DHCS
TOBY DOUGLAS
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

SEP 2 0 2012

Gloria Nagle, PhD, MPA
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:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 12-024 and is requesting to split the SPA into 12-024A, 12-024B and 12-024C.

SPA 12-024A changes the reimbursement methodology for Non-Designated Public Hospitals (NDPHs) to a Certified Public Expenditure (CPE) methodology.

SPA 12-024B discontinues the supplemental reimbursement program for inpatient hospital services for NDPHs.

SPA 12-024C will add NDPHs to the existing State Plan supplemental payment program that will allow them to obtain reimbursement for the uncompensated costs of providing physician and non-physician practitioner professional services to Medi-Cal beneficiaries.

California Assembly Bill (AB) 1467 (Chapter 23, Statutes of 2012) authorized the change in reimbursement methodology to a CPE methodology in State law. Additionally AB 1467 eliminated supplemental payments under the NDPH IGT program established by AB 113 (Chapter 20, Statutes of 2011).

The Department is seeking approval of SPAs 12-024A, 12-024B and 12-024C to implement the changes approved in State law. We are requesting that these SPAs be approved concurrently, in conjunction with the proposed Bridge to Reform Waiver Amendment that the Department submitted to CMS on June 28, 2012.

(Continue Next Page)

If you or your staff have questions or need additional information, please contact Mrs. Pilar Williams, Chief of Safety Net Financing Division, at (916) 552-9130.

Sincerely,

Toby Douglas
Director

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: **12-024A**

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, 2012

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 C
42 CFR 433.51

7. FEDERAL BUDGET IMPACT:
a. FFY 12/13 $18,030
b. FFY 13/14 $25,090

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19 – A, page 46-51
Appendix 1 to Attachment 4.19 – A, page 1-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 – A, page 46-51
Appendix 1 to Attachment 4.19 – A, page 1

10. SUBJECT OF AMENDMENT:
Non-Designated Public Hospitals Reimbursement Methodology to Certified Public Expenditure

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:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED: SEP 2 0 2012

16. RETURN TO:

Department of Health Care Services
Attn: 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:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO SPECIFIED GOVERNMENT-OPERATED HOSPITALS AND NON-DESIGNATED PUBLIC HOSPITALS FOR INPATIENT HOSPITAL SERVICES

Notwithstanding any other provision of this State Plan, reimbursement for the costs of inpatient hospital services described in this segment of Attachment 4.19-A that are provided to Medi-Cal beneficiaries by government-operated hospitals and non-designated public hospitals meeting the requirements below will be governed by this segment of Attachment 4.19-A.

A. Eligible Hospitals

1. Hospitals eligible for reimbursement under this segment of Attachment 4.19-A are government-operated hospitals and non-designated public hospitals specified in Appendix 1 to this Attachment 4.19-A, and any other government-operated hospitals and non-designated public hospitals receiving approval of the Centers for Medicare & Medicaid Services.

B. General Reimbursement Requirements

1. Except as provided in subparagraphs B.2 and B.3, below, payments to eligible hospitals for inpatient hospital services rendered to Medi-Cal beneficiaries, exclusive of psychiatric services and professional services, will be determined on a cost basis in accordance with this segment of Attachment 4.19-A.

2. Eligible hospitals may receive payments for specified inpatient hospital services that are paid independent of the cost-based payments specified in subparagraph B.1. Services to be paid pursuant to this subparagraph B.2 will be determined by the State. Such payments will be appropriately offset against the hospital's costs pursuant to subparagraph C.1.d, subparagraph D.3, and subparagraph E.4.

3. Government-operated hospitals may receive supplemental payments for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code section 14085.5. Government-operated and non-designated public hospitals may also receive supplemental payments for disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment.

4. The hospital's Medi-Cal 2552-96 cost report will be the basis for determining the reimbursable costs under this segment of Attachment 4.19-A.

   a. The term "finalized Medi-Cal 2552-96 cost report" refers to the cost report that is settled by the California Department of Health Care Services, Audits and Investigations (A&I) Division with the issuance of a Report On The Cost Report Review (Audit Report).

   b. The term "filed Medi-Cal 2552-96 cost report" refers to the cost report that is submitted by the hospital to A&I and is due five months after the end of the cost reporting period.

   c. Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics, such as relative value units, in the cost report apportionment process) may also use alternative statistics as a substitute for charges in the apportionment processes described in this segment of Attachment 4.19-A. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

5. Nothing in this segment of Attachment 4.19-A shall be construed to eliminate or otherwise limit a hospital's right to pursue all administrative and judicial review available under the Medicaid program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

C. Interim Per Diem Rates

For each eligible hospital, an interim per diem rate will be computed on an annual basis using the following methodology:

1. Using the most recently filed Medi-Cal 2552-96 cost report, the cost apportionment process as prescribed in the Worksheet D series will be applied to arrive at the total Medicaid non-psychiatric inpatient hospital cost.

   a. On the Medi-Cal 2552-96 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26. If the costs have been removed, the allowable interns and residents costs will be added back to each affected cost center prior to the computation of cost-to-charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) for the Worksheet C computation of cost-to-charge ratios. Only those allowable interns and residents costs that

are consistent with Medicare cost principles will be added back. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as Graduate Medical Education (GME) under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

b. For hospitals that remove Medicaid inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), necessary adjustments will be made to the Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for the Medicaid inpatient dental services. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

c. The DHCS will perform those tests necessary to determine the reasonableness of the Medicaid program data (i.e., Medicaid days and Medicaid charges) from the reported Medi-Cal 2552-96 cost report's Worksheet D series. This will include reviewing the Medicaid program data generated from its MMIS/claims system for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report. However, because the MMIS/claims system data would generally not include all paid claims until at least 18 months after the Fiscal Year Ending (FYE) of the cost report, the DHCS will take steps to verify the filed Medicaid program data, including the use of submitted Medicaid claims. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

d. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost before a per diem is computed in subsection 2. below. Supplemental payments under the contract for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code section 14085.5, and/ordisproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment, are not offset.

2. The Medicaid non-psychiatric inpatient hospital cost computed in subsection 1. above should be divided by the number of Medicaid non-psychiatric inpatient hospital days as determined in subsection 1 above for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.

3. The Medicaid per day amount computed in subsection 2 above will be trended to current year based on Market Basket update factor(s) or other approved hospital-related indices. The Medicaid per day amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

   a. Inpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the current year to which the interim rate will apply.

   b. Inpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred and not reflected on the Medi-Cal 2552-96 cost report for the current year to which the interim rate will apply.

   Such costs must be properly documented by the hospital, and are subject to review. The result is the Medicaid non-psychiatric inpatient hospital cost per day amount to be used for interim Medicaid inpatient hospital payment rate purposes.

4. The DHCS may apply an audit factor to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. The DHCS will identify such percentage to CMS.

D. Interim Reconciliation

1. Each eligible hospital's interim Medicaid payments with respect to services rendered in a fiscal year will be reconciled to its filed Medi-Cal 2552-96 cost report for that same fiscal year.

2. The hospital's total Medicaid non-psychiatric inpatient hospital costs shall be determined using its filed Medi-Cal 2552-96 cost report for the applicable fiscal year and applying the steps set forth in paragraphs a – c of subsection 1 of Section C.

3. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, along with the interim Medicaid payments received for services rendered in the fiscal year, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost. Supplemental payments under the contract for hospital facility construction, renovation or

replacement pursuant to California Welfare and Institutions Code section 14085.5, and/or disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment, are not offset.

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5. If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, appropriate adjustments will be made to offset or otherwise recover the overpayment.

E. Final Reconciliation

1. Each eligible hospital's interim payments and interim adjustments with respect to services rendered in a fiscal year subsequently will be reconciled to its Medi-Cal 2552-96 cost report for that same fiscal year as finalized by A&I for purposes of Medicaid reimbursement.

2. The hospital's total Medicaid non-psychiatric inpatient hospital costs shall be determined using its finalized Medi-Cal 2552-96 cost report and applying the steps set forth in paragraphs a – b of subsection 1 of Section C.

3. In computing the Medicaid non-psychiatric inpatient hospital cost from the finalized Medi-Cal 2552-96 cost report, the Medicaid program data (such as Medicaid days and charges) on the finalized cost report Worksheet D series will be updated as necessary using Medicaid program data generated from its MMIS/claims system for the respective cost reporting period. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

4. Non-contract Medicaid payments for the Medicaid inpatient hospital services of which the costs are included in the Medicaid inpatient hospital non-psychiatric cost computation described above, along with the interim Medicaid payments and interim adjustments received for services rendered in the fiscal year, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost. Supplemental payments under the contract for hospital facility construction, renovation or replacement pursuant to California Welfare and Institutions Code section 14085.5, and/or disproportionate share hospital payments pursuant to the Disproportionate Share Hospital State Plan provisions at page 18 et seq. of this Attachment, are not offset.

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~~2. To be eligible for reimbursement under this segment of Attachment 4.19-A, government-operated hospitals specified pursuant to subsection 1 are required to maintain a Selective Provider Contracting Program (SPCP) contract with the California Department of Health Services (CDHS) in accordance with California Welfare and Institutions Code section 14081 et seq.~~

B. General Reimbursement Requirements

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

The government-operated hospitals listed below, and any other government-operated hospital that subsequently is approved by the Centers for Medicare & Medicaid Services, will receive federal reimbursement for inpatient hospital services provided to Medi-Cal beneficiaries using the cost-based reimbursement methodology specified on pages 46 through 510 of this Attachment:

(1) UC Davis Medical Center
(2) UC Irvine Medical Center
(3) UC San Diego Medical Center
(4) UC San Francisco Medical Center
(5) UC Los Angeles Medical Center~~, including Santa Monica/UCLA Medical Center~~
(6) Santa Monica UCLA Medical Center
(~~6~~7) L.A. County Harbor/UCLA Medical Center
(~~7~~8) LA County Martin Luther King Jr. Charles R. Drew Medical Center (for the period of July 1, 2005 – August 2007 only)
(~~8~~9) LA County Olive View UCLA Medical Center
(~~9~~10) LA County Rancho Los Amigos National Rehabilitation Center
(~~10~~11) LA County University of Southern California Medical Center
(~~11~~12) Alameda County Medical Center
(~~12~~13) Arrowhead Regional Medical Center
(~~13~~14) Contra Costa Regional Medical Center
(~~14~~15) Kern Medical Center
(~~15~~16 Natividad Medical Center
(~~16~~17) Riverside County Regional Medical Center
(~~17~~18) San Francisco General Hospital
(~~18~~19) San Joaquin General Hospital
(~~19~~20) San Mateo Medical Center
(~~20~~21) Santa Clara Valley Medical Center
(~~21~~22) Tuolumne General Hospital (for the period of July 1, 2005 – June 30, 2007 only)
(~~22~~23) Ventura County Medical Center

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Effective July 1, 2012, the non-designated public hospitals listed below, and any other non-designated public hospital that subsequently is approved by the Centers for Medicare & Medicaid Services, will receive federal reimbursement for inpatient hospital services provided to Medi-Cal beneficiaries using the cost-based reimbursement methodology specified on pages 46 through 51 of this Attachment:

1. Alameda Hospital
2. Antelope Valley Hospital
3. Bear Valley Community Hospital
4. Coalinga Regional Medical Center
5. Colorado River Medical Center
6. Corcoran District Hospital
7. Doctors Medical Center – San Pablo Campus
8. Eastern Plumas Hospital – Portola Campus
9. El Camino Hospital
10. El Centro Regional Medical Center
11. Fallbrook Hospital District
12. Hazel Hawkins Memorial Hospital
13. Healdsburg District Hospital
14. Hi-Desert Medical Center
15. Jerold Phelps Community Hospital (Southern Humboldt)
16. John C Fremont Healthcare District
17. Kaweah Delta District Hospital
18. Kern Valley Healthcare District
19. Lompoc Valley Medical Center
20. Mammoth Hospital
21. Marin General Hospital
22. Mayers Memorial Hospital
23. Mendocino Coast District Hospital
24. Modoc Medical Center
25. Mountains Community Hospital
26. Alameda Hospital
27. Antelope Valley Hospital
28. Bear Valley Community Hospital
29. Coalinga Regional Medical Center
30. Colorado River Medical Center
31. Corcoran District Hospital
32. Doctors Medical Center – San Pablo Campus
33. Eastern Plumas Hospital – Portola Campus
34. El Camino Hospital
35. El Centro Regional Medical Center
36. Fallbrook Hospital District
37. Hazel Hawkins Memorial Hospital

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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38. Sonoma Valley Hospital
39. Southern Inyo Hospital
40. Surprise Valley Community Hospital
41. Tahoe Forest Hospital
42. Tehachapi Hospital
43. Tri-City Medical Center
44. Trinity Hospital
45. Tulare District Hospital
46. Washington Hospital - Fremont

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(1) UC Davis Medical Center
(2) UC Irvine Medical Center
(3) UC San Diego Medical Center
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(5) UC Los Angeles Medical Center
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(9) LA County Olive View UCLA Medical Center
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(14) Contra Costa Regional Medical Center
(15) Kern Medical Center
(16 Natividad Medical Center
(17) Riverside County Regional Medical Center
(18) San Francisco General Hospital
(19) San Joaquin General Hospital
(20) San Mateo Medical Center
(21) Santa Clara Valley Medical Center
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19. Lompoc Valley Medical Center
20. Mammoth Hospital
21. Marin General Hospital
22. Mayers Memorial Hospital
23. Mendocino Coast District Hospital
24. Modoc Medical Center
25. Mountains Community Hospital
26. Alameda Hospital
27. Antelope Valley Hospital
28. Bear Valley Community Hospital
29. Coalinga Regional Medical Center
30. Colorado River Medical Center
31. Corcoran District Hospital
32. Doctors Medical Center – San Pablo Campus
33. Eastern Plumas Hospital – Portola Campus
34. El Camino Hospital
35. El Centro Regional Medical Center
36. Fallbrook Hospital District
37. Hazel Hawkins Memorial Hospital

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

38. Sonoma Valley Hospital
39. Southern Inyo Hospital
40. Surprise Valley Community Hospital
41. Tahoe Forest Hospital
42. Tehachapi Hospital
43. Tri-City Medical Center
44. Trinity Hospital
45. Tulare District Hospital
46. Washington Hospital - Fremont

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
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San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

DEC 19 2012

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

Re: Request for Additional Information
California State Plan Amendment 12-024A

Dear Mr. Douglas:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-024A. This amendment changes the inpatient hospital reimbursement methodology for hospitals classified as "non-designated public hospitals (NDPHs)" to a certified public expenditure (CPE) cost reimbursement methodology, effective July 1, 2012.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of Federal financial participation (FFP) and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following questions regarding TN 12-024A:

General questions:

1. In conjunction with this SPA, the state has submitted an 1115 waiver amendment regarding the NDPHs. The state has agreed that the approval of this SPA, along with SPAs 12-024B and 12-024C, should be coordinated with the approval of the waiver amendment.

2. The state has submitted an inpatient hospital upper payment limit (UPL) demonstration along with the 1115 waiver amendment. In the NDPH UPL, it appears that certain governmental hospitals have been excluded: Humboldt County-PHF; Santa Barbara County Mental Health PHF; and Laguna Honda Hospital. Are these certified/licensed as hospitals providing inpatient

hospital services? If so, the state needs to ensure that the fee-for-service inpatient hospital payments for these hospitals are in compliance with the UPL provision per 42 CFR 447.272. This is regardless of whether these hospitals are defined by the state as NDPHs or whether any potential positive UPL room for these hospitals are added to the NDPH 1115 waiver budget neutrality.

3. During our preliminary review, the state had explained that dually eligible Medicare-Medicaid services may have been included in the NDPH UPL. We do not believe this is proper where the state is only responsible to pay for unpaid Medicare coinsurance and deductible amounts on these dual claims. In these cases, the state is not paying these claims as a Medicaid fee-for-service inpatient hospital service under Attachment 4.19-A but rather as a Medicare "cost sharing" payment. Please verify and explain the state's treatment of dual claims in the UPL.

4. In the NDPH UPL, the state has made various reducing adjustments to Medicaid fee-for-service statistics due to managed care transitions. There is also a component in the California 1115 demonstration regarding California Children's Services (CCS) affecting children with special needs. Please explain whether the CCS demonstration has any impact to the fee-for-service inpatient hospital services included in the UPL.

State plan pages questions:

5. On page 48, paragraph a, the Worksheet B, Part I column numbers need to be revised to reflect the CMS 2552-10 cost reporting form update. Column 26 is now column 25; column 25 is now column 24; and column 27 is now column 26.

6. The state had clarified during our preliminary review that the NDPHs, listed on pages 2-3 of Appendix 1 of the Attachment 4.19-A, will not be treated as a "cost-based DSH facilities." This needs to be clarified in Attachment 4.19-A, page 21, paragraph C.2. As it reads currently, this paragraph defines "cost-based DSH facilities" as government-operated hospitals in Appendix 1. The state should modify this to refer to only "Appendix 1, page 1" so that the NDPHs listed on pages 2-3 are excluded from this definition.

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to 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, we will initiate disapproval action on the amendment.

If you have any questions, please call Mark Wong of my staff at 415-744-3561.

Sincerely,

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations