DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

October 28, 2015

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

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 15-013. SPA CA-15-013 was submitted to my office on April 20, 2015. This SPA modifies the cost report used for the Drug Medi-Cal Program and ensures the state-developed cost report is in a format that meets CMS's reimbursement requirements for cost-based methodology. The SPA also rescinds the prohibition on receiving Federal Financial Participation (FFP) after 6/30/15 that was imposed by SPA 09-022.

The effective date of this SPA is July 1, 2015. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 4.19-B, pages 41a and 41c

If you have any questions, please contact Cheryl Young by phone at (415) 744-3598 or by email at cheryl.young@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Nathaniel Emery, California Department of Health Care Services (DHCS)
Sandy Yien, CA DHCS

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: **15-013**

2. STATE: CA

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, 2015

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 440.130

7. FEDERAL BUDGET IMPACT:
a. FFY 15 $0
b. FFY 16 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, page 41a
Attachment 4.19-B, page 41c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, page 41a
Attachment 4.19-B, page 41c

10. SUBJECT OF AMENDMENT:
Amends Drug Medi-Cal cost report to be approved by the Centers for Medicare and Medicaid Services.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
ORIGINAL SIGNED

13. TYPED NAME:
ORIGINAL SIGNED

14. TITLE:
Director

15. DATE SUBMITTED:

16. RETURN TO:

Department of Health Care Services
Nathaniel Emery
State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
ORIGINAL SIGNED

21. TYPED NAME:
ORIGINAL SIGNED

22. TITLE:

23. REMARKS:
ORIGINAL SIGNED

State/Territory: California

a. SMA METHODOLOGY FOR NON-NTP SERVICES

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

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

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

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

2. Cost Determination Protocol

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

State/Territory: California

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

1. Final Settlement Process

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