

ENCLOSURE

Revised Pages for:
CALIFORNIA MEDICAID STATE PLAN
Under Transmittal of
STATE PLAN AMENDMENT (SPA)

09-015*

All new pages will have this SPA* number identified as the new TN No., so it will not be repeated for each new insert pages.

Remove Page(s)	Insert Page (s)
Attachment 4.19-B, pages 6B, 6B1, 6C (TN 05-006)	Attachment 4.19-B, pages 6B, 6B1, 6C



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

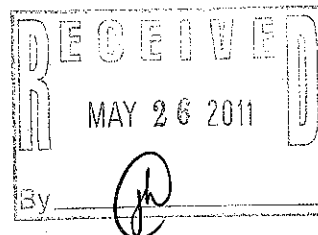
Region IX

Division of Medicaid & Children's Health Operations

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

San Francisco, CA 94103-6706

MAY 23 2011



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

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 09-015. This SPA was submitted to my office on July 30, 2009 requesting to amend the State Plan to exclude coverage of optional benefits to Federally Qualified Health Centers (FHHCs) and Rural Health Centers (RHCs).

This effective date of this SPA is July 1, 2009. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 4.19-B, pages 6B, 6B.1, and 6C

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

Sincerely,

Gloria Nagle, Ph.D., MPA

Associate Regional Administrator

Division of Medicaid & Children's Health Operations

Enclosure

cc: Janice Spitzer, California Department of Health Care Services

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL	1. TRANSMITTAL NUMBER: 09-015	2. STATE California
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION	4. PROPOSED EFFECTIVE DATE July 01, 2009	
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

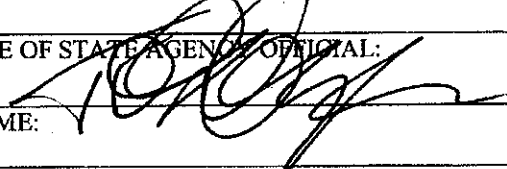
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Section 491.2 & 2 CFR 440.20	7. FEDERAL BUDGET IMPACT: a. FFY 2009-2010 \$0 \$ -130,058,000 (Reduction) b. FFY 2010-2011 \$0 \$ -150,393,000 (Reduction)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19B, Pages 6B, 6B.1, 6C	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19B, Pages 6B, 6C

10. SUBJECT OF AMENDMENT:
Reduction in optional benefits for Federally Qualified Health Centers and Rural Health Clinics

11. GOVERNOR'S REVIEW (Check One):


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

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Department of Health Care Services Attn: State Plan Coordinator 1501 Capitol Avenue, Suite 71.3.26 P.O. Box 997417 Sacramento, CA 95899-7417
13. TYPED NAME: Toby Douglas	
14. TITLE: Chief Deputy Director	
15. DATE SUBMITTED: 7/30/09	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 7/30/09	18. DATE APPROVED: MAY 23 2011
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/09	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Gloria Nagle	22. TITLE: Associate Regional Administrator

23. REMARKS:

Pen and ink change to Box 6 confirmed via emails dated 4/22/11 and 4/28/11.

Pen and ink changes to Box 7 confirmed via email dated 4/28/11.

costs directly attributable to the operation of the RHC site, and do not include inpatient hospital costs that have been, or should have been, included in the hospital cost reports.

If subsequent to the approval of this State Plan Amendment, an RHC receives provider-based designation and RHC certification under Medicare from CMS as a "provider-based RHC", pursuant to 42 CFR Part 413.65, the RHC may apply to DHCS for Medi-Cal provider-based RHC reimbursement status pursuant to 42 CFR Part 491.3. Upon verification of such status, the RHC will be paid under the new facility's rate setting methodology (Section J), as appropriately adjusted in accordance with its RHC provider-based status.

6. An FQHC or RHC may elect to have pharmacy services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. An FQHC or RHC that elects to have pharmacy services reimbursed on a fee-for-service basis will not have its reimbursement rate for those services converted to a fee-for-service basis until the FQHC or RHC completes a scope-of-service rate change request and the adjustment to the prospective payment system reimbursement rate has been completed. An FQHC or RHC that reverses its election under this provision will revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period adjusted for any increase or decrease associated with an applicable scope-of-service change as provided in Section K.

B. FQHCs and RHCs Eligible for Reimbursement Under This Amendment

FQHCs and RHCs eligible for prospective or alternative payment reimbursement are those defined as a "Federally Qualified Health Center" or "Rural Health Clinic" in Section 1905(1)(2)(B), and Section 1905(1)(1), respectively, of the Act.

C. Services Eligible for Reimbursement Under This Amendment

1. (a) Services eligible for prospective or alternative payment reimbursement are covered benefits described in Section 1905(a)(2)(C) of the Act that are furnished by an FQHC and services described in Section 1905(a)(2)(B) of the Act that are furnished by an RHC. The services furnished will be reported to DHCS annually, in a format prescribed by DHCS.

- (b) Optional services that are furnished by an FQHC and RHC within the scope of subparagraph C.1(a), or any other provision of this State Plan, are covered only to the extent that they are identified in the state plan segments entitled, "Limitations on Attachment 3.1-A" and "Limitations on Attachment 3.1-B" on pages 3 through 3e, effective July 1, 2009.
2. A "visit" for purposes of reimbursing FQHC or RHC services includes any of the following:
- (a) A face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse

TN No. 09-015
Supersedes
TN No. None

Approval Date MAY 23 2011

Effective Date 07/01/09

midwife, clinical psychologist, licensed clinical social worker, or visiting nurse, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits under C.1.(a). For purposes of this subparagraph 2(a), "physician" includes the following:

- (i) A doctor of medicine or osteopathy licensed by the State to practice medicine and/or surgery and who is acting within the scope of his/her license.
- (ii) A doctor of podiatry licensed by the State to practice podiatric medicine and who is acting within the scope of his/her license.
- (iii) A doctor of optometry licensed by the State to practice optometry and who is acting within the scope of his/her license.
- (iv) A chiropractor licensed by the State in the practice of chiropractic and who is acting within the scope of his/her license.
- (v) A doctor of dental surgery (dentist) licensed by the State to practice dentistry and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

- (b) Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner as defined in the California Code of Regulations, title 22, Section 51179.7
- (c) Adult Day Health Care (ADHC) services when all of the following requirements are met:
 - (i) ADHC services are provided pursuant to the requirements of the California Code of Regulations, title 22, chapter 5, articles 1 through 5 (commencing with Section 54001, including Section 54113, which requires four or more hours of ADHC services per day be provided).