions**

The February 24<sup>th</sup> response to the CMS informal comments indicate that the State was in process of researching responses for the following standard funding questions. As such, these questions have been restated below. These 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 of payment for clinic or outpatient hospital services or for enhanced or supplemental payments to physicians or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1) 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 ICTs, 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).**

**State Response:** Appropriation is made annually to DHCS through the Governor's budget (as approved by the Legislature) for the services provided. For the services that this SPA addresses, intergovernmental transfers, provider taxes, or any other mechanism used by states to provide the non-federal share, are not used. In addition to the rate of payment, public hospitals' uncompensated care costs associated with outpatient hospital services are used to claim federal reimbursement [Federal Financial Participation (FFP)] based on certified public expenditures (CPEs), as authorized under AB 915 (2002). Therefore, the outpatient hospital services rendered by the public hospitals are considered fully reimbursed.

**2) 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.**

**State Response:** California has implemented the following supplemental payment programs for services provided in an outpatient setting: Outpatient Disproportionate Share Hospitals, AB 915 Payments, and Outpatient Small and Rural Hospitals. Each is defined in California's State Plan.

Outpatient Disproportionate Share Hospitals is defined in Attachment 4.19-A, beginning on page 18, entitled "Increase in Medicaid Payment Amounts for California Disproportionate Share Hospitals." Assembly Bill 915 Payments are defined in Attachment 4.19-B, beginning on page 46, entitled "Supplemental Reimbursement for Public Outpatient Hospital Services." Supplemental Reimbursement for Outpatient Small and Rural Hospitals is specified in California Code of Regulations, Title 21, Section 51509.

The total amounts paid for Outpatient Disproportionate Share Hospitals, Assembly Bill 915 Payments, and Outpatient Small and Rural Hospitals is for fiscal year July 1, 2009, through June 30, 2010 and is as follows:

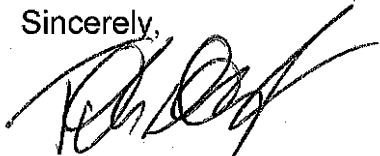
▪ Outpatient Disproportionate Share Hospitals.....	\$ 10,000,000
▪ Assembly Bill 915 Payments.....	\$ 329,227,356*
▪ Outpatient Small and Rural Hospitals.....	\$ 8,000,000

\* Total funds expenditures by the counties on which the claim for FFP is based.

Ms. Nagle  
Page 7

If you have any questions regarding this SPA or the responses to the RAI, please contact Mr. Timothy Matsumoto, Acting Chief, Fee-for-Service Rates Development, at (916) 552-9400.

Sincerely,



Toby Douglas  
Director

Enclosures: 1. HCFA 179 Form  
2. May 2010 Medi-Cal Estimate  
3. Attachment 4.19-B Pages 3c, 3d and 3f

cc: Timothy Matsumoto, Acting Chief  
Fee-for-Service Rates Development  
1501 Capitol Avenue, MS 4600  
Sacramento, CA 95814

## REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 191  
 IMPLEMENTATION DATE: 10/2010  
 ANALYST: Davonna McClendon  
 FISCAL REFERENCE NUMBER: 1505

	<u>FY 2009-10</u>	<u>FY 2010-11</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$36,248,000
- STATE FUNDS	\$0	-\$18,124,000
PAYMENT LAG	1.0000	0.7515
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$27,240,400
STATE FUNDS	\$0	-\$13,620,180
FEDERAL FUNDS	\$0	-\$13,620,190

### DESCRIPTION

The Department is proposing legislation to reduce Medi-Cal rates for radiology services to 80 percent of Medicare rates, effective October 1, 2010.

#### Assumptions:

1. Implementation will begin with dates of service on or after October 1, 2010.
2. The rate reductions will apply to radiology services that currently have reimbursement rates exceeding 80 percent of Medicare rates.
3. Based on FY 2008-09 data, the rate reductions will result in an annual fee-for-service savings of \$48,330,000. There is no managed care impact as a result of this reduction, because managed care capitation rates are calculated using radiology rates that are at or below 80 percent of Medicare rates.

$$\$48,330,000 \times 75\% = \$36,248,000 \text{ FY 2010-11 Savings}$$

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 10-020	2. STATE California
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE October, 1, 2010	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		

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 435.831	7. FEDERAL BUDGET IMPACT: a. FFY 2011: <del>\$27.46 million (savings)</del> b. FFY 2012: <del>\$24.17 million (savings)</del> <b>a. FFY 2011: -\$23 Million (Savings)</b> <b>b. FFY 2012: -\$20.3 Million (Savings)</b>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19B - Amend pages 3a, 3d and 3f	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 4.19B, pages 3a, 3d and 3f

Pen & Ink Change

10. SUBJECT OF AMENDMENT:  
  
Medi-Cal Reimbursement Methodology for Radiology Services

11. GOVERNOR'S REVIEW (Check One):

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Governor's Office does not wish to Review  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      State Plan Amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:
13. TYPED NAME: Toby Douglas	
14. TITLE: Chief Deputy Director, Health Care Programs	
15. DATE SUBMITTED: 12-22-2010	

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:

REIMBURSEMENT METHODOLOGY FOR ESTABLISHING  
REIMBURSEMENT RATES FOR DURABLE MEDICAL EQUIPMENT,  
ORTHOTIC AND PROSTHETIC APPLIANCES, LABORATORY,  
AND RADIOLOGY SERVICES

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1. The methodology utilized by the State Agency in establishing reimbursement rates for durable medical equipment as described in State Plan Attachment 3.1-A, paragraph 2a, entitled “Hospital Outpatient Department Services and Organized Outpatient Clinic Services”, and Paragraph 7c.2, entitled “Home Health Services Durable Medical Equipment”, will be as follows:
  - (a) Reimbursement for the rental or purchase of durable medical equipment with a specified maximum allowable rate established by Medicare, except wheelchairs, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, shall be the lesser of the following:
    - (1) The amount billed in accordance with California Code of Regulations, Title 22, section 51008.1, entitled “Upper Billing Limit”, that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public or the net purchase price of the item (as documented in the provider’s books and records), plus no more than a 100 percent mark-up. (Refer to Reimbursement Methodology table at page 3e.)
    - (2) An amount that does not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item or service. (Refer to Reimbursement Methodology Table at page 3e.)
  - (b) Reimbursement for the rental or purchase of a wheelchair, wheelchair accessories, wheelchair replacement parts, and speech-generating devices and related accessories, with a specified maximum allowable rate established by Medicare shall be the lowest of the following:
    - (1) The amount billed in accordance with California Code of Regulations, Title 22, Section 51008.1 entitled “Upper Billing Limit”, that states that bills submitted shall not exceed an amount that is the lesser of the usual charges made to the general public, or the net purchase price of the item (as documented in the provider’s books and records),

schedule and any annual or periodic adjustments to the fee schedule are published in the provider manual and on the California Department of Health Services Medi-Cal website.

3. Reimbursement rates for orthotic and prosthetic appliances as described in State Plan Attachment 3.1-A, paragraph 12c, entitled “Prosthetic and Orthotic Appliances,” shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar item. (Refer to Reimbursement Methodology Table at page 3f.)
4. Reimbursement rates for clinical laboratory or laboratory services as described in State Plan Attachment 3.1-A, paragraph 3, entitled “Laboratory, Radiological, and Radioisotope Services,” shall not exceed 80 percent of the lowest maximum allowance for California established by the federal Medicare program for the same or similar service. (Refer to Reimbursement Methodology Table at page 3f.)
5. Reimbursement rates for radiology services as described in State Plan Attachment 3.1-A, paragraph 3, entitled “Laboratory, Radiological, and Radioisotope Services,” shall not exceed 80 percent of the lowest maximum allowance for California established by the current federal Medicare program for the same or similar service. (Refer to Reimbursement Methodology Table at page 3f.)

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TN No. 10-020

Supersedes

TN No. 06-015

Approval Date \_\_\_\_\_

Effective Date OCT 01 2010

**Reimbursement Methodology Table**

Paragraph	Effective Date	Percentage	Authority
1(d)(3)	January 1, 2004	The manufacturer's suggested retail purchase price reduced by a percentage discount of 20%, or by 15% if the provider employs or contracts with a qualified rehabilitation professional	California Welfare and Institutions Code section 14105.48
1(e)(2)	October 1, 2003	The acquisition cost plus a 23% markup	California Welfare and Institutions Code section 14105.48
3	October 1, 2003	May not exceed 80% of the lowest maximum allowance for California established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.21
4	October 1, 2003	May not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.22
5	October 1, 2010	May not exceed 80% of the lowest maximum allowance established by the federal Medicare program for the same or similar services	California Welfare and Institutions Code section 14105.08



Region IX  
Division of Medicaid & Children's Health Operations  
90 Seventh Street, Suite 5-300 (5W)  
San Francisco, CA 94103-6706

MAR 4 2011

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

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-B of your State Medicaid plan submitted to the Centers for Medicare & Medicaid Services (CMS) on December 22, 2010, under State Plan Amendment (SPA) 10-020. This SPA, with a proposed effective date of October 1, 2010, updates the Medi-Cal reimbursement rate methodology for Radiology Services. Before we can continue processing this amendment, we need additional or clarifying information. Therefore, we are requesting the following additional information (RAI) pursuant to Section 1915(f)(2) of the Social Security Act (the Act).

#### General Questions

- 1) The fiscal budget impact in Box 7 of the HCFA 179 form (FFY 2011: -\$27.46 million, FFY 2012: -\$24.17 million) does not appear to agree with the State's February 24, 2011 response to CMS informal questions (FFY 2011: -\$28,327,657, FFY 2012: -\$24,931,930). Please clarify whether a pen and ink change is necessary to reflect the calculation in the February 24, 2011 response.
- 2) The February 24<sup>th</sup> response to the CMS informal comments includes the portion of the State's register that provided public notice for CA 10-020. It has been noted that the State register did not provide an estimate of the cost/savings that would result from implementation of this SPA. Were there any documents on display which furnished the above referenced estimation of cost/savings resulting from implementation of this SPA? If so, please provide those documents.
- 3) Page 3d of Attachment 4.19-B, Paragraph 5: Please change the State plan reference for "80% of the lowest maximum allowance for California established by the Federal Medicare program" to "80% of the lowest maximum allowance for California established by the current Federal Medicare program."
- 4) The February 24<sup>th</sup> response to the CMS informal comments indicates that providers of radiology services can receive between 1% and 80 % of the lowest maximum allowance for California. 42 CFR 430.10 and section 1902(a) of the Social Security Act require that State plan language be clear, auditable and unambiguous. The referenced language, as currently structured, would not comport with the above

referenced regulation and statute as it allows for a wide fluctuations in payment. Please revise this language to create a fixed amount of reimbursement for this service.

### **Access Questions**

The February 24<sup>th</sup> response to the CMS informal comments indicates that the State does not anticipate that the rate reduction to radiology services will have an impact on access to care, yet the State also indicates that it is in the process of conducting a study on access to care. Therefore, various questions regarding access to care have been restated below and should be addressed when the State has conclusive evidence regarding reductions proposed by this SPA and any impact to patient access and quality of care.

- 1) How will the proposed service rate reductions in SPA 10-020 allow the State to comply with requirements of Section 1902(a)(30) of the Act?
- 2) How did the State determine that the proposed service rate reductions in SPA 10-020 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?
- 3) What data did the State rely on to assure that access would not be negatively impacted by the proposed service rate reductions in SPA 10-020 (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)?
- 4) How were providers, advocates and beneficiaries engaged in the discussion related to the proposed service rate reductions in SPA 10-020? What were their concerns, and how did the State address these concerns?
- 5) The State's responses to access questions # 13 and #14 on February 24, 2011 indicates that the payment reduction will not be implemented until the rate/access study is completed; however, the proposed effective date for the SPA is October, 1, 2010. Please confirm if the State intended to apply the rate reduction to radiology services retroactively back to October 1, 2010 upon the completion of the rate/access study.

### **Standard Funding Questions**

The February 24<sup>th</sup> response to the CMS informal comments indicate that the State was in process of researching responses for the following standard funding questions. As such, these questions have been restated below. These questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

- 1) Section 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 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).
  
- 2) 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.


We are requesting this additional clarifying information under provisions of Section 1915(f) of the Social Security Act (added by P.L. 97-35). This has the effect of stopping the 90-day clock with respect to CMS taking further action on this State plan submittal. A new 90-day clock will not begin until we receive your response to this request for additional information.

In accordance with our guidelines to all State Medicaid Directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, will initiate disapproval action on the amendment.

Page 4 – Toby Douglas, Director

If you have any questions, please contact Kristin Curran at (415) 744-3579 or via email at Kristin.Curran@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Gloria Nagle". The signature is fluid and cursive, with the first name "Gloria" written in a larger, more prominent script than the last name "Nagle".

Gloria Nagle

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Cc: Linda Machado, California Department of Health Care Services  
Vickie Orlich, California Department of Health Care Services  
Christopher Thompson, Centers for Medicare and Medicaid Services  
Kathryn Waje, California Department of Health Care Services