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State/Territory Name: CA

State Plan Amendment (SPA) #: 21-0015

This file contains the following documents in the order

listed: 1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

September 15, 2022

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

RE: TN 21-0015

Dear Ms. Cooper:

We have reviewed the proposed California State Plan Amendment (SPA) to Attachment 4.19-B, CA-21-0015, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on December 8, 2021. This SPA establishes an Alternative Payment Methodology (APM) for qualifying Federally Qualifed Health Centers (FQHCs) and Rural Health Clinics (RHCs) to pay a per visit add payment to providers that are providing additional level of engagement to integrate, coordinate health care, and manage the array of beneficiary health complexities.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Blake Holt at 303-844-6218 or blake.holt@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21-0015

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F SSA 1902(bb)(6)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 39,875,000 37,000,000
b. FFY 2023 $ 39,375,000 37,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement 36 to Attachment 4.19-B pages 1-3
Attachment 4.19-B pages 6AA0-6AA3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
N/A

9. SUBJECT OF AMENDMENT
Supplemental Payment for Non-Hospital 340B Clinics Effective January 1, 2022
Health Centers

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]
Jacey Cooper

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
December 8, 2021

15. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR CMS USE ONLY

16. DATE RECEIVED
December 8. 2021

17. DATE APPROVED
September 15, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1 , 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS
For Box 10 "Other, As Specified," Please note: The Governor's Office does not wish to review the State Plan Amendment.

CMS: Pen and ink changes in Boxes 5, 6, 7, and 9 were made by the state in resubmitting the 179 as a part of the official RAI response.

Instructions on Back

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

Z. ALTERNATIVE PAYMENT METHODOLOGY (APM) for payments to Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) for SUPPLEMENTAL PAYMENT FOR NON-HOSPITAL 340B CENTERS

In order for the APM methodology to be used, the following statutory requirements must be met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the FQHC/RHC that is at least equal to the amount to which the FQHC/RHC is entitled under Medicaid BIPA PPS rate.

A. The APM will support eligible centers that certify they are providing an additional level of engagement to integrate and coordinate health care services and manage the array of beneficiary health complexities.

B. APM Pilot Term: The APM will be available to eligible centers for services provided for dates of service from January 1, 2022 – June 30, 2022 (program period 1) and July 1, 2022 – June 30, 2023 (program period 2).

C. Eligible Providers:
   1. Non-hospital 340B centers eligible for the supplemental payment under this amendment are non-hospital 340B centers reimbursed under 1905(l)(2) that meet the following conditions:
      i. Actively enrolled as a Medi-Cal provider.
         A licensed clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. with less than twenty percent (20%) private pay patients according to Office of Statewide Health Planning and Development 2019 utilization or licensed under subdivision (a) of Section 1204 that operate in a designated HRSA rural area or an exemption from licensure clinic operated by a city, county, city and county, or hospital authority or an exempt from licensure clinic operated by a federally recognized Indian tribe or tribal organization.
      ii. A 340B covered entity pursuant to Section 256b of Title 42 of the United States Code for the entire duration of each applicable program period.
      iii. Actively providing at least three of the following services under (a) or (b):

a. Pharmacy
   i. Medication management;
   ii. Clinical pharmacy services;
   iii. Immunizations/ vaccines;
   iv. Improving medication compliance;
   v. Opioid remediation;
   vi. Patient Assistance Program (especially for patients with Emergency Medi-Cal and prescriptions are not covered)

b. Patient support services
   i. Case management;
   ii. Hard to recruit specialties such as Orthopedics, Urology, Gastroenterology;
   iii. Care coordination;
   iv. Disease-state programs, such as Infectious Disease, HIV/AIDS;
   v. Health education

iv. Submit an application to DHCS demonstrating compliance with items (i) through (iii) of this section within 15 days of approval of the state plan.

D. APM Payment Methodology

APM = [Applicable Office Visit PPS or Office Visit APM for the visit] + [SUPPLEMENTAL PAYMENT FOR NON-HOSPITAL 340B CENTERS]

a. The supplemental payments will be paid per-visit for visits provided by eligible centers during the program period.
b. The pool amounts will be determined by the following formulas:
   i. Program Period 1: $52,500,000 x [number of adjudicated visits provided by all participating centers with dates of service from January 1, 2022 – June 30, 2022 divided by the total number of adjudicated visits for all participating clinics and centers including those authorized under SUPPLEMENTAL PAYMENT FOR NON-HOSPITAL 340B CLINICS, Supplement 36 to Attachment 4.19-B) with dates of service from January 1, 2022 – June 30, 2022.
   ii. Program Period 2: 105,000,000 x [number of adjudicated visits provided by all participating centers with dates of service from July 1, 2022 – June 30, 2023 divided by the total number of adjudicated visits for all participating clinics and centers including those authorized under SUPPLEMENTAL PAYMENT FOR NON-HOSPITAL 340B CLINICS, Supplement 36 to Attachment 4.19-B) with dates of service from July 1, 2022 – June 30, 2023.
c. The final per-visit supplemental payment for program period 1 will be calculated based on the pool amount determined in D.b.i divided by the

total adjudicated visits provided by all participating centers with dates of service from January 1, 2022 – June 30, 2022. The final per-visit supplemental payment for program period 2 will be based on the pool amount determined in D.b.ii divided by the total adjudicated visits provided by all participating centers with dates of service from July 1, 2022 to June 30, 2023.

i. An Interim rate will be determined as follows:
    1. For Program Period 1: Pool size will be determined by the formula of 52,500,000 x [number of historically adjudicated visits provided by all participating centers trended by 5% divided by the total number of historically adjudicated visits for all participating clinics and centers including those authorized under SUPPLEMENTAL PAYMENT FOR NON-HOSPITAL 340B CLINICS, Supplement 36 to Attachment 4.19-B). The interim rate will be determined by dividing the interim pool amount by the number of historically adjudicated visits by all participating centers trended by 5%.
    2. For Program Period 2: Pool size will be determined by the formula of 105,000,000 x [number of historically adjudicated visits provided by all participating centers trended by 5% divided by the total number of historically adjudicated visits for all participating clinics and centers including those authorized under SUPPLEMENTAL PAYMENT FOR NON-HOSPITAL 340B CLINICS, Supplement 36 to Attachment 4.19-B). The interim rate will be determined by dividing the interim pool amount by the number of historically adjudicated visits by all participating centers trended by 5%.
    3. The interim rate will be paid during each program period on a per-visit basis.
    4. Historically adjudicated visits will be determined as follows: For Program Period 1, the adjudicated visits will be for the claims adjudicated for dates of service from July 1, 2020 to June 30, 2021. For Program Period 2, the adjudicated visits will be for the claims adjudicated for dates of service from January 1, 2021 to December 31, 2021.

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ii. The final per-visit rate will be calculated no sooner than 90 days after the end of the program period based on adjudicated visits for all participating centers during the applicable program period. The department will use the adjudicated claim data from the California Medicaid Management Information System as of 90 days after the end of each program period.

iii. No later than 180 days after the end of each program period, the department will complete a reconciliation of interim to final supplemental payment amount for each participating center.

1. The final supplemental payment will be calculated by multiplying the final per-visit rate determined in (ii) by the number of adjudicated visits.
2. If the amount calculated is greater than the total amount of interim revenue received by the center, the center will be paid the difference.
3. If the amount calculated is less than the total amount interim revenue received by the center, the center will refund the difference to the state.