CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00193/9**

TITLE: **California Bridge to Reform Demonstration**

AWARDEE: **California Health and Human Services Agency**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for California's Bridge to Reform section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"), to enable the California Health and Human Services Agency (State) to operate this Demonstration, The Centers for Medicare & Medicaid Services (CMS) has granted waivers of statutory Medicaid requirements permitting deviation from the approved State Medicaid plan, and expenditure authorities authorizing expenditures for costs not otherwise matchable. These waivers and expenditure authorities are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration.

The periods for each Demonstration Year (DY) will consist of 12 months with the exception of DY 6, which will be eight months, and DY 10 which will be 16 months. The periods are:

- DY 6 November 1, 2010 through June 30, 2011
- DY 7 July 1, 2011 through June 30, 2012
- DY 8 July 1, 2012 through June 30, 2013
- DY 9 July 1, 2013 through June 30, 2014
- DY 10 July 1, 2014 through October 31, 2015

The STCs related to the programs for those State Plan and Demonstration Populations affected by the Demonstration are effective from the date of the CMS approval letter through October 31, 2015 except for the Low Income Health Program (the Medicaid Coverage Expansion and the Health Care Coverage Initiative) that will be effective through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Historical Context
III. General Program Requirements
IV. General Reporting Requirements
V. General Financial Requirements
    A. Payments for Medicaid-Eligible Patients
    B. Safety Net Care Pool
    C. Low Income Health Program
    D. LIHP - Health Care Coverage Initiative
VI. State Plan and Demonstration Populations Affected by the Demonstration;
    A. Low Income Health Program (LIHP)
        1. Medicaid Coverage Expansion (MCE)

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

With the approval of the State's section 1115(a) Demonstration in September 2005, the State was provided the authority to receive federal matching funding for a Safety Net Care Pool (SNCP) through which the State made total computable payments of up to $1.532 billion per year for 5 years (total of $7,660,000,000) for medical care expenditures for the uninsured and for the expansion of health care coverage to the uninsured. Of this annual $1.532 billion total computable expenditure, $360 million (total computable) per year was defined as "restricted use SNCP funds," and federal matching was conditioned on the State meeting specified milestones. In Demonstration Years 1 and 2 the restricted use funds were tied to goals associated with the expansion of managed care to the Aged, Blind, and Disabled population in the State. The State failed to meet these milestones. In Demonstration Years 3, 4, and 5 the restricted use funds were tied to goals for expansion of health care coverage to uninsured individuals.

In October 2007, the State (for Demonstration Years 3, 4 and 5) amended the Demonstration to meet the milestones for coverage expansion through the development and implementation of a Health Care Coverage Initiative (HCCI) that expanded coverage options for uninsured individuals in the State. The State designed the HCCI to utilize existing relationships between the uninsured and safety net health care systems, hospitals, and clinics and has been constructed to:

a. Expand the number of Californians who have health care coverage;
b. Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, and county and community clinics;
c. Improve access to high quality health care and health outcomes for individuals; and.
d. Create efficiencies in the delivery of health care services that could lead to savings in health care costs.

During SFY 2009, California reported that it began to experience significant fiscal difficulties that impacted the Medi-Cal program, and the safety net health care system in the State. In July, 2009 the State requested amendments to the STCs in order to: 1) reflect the American Reinvestment and Recovery Act (ARRA) FMAP rates for Safety Net Care Pool (SNCP) expenditures; 2) expand the Health Care Coverage Initiative (HCCI), and 3) include in the Demonstration certain previously State-only funded health care programs. This amendment was approved by CMS effective February 1, 2010.

The July 2009 amendment request also included a proposal for CMS to recognize a new set of milestones in Demonstration Year (DY) 5. These milestone programs included: disease management pilot programs; and care coordination programs. In exchange for the State achieving various enrollment goals in the stated

milestone programs, California proposed that CMS include in the Demonstration an array of Designated State Health Programs (representing $720 million total computable expenditures in Demonstration Year 5).

On June 3, 2010 the State submitted a section 1115 Demonstration proposal as a bridge toward full health care reform implementation in 2014. The States proposal seeks to: phase in coverage in individual counties for adults aged 19-64 with incomes at or below 133 percent of the federal poverty level (FPL), who are eligible under the new Affordable Care Act State option and adults between 133 percent - 200 percent of the FPL who are not otherwise eligible for Medicaid; expand the existing Safety Net Care Pool (SNCP) that was established to ensure continued government support for the provision of health care to the uninsured by hospitals, clinics, and other providers; implement a series of infrastructure improvements through a new funding sub-pool, that would be used to strengthen care coordination, enhance primary care and improve the quality of patient care; create coordinated systems of care for Seniors and Persons with Disabilities (SPDs) in counties with new or existing Medi-Cal managed care organizations through the mandatory enrollment of the population into Medicaid managed care plans.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement[s] will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation actually becomes effective, on the first day of the calendar quarter beginning after the legislature has met for six months in regular session after the effective date of the change in federal law, or such other date provided for in the applicable federal law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the

Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, reimbursement methodologies, cost sharing, evaluation design, Federal financial participation (FFP), sources of non-Federal share funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The State will not implement changes to these elements without prior approval by CMS. Amendments relating to these elements to the Demonstration are not retroactive except as otherwise specified in these STCs and FFP will not be available for changes to the Demonstration relating to these elements that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:
   a. An explanation of the public process used by the State, consistent with the requirements of paragraph 12, to reach a decision regarding the requested amendment;
   b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis will include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
   c. An up-to-date CHIP allotment neutrality worksheet, if necessary;
   d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
   e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **CMS Right to Terminate or Suspend**. CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs. CMS will promptly notify the State in writing of the determination and the reasons for suspension or termination of the Demonstration, or any withdrawal of an expenditure authority, together with the effective date.

9. **Findings of Non-Compliance or Disallowance.** The State does not relinquish either its rights to challenge the CMS finding that the State materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

10. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal

closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; payment and reporting systems compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and /or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the Demonstration, documentation of these activities must be provided to CMS.

13. **FFP.** No Federal matching funds for expenditures for this amended Demonstration will take effect until the effective date identified in the Demonstration approval letter.

14. **Federal Financial Participation (FFP) for Medicaid and Safety Net Care Pool Payments.** Payments for Medicaid, and Safety Net Care Pool (SNCP) payments funded by certified public expenditures (CPEs) are limited to the costs incurred by the certifying entity. No FFP is available for claims of government-operated hospitals designated in Attachment C in excess of costs as defined in paragraph 33 entitled **Certified Public Expenditures** or recognized under paragraph 34 entitled **Payments to Hospitals.** To the extent that the county delivery systems providing services to Medicaid Coverage Expansions and Health Care Coverage Initiative utilize CPEs, the payment must be based on cost and in accordance with a CMS approved protocol. This restriction does not preclude payments to Delivery System Incentive Pool Payments funded through intergovernmental transfers or to capitated payments received by county health systems or public hospitals funded through IGTs or general fund payments. Additionally, cost limitations do not apply to risk-based payments for services under the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI) programs, or to payments received by government operated hospitals from Medi-Cal managed care organizations, consistent with Federal law as these payments cannot be funded by CPEs. All DSH costs must be calculated according to the protocols under 42 CFR 447 and 455, however this cost limitation does not preclude IGT funded DSH payments applicable under section 4721(e) of the Balanced Budget Act of 1997.

IV. GENERAL REPORTING REQUIREMENTS

15. **General Financial Requirements.** The State will comply with all general financial requirements under title XIX.

16. **Reporting Requirements Relating to Budget Neutrality.** The State will comply with all reporting requirements for monitoring budget neutrality set forth in these STCs.

17. **Accounting Procedure.** The State has submitted and CMS has approved accounting procedures for the Medi-Cal Hospital/Uninsured Demonstration to ensure oversight and monitoring of Demonstration

claiming and expenditures. These procedures are included as Attachment H. The State shall submit a modification to the "Accounting Procedures" within 90 days after Demonstration approval to account for changes and expansions to the waiver as described within these STCs for the California Bridge to Reform Demonstration.

18. **Contractor Reviews**. The State will forward to CMS summaries of the financial and operational reviews that the State completes on applicants awarded contracts through the Demonstration's Low Income Health Program (LIHP), the Seniors and Persons with Disabilities Program (SPD), the California Children's Services Program (CCS) and Managed Care Health Plans operating in the State.

19. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to;,
    a. The health care delivery system;
    b. The Medicaid Coverage Expansion (MCE) program;
    c. The Health Care Coverage Initiative (HCCI);
    d. The Seniors and Persons with Disabilities (SPD) Program;
    e. California Children Services (CCS) Program;
    f. Designated State Health Programs (DSHP) receiving federal financial participation. – as defined within these STCs;
    g. Enrollment , quality of care, access to care;
    h. The benefit package, cost-sharing;
    i. Audits, lawsuits;
    j. Financial reporting and budget neutrality issues;
    k. Progress on evaluations;
    l. State legislative developments; and,
    m. Any Demonstration amendments, concept papers or State plan amendments the State is considering submitting.

    CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

20. **Demonstration Quarterly Reports.** The State will submit progress reports 60 days following the end of each quarter (Attachment I). The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports will include, but are not limited to:
    a. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package and other operational issues.
    b. Action plans for addressing any policy, operational and administrative issues identified.
    c. Monthly enrollment data during the quarter and Demonstration Year to Date by:
        i. County of participation the number of persons in the Medicaid Coverage Expansion Program who are applicants, new recipients and existing recipients by FPL;
        ii. County of participation the number of persons in the HCCI program who are applicants, new recipients and existing recipients by FPL;
        iii. County of participation the number of persons enrolled in the SPD program;
        iv. County of participation the number of persons enrolled in the California Children Services Program based on Medi-Cal eligibility and DSHP; and
        v. County of participation the number of persons participating in any Demonstration programs receiving FFP.

d. Budget neutrality monitoring tables.
e. Other items as requested:
    i. Quarterly reports of any Designated State Health Program (DSHP) obtaining Federal Matching funds through this Demonstration.
    ii. By County of participation Demonstration population complaints, grievances and appeals

21. **SPD Specific Progress Reports.** During the first year of implementation of the mandatory enrollment of SPDs, the State will submit regular progress updates to CMS. After the first year of the waiver, the State will submit quarterly progress reports that are due 60 days after the end of each quarter as described in paragraph 20 entitled **Quarterly Reports**. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. CMS reserves the right to request the annual report in draft. The quarterly and annual reports will address, at a minimum:
    a. A discussion of the State's progress in completing enrollments in accordance with approved enrollment strategy in paragraph 77 and completing steps outlined in the Quality Assurance and Quality Improvement Plan as described in paragraph 86;
    b. An aggregation and analysis of encounter data for SPD population;
    c. A discussion of trends or issues identified through the review of such analysis;
    d. A discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
    e. Aggregated information on all measures utilized to assess the plan performance and outcomes for seniors and persons with disabilities;
    f. Notable accomplishments and areas for improvement, including findings from Quality Assurance and Quality Improvement Plan, participant survey and evaluation activities, and review of plan grievance process results and State Fair hearing information;
    g. Reports on ongoing data collection and analysis of required measurement elements, including HEDIS and other measurement; and
    h. Problems/issues that were identified, steps taken to correct them, how they were solved, and if any progress has occurred in the resolution of the issue.

22. **Demonstration Annual Report.** The State will submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State will submit the draft annual report no later than 120 days after the end of each operational year. Within 60 days of receipt of comments from CMS, a final annual report will be submitted for the Demonstration year to CMS. The annual report will also contain:
    a. The previous State fiscal year appropriation detail for those State programs referenced in paragraph 35.b.ii, which are permissible expenditures under the Safety Net Care Pool.
    b. The progress and outcome of program activities related to the:
        a. Medicaid Coverage Expansion;
        b. HCCI;
        c. SPD program; and
        d. California Children's Services Program.
    c. The progress and outcome of activities related to any DSHP obtaining Federal Matching funds through this Demonstration.

23. **Transition Plan.** This Demonstration will not be extended by CMS beyond December 31, 2013 for the Medicaid Coverage Expansion and the Health Care Coverage Initiative Demonstration populations. The State is required to prepare, and incrementally revise, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in these Demonstration

populations, including details on how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The State must meet the following transition milestones.

a. **Affordable Care Act Transition Plan** - By July 1, 2012, the State must submit to CMS for review and approval an initial transition plan, consistent with the provisions of the Affordable Care Act for all individuals enrolled in the Demonstration, The plan must outline how the State will begin transition activities beginning July 1, 2013, including:
    i. The State shall determine eligibility for coverage for these individuals beginning January 1.2014 under all eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL. To ensure that eligibility for medical assistance is not disrupted for any individual covered who will be eligible under any such eligibility group as of January 1.2014, prior to December 31.2013, the State shall obtain any additional information needed from each individual to determine eligibility under such eligibility groups beginning January 1.2014 and shall make and provide notice to the individual of such determination on or before December 31.2013. In transitioning these individuals from coverage under the waiver to coverage under the State Plan, the State will not require these individuals to submit a new application.
    ii. A plan to manage the transition to new Medicaid eligibility levels in 2014 by considering, reviewing, and preliminarily determining new applications for Medicaid eligibility beginning as early as July 1, 2013.
    iii. Criteria for provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.
    iv. The schedule of implementation activities for the State to operationalize the transition plan.
    v. The process the State will use to assure adequate primary care and specialty provider supply for the State Plan and Demonstration Populations affected by the Demonstration on December 31, 2013.

b. **Access Report and Plan**. The State will by July 1, 2012, submit to CMS an assessment of access to care for the populations currently enrolled in Medicaid through the state plan or under this Demonstration. This assessment will measure access to primary care services and specialty care, including access by major type of specialty provider. This assessment will also identify variations in access in the various counties participating in the Demonstration including differences in access to care that exist between urban and rural areas. The assessment shall include the State's projections for adequacy of access to care for persons who will be eligible on January 1, 2014 through Medicaid or Exchange coverage, along with an evaluation of factors that will affect such access, including but not limited to workforce development and network adequacy. The state will identify policy approaches that it intends to pursue to ensure access to care for these groups as well as for the pre-2014 Medicaid population.

c. **Behavioral Health Services Assessment** - By March 1, 2012, the State will submit to CMS for approval an assessment that shall include information on available mental health and substance use service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

d. **Behavioral Health Services Plan** - By October 1, 2012, the State will submit to CMS for approval a detailed plan, including how the State will coordinate with the Department of Mental Health and Alcohol and Drug Programs outlining the steps and infrastructure

necessary to meet requirements of a benchmark plan no later than 2014.

e. **Implementation** - By July 1, 2013, the State must begin implementation of a simplified, streamlined process for transitioning eligible enrollees from the Demonstration to Medicaid or the Exchange in 2014 without need for additional determinations of enrollees' eligibility.

f. **Penalty** - Failure to implement or operationalize the milestones listed in this STC will result in the loss of a percentage of the expenditure cap applicable to Safety Net Care Pool (SNCP) expenditures cap (not including HCCI expenditures) under the expenditure authorities. If the State fails to meet a milestone, the annual expenditure authority cap will be reduced by the amount(s) listed in the table below for SNCP expenditures other than those reserved for the HCCI.

Demonstration Year (DY) Deadline	Milestone Reference	Penalty Amount as a percentage of The Annual Safety Net Care Pool Expenditure (Total Computable)
DY 7 - July 1, 2012	23.a	0.5%
DY 7 - July 1, 2012	23.b	1.0%
DY 6- Mar. 1, 2012	23. c.	2.0%
DY 7 - Oct. 1, 2012	23. d	2.0%
DY 8 - July 1, 2013	23. e.	5.0%

g. **Application of the Penalty.** The State's annual expenditures under the SNCP will be reduced in the proceeding DY to the extent described above. Thirty days after the close of the DY, the State's annual expenditures under the SNCP for that year will be determined. The reduction in expenditure authority shall be applied to sequential DYs, if the State has not met the required milestones. Once a milestone has been met, no further penalties associated with that milestone completion will be imposed.

24. **Final Report. -** Within 120 days following the end of the Demonstration, the State will submit a draft final report to CMS for comments. The State will take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.
    a. Population related Reporting - Within the final Demonstration and evaluation report the State will include:
        i. An assessment using pre-mandatory enrollment as a baseline of the impact on mandatory managed care on the SPD population, including all notable findings.
        ii. Baseline assessment of populations enrolled between 0 through 133 percent FPL, and 133 percent through 200 percent FPL.

25. **Evaluation Design.** Within 120 days the effective date of these STCs, the State must submit to CMS for approval a draft evaluation design for the Demonstration.
    a. At a minimum, the draft design will discuss the outcome measures, including those in Attachment G, which will be used in evaluating the impact of each Demonstration related program during the period of approval, particularly among the target populations. The design will also include the specific hypotheses being tested including an evaluation of the effectiveness of using SNCP funding for Demonstration related programs. Further, it will discuss the data sources and sampling methodology for assessing these outcomes, including the per capita cost of each Demonstration related program. Finally, the draft evaluation design will include a detailed analysis plan that describes how the effects of all Demonstration related programs will be isolated from other initiatives occurring in the State.

b. State shall include an assessment, using pre-mandatory enrollment as a baseline, of the impact on mandatory managed care on the SPD population, including all significant and notable findings based on all of the data accumulated through the quarterly progress report. The State will submit its plan for CMS review and approval for this aspect of the evaluation.
c. CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State will submit a final evaluation design within 60 days of receipt of CMS' comments.

26. **Implementation of Evaluation Design.**
    a. The State will implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.
    b. CMS shall provide comments within 60 days after receipt of the report. The State will submit the final evaluation report within 60 days after receipt of CMS comments.

27. **Revision of the State Quality Strategy.** In accordance with Federal regulations at Subpart D 438.200 regarding Quality Assessment and Performance Improvement to ensure the delivery of quality health care and establishment of standards, the State must update its Quality Strategy to reflect all managed care plans being proposed through this Demonstration and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of its revised Quality Strategy and make the Strategy available for public comment before adopting it as final, and submitting to CMS for approval. The State must revise the strategy whenever significant changes are made, including changes through this Demonstration. The State will also provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy as it impacts the Demonstration. This paragraph does not apply to low income health plans as referenced in Section 3, #1 (Expenditure Authority).

28. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators' and their contractors' efforts to conduct an independent, federally funded evaluation of the Demonstration program.

V. GENERAL FINANCIAL REQUIREMENTS

A. Payments for Medicaid-Eligible Patients

29. **Selective Provider Contracting Program (SPCP).** The State will continue the SPCP for payment of certain private hospitals (as described in Attachment E) and non-designated government-operated hospitals as part of the 1115 Demonstration, subject to Attachment F and other applicable STCs. This component of the Demonstration is now referred to as the "Inpatient Hospital" component. The State may discontinue this program in whole or in part at any time through the submission of a State plan amendment to Attachment 4.19-a.

30. **Payments to Contracted Hospitals.** With the exception of payments for emergency hospital services, base payments to hospitals that contract with the State under the Inpatient Hospital component will be limited to rates determined through negotiations with California Medical Assistance Commission (CMAC) and shall follow the following principles:

    a. The negotiated reimbursement rates to hospitals shall be on a per diem or other basis, and may include supplemental payments, but in no case shall such reimbursement exceed, in the aggregate, the upper payment limit for private hospitals established under CMS regulations. Should CMS promulgate new regulations governing hospital reimbursement, the reimbursement rates must reflect such new regulations as of the effective date of the new regulations.

b. The non-Federal share of payments to private hospitals may be funded by transfers from units of local government, at their option, to the State. Any payments funded by intergovernmental transfers shall remain with the hospital and shall not be transferred back to any unit of government.

c. The State will inform CMS of the funding of all Medicaid payments to these hospitals through the quarterly payment report currently submitted to the Regional Office. This report has been modified to accommodate the identification of funding sources associated with each type of Medicaid payment received by each hospital.

31. **Payments to Non-Designated Government-Operated Hospitals.** With the exception of emergency hospital services, base payments to government-operated hospitals not identified in Attachment C will be limited to payments that participate in the Inpatient Hospital component. Payment to such hospitals is determined through negotiations with CMAC.

a. The negotiated reimbursement rates to non-designated government-operated hospitals shall be on a per diem or other basis, and may include supplemental payments, but in no case shall aggregate payments to government-operated hospitals exceed the upper payment limit for such hospitals established under CMS regulations. Should CMS promulgate new regulations governing hospital reimbursement, the reimbursement rates must reflect such new regulations as of the effective date of the new regulations.

b. The State will inform CMS of the funding of all Medicaid payments to these non-designated government-operated hospitals through the quarterly payment report currently submitted to the Regional Office. This report has been modified to accommodate the identification of funding sources associated with each type of Medicaid payment received by each hospital.

32. **Reimbursement to Designated Government-Operated Hospitals.** Reimbursement to those hospitals identified in Attachment C will be based on allowable Medicaid inpatient hospital costs as identified on Medi-Cal 2552-96 cost reports. The methodology for computing such costs and the required procedures for claiming Federal matching funds is detailed in the Funding and Reimbursement Protocol included as Attachment F.

33. **Certified Public Expenditures (CPEs).** Total computable expenditures for patient care that are either directly payable under this Demonstration, or the basis for DSH or SNCP reimbursement, may be certified by government entities that directly operate health care providers as long as the expenditures are not funded using impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act or using Federal funds other than Medicaid funds (unless the other Federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). To the extent that the funding source for expenditures is a state program funded through this Demonstration, expenditures may be certified only as a total computable expenditure under such program. The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). For this purpose, Federal funds do not include, Delivery System Reform Incentive Payments, patient care revenue received as payment for other services rendered under programs such as Designated State Health Programs, Health Care Coverage Initiative program, Medicare or Medicaid.

34. **Payments to Hospitals.** Under this Demonstration, payments to hospitals may include supplemental Medicaid inpatient and outpatient payments to hospitals identified in Attachment C that meet the eligibility requirements for participation in the Construction/Renovation Reimbursement Program, pursuant to California Welfare and Institutions Code section 14085.5 and 14085.57. To the extent that the State continues to make these payments, such payments may be funded by the State general fund, by CPEs and intergovernmental transfers and shall be considered Medicaid revenue that must be offset against uncompensated costs eligible for Disproportionate Share Hospital (DSH) payments. These supplemental payments are in addition to the Medicaid rates described in Attachment F for inpatient Medicaid services, and the non-Federal share must be funded by State or local general funds or intergovernmental transfers.

B. Safety Net Care Pool (SNCP)

35. **Safety Net Care Pool Expenditure**. California may claim FFP for expenditures in the defined categories of spending (subparagraphs a, b, and c) subject to the spending limits defined in this section (subparagraphs a, b.iii, and c.v) for each category and subject to the limitations in the Section of these STCs entitles "Monitoring Budget Neutrality in the Demonstration."

    a. **LIHP-HCCI.** California may spend up to $360 million total computable per year in DY 6-8 and $180 million total computable in DY 9 on expenditures associated with defined services and populations under the Health Care Coverage Initiative, which is part of the Low-Income Health Program, as described in paragraphs 48.a.ii.
        i. Claims for expenditures in the counties participating in the HCCI program as of November 1, 2010 are subject to the funding and claiming protocols described in Attachment G the coverage limits in paragraphs 63.b and the eligibility limits in paragraph 48a.ii.
        ii. Additional counties seeking to participate in the HCCI program must submit funding and claiming protocols to the State. The State must then submit the protocols to CMS and may not claim FFP prior to CMS' approval of the funding and claiming protocols.
        iii. Spending in the HCCI is subject to the limitations described in paragraph 47 describing the LIHP- HCCI Allocations cost allocation plan.
        iv. To the extent counties are unable to utilize the full $360 million per year in DY 6-8 and $180 million in DY 9 on expenditures associated with defined services and populations the HCCI for a Demonstration year, CA may request that such funds may be available for use in one of the other three categories of SNCP spending described in 35(b)(i), 35(b)(ii) and 35(c). The State must use the process described in term and condition 7. Such redirected SNCP funds may be available for allowable expenditures incurred during the Demonstration year for which the funds were initially reserved, or may be rolled over to subsequent Demonstration years for unrestricted use SNCP expenditures subject to CMS approval.
            v. **Transition Period**. - From the period of approval through July 1, 2011 counties currently participating in the HCCI may claim FFP subject to the SNCP limits for qualifying expenditures for enrollees with family incomes from 0-200 percent FPL as the counties implement the new MCE coverage requirements. By January 1, 2011, the State will submit to CMS a plan identifying:
                A. Which counties intend to offer Medicaid expansion coverage;
                B. The upper income levels and benefit packages that the county will cover for both MCE and HCCI coverage during DY 6;
                C. The counties' plans for implementing the new MCE coverage requirements, including the counties' plans to meet any requirements not enumerated in the

Demonstration waiver and expenditure authorities that MCE requirements are fully achieved by July 1, 2011.

By July 1, 2011, the state will demonstrate to CMS that counties meet the new MCE coverage requirements and that the expenditures related to this coverage can be claimed as FFP under the MCE EG (hypothetical). For those counties meeting this timeframe, FFP claimed from the date of Demonstration approval will be treated as MCE expenditures.

For counties that do not elect to participate in the MCE category, FFP will be claimed against the HCCI in the SNCP for all member months from the date of Demonstration approval.

For DY 7-10, the State must inform CMS of any county that intends to participate in the MCE program 90 days prior to the county enrolling people in that program under the Medicaid Coverage Expansion and must demonstrate that the county meets the new MCE coverage requirements 45 days prior to the county beginning enrollment in the program. All FFP will be treated as MCE for enrollees qualifying for the MCE category from the period that enrollment begins in the MCE

b. **SNCP Uncompensated Care**. Expenditures may be made through the SNCP for uncompensated care provided to individuals with no source of third party coverage for the services they received furnished by hospitals or other providers identified by the State. To the extent that uncompensated care expenditures are made for services furnished by entities other the designated public hospitals, the state must identify the provider and the source of the non-federal share of the SNCP Uncompensated Care payment.

   i. **Safety Net Care Uncompensated Care Pool -** funds may be used for expenditures for care and services **that meet** the definition of 'medical assistance' contained in section 1905(a) of the Act that are incurred by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services provided to uninsured individuals, as agreed upon by CMS and the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.

   ii. **SNCP Designated State Health Programs (DSHP)**. The State may claim FFP for the following State programs subject to the annual limits described below and the restrictions described in paragraph 40 "**Prohibited Uses of SNCP funds.**. Expenditures are claimed in accordance with CMS-approved claiming protocols. The State should modify Attachment F to account for any DSHP expenditure claiming in DYs 6 through10. No FFP is allowed until the year 6-10 DSHP claiming protocol is approved by CMS.

   iii. **SNCP Uncompensated Care Annual Limits** – Taken together, the total computable annual limits for Safety Net Care Uncompensated Care Pool and Designated State Health Programs cannot exceed the following:
      1. DY 6 - $1.633 billion
      2. DY 7 - $1.672 billion
      3. DY 8- $1.572 billion
      4. DY 9 - $1.422 billion
      5. DY 10 - $1.272 billion

   The annual limit the State may claim FFP for DSHP is limited to the programs listed

above and shall not exceed $400,000,000 FFP per year for a 5 year total of $2,000,000,000 FFP.

iv. **Approved Designated State Health Programs** for which FFP can be claimed subject to the limits in this paragraph are:

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIALTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD) • Song Brown HealthCare Workforce Training • Health Professions Education Foundation Loan Repayment • Mental Health Loan Assumption

v. **SNCP Workforce Development in Low Income/Underserved Communities.** The State may claim FFP for workforce development programs funded by the Universities of California, California State Universities and/or California community colleges to the extent those programs are targeted to benefit low income populations or underserved areas and this justification must be submitted to CMS for its review and approval. The State must then obtain prior CMS approval for the methodology used to capture the workforce development costs eligible for FFP. Once all relevant approvals are obtained, CMS will add this program to the approved DSHP list.

c. **SNCP Delivery System Reform Incentive Payments**. Within the SNCP, a Delivery System Reform Incentive Pool (DSRIP) is available to for the development a program of activity that supports California's public hospitals efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be foundational, ambitious, sustainable and directly sensitive to the needs and characteristics of an individual hospital's population, and the hospital's particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement.

DSRIP Proposals must be consistent with the hospitals' shared mission and quality goals as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care (without any harm whatsoever to individuals, families or communities).

There are 4 areas for which funding is available under the DSRIP, each of which has explicit connection to the achievement of three aims:

i. **Infrastructure Development** – Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services. Examples of such initiatives drawn from the hospitals' initial proposals are:
   A. Increase in Primary Care Capacity
   B. Introduction of Telemedicine
   C. Enhanced Interpretation Services
   D. Enhanced Improvement Capacity

ii. **Innovation and Redesign** – Investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management. Examples of such initiatives drawn from the hospitals' initial proposals are:
   A. Expansion of Medical Homes
   B. Expansion of Chronic Disease Management Systems
   C. Primary Care Redesign
   D. Redesign for Cost Savings

iii. **Population-focused Improvement** - Investments in enhancing care delivery for the 5-10 highest burden (morbidity, cost, prevalence, etc.) conditions in public hospital systems for the population in question. Examples of such initiatives drawn from the hospitals' initial proposals are:
   A. Improved Diabetes Care Management and Outcomes
   B. Improved Chronic Care Management and Outcomes
   C. Reduction of Readmissions
   D. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems)

iv. **Urgent Improvement in Care** – Broad dissemination of top-level performance on 2 or 3 interventions (preferably drawn from a superset of interventions) where there is deep evidence, including evidence from within the safety net, that major improvement in care is possible within 5 years, measurable and meaningful for almost all hospital populations such as those served by the California Public Hospitals. These are hospital specific initiatives and will be jointly developed by hospitals, the State and CMS, and need not be uniform across all of the hospitals or the initiative.

v. **General Overview of Payments -** Payments for both the Infrastructure Development and Innovation and Redesign shall be tied to process measures (e.g., successful initiation of an enhanced interpretation program, enrollment of a majority of patients into a Medical Home model). Payments related to Innovation and Redesign shall recognize that the initiatives do not guarantee outcomes, but that the milestones will result in learning, adaptation and progress. The total Demonstration funding for DSRIP shall not exceed total computable expenditures of $6.506 billion over five years. Annual limits on this SNCP category of spending are:
   1. DY 6 - $1.006 billion
   2. DY 7 - $1.3 billion
   3. DY 8- $1.4 billion
   4. DY 9 - $1.4 billion
   5. DY 10 - $1.4 billion

vi. **Payment for both the Population-Focused Improvement and Urgent Improvement in Care** shall be tied chiefly to an organization's absolute progress from the time it initiates its improvement activities with recognition of demonstrated advancement from each facility's starting point. In some cases, it may also be tied to outcome measures (e.g., an infection rate, the rate of reliable delivery of an evidenced-based care protocol). Payments for metrics may be graduated or based on making meaningful and significant progress rather than full achievement of a particular metric. Organizations will have the opportunity to recapture payment in subsequent years if that do not meet a milestone /metric. For all categories of payment, metrics should, whenever possible,: (1) reference a nationally or statewide accepted measurement, including but not limited to CHART, HEDIS, CMS, NQF, and the U.S. Task Force on Prevention; and (2) an individual plan must include the measurement specifications for each initiative.

vii. **Total payment amounts** available for each of the public hospital system proposal will be determined prior to submission for final approval by CMS. Each public hospital system will be responsible for developing proposals that include proposed payment mechanisms based on the metrics guidelines developed in future Attachment P.

Each public hospital system will provide the non-federal share of its pool payments through an intergovernmental transfer. Available funding under the four defined areas of focus may be weighted more heavily toward Infrastructure Investment and Innovation and Redesign initiatives in the first two years of the Demonstration and inversely weighted toward Population-focused Improvement and Urgent Improvement in Care initiatives in the last two years of the Demonstration.

In consultation with the designated public hospitals and to the degree it does not impede the ability of the designated public hospitals to meet the requirements and conditions contained for Delivery System Reform Incentive Payments set forth in this section, the State may provide for milestone incentive payments to private disproportionate share hospitals and/or non-designated public disproportionate share hospitals to incentivize improvement activities towards, and achievement of, delivery system transformation. Such milestone incentive payments to private disproportionate share hospitals and/or non-designated public disproportionate share hospitals must be structured in accordance with the requirements and conditions for Delivery System Reform Incentive Payments set forth in this section. Incentive payments may be funded by voluntary intergovernmental transfers made by the designated public hospitals and/or non-designated public hospitals. All incentive pool funding, including any potential private and/or non-designated public hospital sub-pools, will be limited to the total amount of incentive pool funding allowed for Delivery system Reform Incentive Payments as set forth in this section.

viii. **Finalize DSRIP Protocol -** Within the 60 days following the acceptance of the terms and conditions, CMS, the State and the California Association of Public Hospitals will, through a collaborative process, develop a blueprint to move quickly forward to develop more specific standards, measures and evaluation protocols with the intention of clarifying requirements and expediting the approval of the plans. Specifically, the deliverable will be future Attachment Q and will:

A. Develop standard metrics for both process measures and absolute improvement measures;
B. Finalization of scorecard process and metric grouping to measure project progress;
C. Finalization of payment mechanisms for projects based the agreed upon metrics;

D. Finalize a State review process that will assure action on the proposal within 30 days of submission by the hospitals. Approval results in submission to CMS by the State for approval of Incentive Pool funding.
E. Finalize a review and approval process for proposals received by CMS that assures action on the proposal with 30 days from submission by the State; finalize a process for ongoing support and collaboration, annual reporting process and project coordination.

ix. **DSRIP Payments are Not Direct Reimbursement for Expenditures or Payments for Services -** Payments from the DSRIP are intended to support and reward hospital systems for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The payments are not direct reimbursement for expenditures incurred by hospitals in implementing reforms. The DSRIP payments are not reimbursement for health care services that are recognized under these Special Terms and Conditions or under the State plan. DSRIP fund payments should not be considered patient care revenue and should not be offset against the certified public expenditures incurred by government-operated hospital systems and their affiliated government entity providers for health care services, DSH or administrative activities as defined under these Special Terms and Conditions and/or under the State plan.

36. **General Funding and Reimbursement Protocol for SNCP Expenditures -** The State must maintain an approved a funding and reimbursement protocol (Attachment F) to document the procedures and methodologies the State will use to determine those costs eligible for Federal matching through the Safety Net Care Pool (SNCP) through the Certified Public Expenditure (CPE) process. The Federal government will only match SNCP expenditures, under the Demonstration, that the State makes with State and Local funds.

The funding and reimbursement protocol must specify the definitions, methodologies and cost-reporting formats for documenting expenditures made by the State and non-hospital based providers in order to claim Safety Net Care Pool (SNCP) Federal matching funds. The funding and reimbursement protocol must be approved by CMS before the State may claim FFP against the SNCP for all medical services. The funding and reimbursement protocol must also include methodologies for reimbursing for the following:

a. **Safety Net Care Uncompensated Care Pool -** furnished by designated public hospitals and other governmental providers that is not otherwise funded through Medicaid, claimed for DSH or reimbursed by other payers - The reimbursement methodologies for designated public hospitals and other governmental providers participating in the Demonstration that are not described in Section 4.19-A of the Medicaid State Plan are described in Attachment F and includes a description of any use of estimates or adjustment factors that will be used to modify actual cost findings;
b. **Designated State Health Programs (DSHP)** – The State must revise and amend Attachment F to document the procedures for DSHP interim claiming and the payment reconciliation process the State will use to determine those costs eligible for Federal matching through the Safety Net Care Pool for DSHP in paragraph 35. b., iv. The State will submit a final proposed revised Attachment F to CMS. Failure of the State to submit the final proposed revised Attachment F to CMS will result in a loss of Federal matching for DSHP expenditures; and
c. **Workforce Development in Low Income/Underserved Communities** as described in paragraph 35b.v.

37. **Restricted Use of SNCP Funds.** Safety Net Care Pool funds are available annually at the levels defined in paragraph 35. Annual limits are further subject to reductions associated with paragraph 23.f., as determined by the State meeting its projected budget neutrality savings. To the extent any of the funds associated with a SNCP category are not fully expended in a given year, they may be available for subsequent years for the purposes for which the funds were initially reserved. However, consistent with paragraph 35, funds spent in a given year cannot exceed the cumulative DY expenditure limits for the individual SNCP category. Funds may also be rolled over to subsequent Demonstration years for use in other SNCP categories subject to CMS approval.

38. **Entities Eligible to Receive SNCP Funds.** The government operated hospitals listed in Attachment C, the State, a county or a city is eligible to receive Safety Net Care Pool funds based upon CPEs determined through an approved cost reimbursement methodology. With prior approval of CMS, the State may add other governmental entities (and may include providers established under State statutes authorizing hospital authorities, hospital districts, or similar entities) to this list. The State must notify CMS when an entity on Attachment C is removed.

39. **Permissible non-Federal Share Funding Mechanisms for SNCP.** The State must have permissible sources for the non-Federal share of payments from the Safety Net Care Pool, which may include CPEs or permissible IGTs from government-operated entities. Sources of non-Federal funding shall not include provider taxes or donations impermissible under section 1903(w), impermissible intergovernmental transfers from SNCP providers, or Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes).

    In the event that the use of CPEs or permissible IGTs by the State and government-operated entities is insufficient to fully utilize the SNCP allowance, the State may propose alternate legitimate funding mechanisms. However, CMS must review and approve any such alternate funding prior to its use as the non-Federal share of a payment under Title XIX.

40. **Prohibited Uses of SNCP funds.** Safety Net Care Pool expenditures do not include expenditures associated with the provision of non-emergency care to non-qualified aliens.

    a. To implement this limitation, 13.95 percent of total provider expenditures or claims through SNCP for uncompensated care or the low-income care program will be treated as expended for non-emergency care to non-qualified aliens.

    b. To implement this limitation with respect to DSHP:
        i. Expenditures for the Medically Indigent Long Term Care (MI/LTC) program will not be reduced by 13.95 percent because there are no non-qualified aliens receiving services under this program.
        ii. Expenditures for the Breast and Cervical Cancer Treatment Program (BCCTP) will be reduced by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens; however, the 13.95 percent reduction will not be applied otherwise.
        iii. Expenditures for the California Children Services (CCS) program will be reduced by 13.95 percent as specified in subparagraph (a).
        iv. Expenditures for the Genetically Handicapped Persons Program (GHPP) will be reduced by 13.95 percent as specified in subparagraph (a).
        v. Expenditures for the Expanded Access to Primary Care (EAPC) will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.

vi. Expenditures for the AIDS Drug Assistance Program (ADAP) will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.
vii. Expenditures for the California Department of Developmental Services will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.
viii. Expenditures for the California County Mental Health Services Program will be reduced by either the 13.95 percent factor as specified in subparagraph (a), or by the costs related to providing services to those individuals with aid codes used to designate non-qualified aliens.

41. **Redistribution of SNCP Funds.** The State may redistribute, among designated public hospitals, Federal matching funds drawn against Safety Net Care Pool claims it receives which are based on providers' CPEs, provided that providers receiving Federal funds in excess of their certified costs cannot return any portion of the payment received to any unit of government and cannot claim the CPEs for any other purpose. No Federal matching funding is available for such redistributions. Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable and subject to paragraph. Any redistribution cannot increase local contributions towards the non-Federal share that would violate maintenance of effort provisions regarding political subdivisions contributions under the Recovery Act of the Affordable Care Act

42. **Low Income Health Program (LIHP).** the LIHP is a county-based elective program that consists of two components, the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI). The MCE is not subject to a cap on federal funding, and provides a broader range of medical assistance than the HCCI, which is subject to a cap on federal funding within the limited amounts available for the SNCP.

43. **LIHP Program Cost Claiming Protocols.** The State must maintain a CMS approved funding and reimbursement protocol (Attachment G) which explains the process the State will use to determine costs incurred by the LIHP under this Demonstration.
    a. Requirements of the funding and reimbursement protocol must:
        i. Indicate how the Low Income Care Programs will document costs; how interim payments will be made; and how reconciliations will be performed.
        ii. Document how the CPE process will interact with the CPE process currently outlined in Attachment F, and used by the hospitals listed in Attachment C to document costs eligible for Federal matching. This process should only address the provision of medical services under the Low Income Health Programs; the administrative cost claiming protocol is separately described in Attachment J.
        iii. The State must submit funding and claiming protocols to CMS with respect to each county participating in the LIHP program. The State may not claim FFP prior to the approval of the funding and claiming protocols. Once the funding and claiming protocol is approved, payment may be rendered as of the date that the LIHP met all requirements.
    b. For any Demonstration program paid based on actuarially sound per capita rates, the requirements of the funding and reimbursement protocol must address:
        i. How the rates will be determined
        ii. Whether the nonfederal share will be provided through intergovernmental transfers or certified public expenditures, and
        iii. The procedures that will apply to payment.
    c. Provide for methodologies to determine the separate costs of HCCI services and MCE services incurred by the LIHP.

44. **LIHP Maintenance of Effort (MOE) -** The State must demonstrate that the annual amount of non-Federal funds expended for the Low Income Health Programs will be maintained or increased above the State Fiscal Year (SFY) 2006 level for the Demonstration period through December 31, 2013, i.e., the State must demonstrate that total non-Federal expenditures for Low Income Health Programs in any Demonstration year is equal to or exceeds the total amount that would have been expended by either the State or local governments in SFY 2006 in the absence of the Demonstration. If the State cannot meet the MOE requirement, CMS will reduce Federal funding for Low Income Health Programs expenditures by the amount of the deficiency.

45. **Prior Approval of Claiming Mechanism.** The State must maintain a CMS approved Administrative Cost Claiming Protocol (Attachment J) which explains the process the State will use to determine administrative costs incurred by the Low Income Health programs. CMS will provide Federal financial participation (FFP) to the State at the regular 50 percent match rate for administrative costs including, start up, implementation and close out costs associated with the approved Low Income Health Program and incurred and subject to the limitations outlined in Attachment J during the Demonstration approval period within these STCs. The claiming protocol should be modified for Demonstration years 6-9 for the new LIHP time periods and also to account for the allocation of administrative costs between the MCE and the HCCI populations. No FFP is allowed until a claiming protocol is approved by CMS.

C. **Funding Limitations on the LIHP - HealthCare Coverage Initiative (HCCI)**

46. **Federal Financial Participation for the LIHC-HCCI Population.** A reserved amount of restricted use SNCP funds as described in paragraph 36(a) may only be used to fund expenditures for the HCCI population program that will expand coverage options for individuals who meet the criteria in paragraph 48.a. ii. The HCCI population program may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals, and clinics.

47. **LIHP- HCCI Allocations**. The State with CMS approval will determine HCCI allocations for expenditures in each county for each year of the Demonstration. The allocations will be the maximum levels of SNCP funding that will be available to pay for expenditures for HCCI recipients in each county during the Demonstration year. Expenditures for health care coverage service costs for county HCCI recipients must be documented by each county and must be compliant with the Office of Management and Budget Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments." Expenditures will be claimed in accordance with the CMS-approved HCCI claiming protocol in Attachment G. Attachment G must be modified for DY's 6 through 9 to accommodate any new/changes to HCCI programs as well as the allocation of expenditures between the MCE and the HCCI medical services.

VI. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION

The Special Terms and Conditions, waivers and authorities separately enumerated for the State Plan and Demonstration Populations affected by the California Bridge to Reform Demonstration, and the corresponding Demonstration programs affected by the Demonstration are effective from the date of the CMS approval letter through October 31, 2015 except for the Low Income Health program that will be effective through December 31, 2013 and will not be extended by CMS beyond December 31, 2013.

48. **Eligibility:** Certain State plan eligibles and Demonstration populations authorized under the

expenditure authorities are affected by the Demonstration. The Medicaid Coverage Expansion (MCE) population, described below in 48.a.i., and California Children with special healthcare needs (CCS) population, described below in 48.b., are subject to all applicable Medicaid laws and regulations except as expressly waived or described herein. The Health Care Coverage Initiative (HCCI) population, described below in 48.a.ii., are subject to Medicaid laws or regulations except as specified in the expenditure authorities for these Demonstration populations.

The following population groups are affected by the Demonstration:

a. **Demonstration Low Income Health Program –** Eligible individuals who meet county residency requirements of a participating county, immigration status, are not eligible for Medicaid or CHIP, are not pregnant, and are within the following populations:

i. **Medicaid Coverage Expansion (MCE) Population** - Adults between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL (less based on participating county income standards).

1. **New MCE Recipients** - Adults between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL (or less based on participating county standards) and who have been determined to be eligible for enrollment into a participating county program after the Demonstration approval date; and
2. **Existing MCE Recipients -** Includes certain adults who have family income at or below 133 percent FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver," HCCI in their county of residence on the effective date of this Demonstration approval;

ii. **Health Care Coverage Initiative (HCCI) Population** – Adults between 19 and 64 years of age who have family incomes above 133 percent through 200 percent FPL (or less based on participating county income standards).

1. **New HCCI Recipients** - Adults between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL (or less based on participating county standards) and who have been determined to be eligible for enrollment into a participating county program after the Demonstration approval date; and
2. **Existing HCCI Recipients** - Includes certain adults who have family income above 133 through 200 percent of the FPL, who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver," in their county of residence on the effective date of this Demonstration approval.

b. **State Plan California Children's Services (CCS) Affected by the Demonstration -** Are those children with Special Health Care Needs who are:

i. Under 21 years of age; and
ii. Meet the medical eligibility criteria as defined in the California Code of Regulations such as congenital anomalies, cerebral palsy, hearing loss, cancer and diabetes; and
iii. Meet financial eligibility criteria for CCS if they are:

1. Enrolled in Medi-Cal (per the Medicaid State Plan);
2. Enrolled in Healthy Families (California's Child Health Insurance Program);
3. Persons in families with an adjusted gross income of $40,000 or less in the most recent tax year, as calculated for California state income tax purposes; or
4. Projected to expend more than 20 percent of their annual, adjusted gross family income for treatment of the CCS-eligible condition.

c. **State Plan Seniors and Persons with Disabilities (SPD) -** Are those persons who derive their eligibility from the Medicaid State Plan and are either aged, blind, or disabled.

d. **1915(b) Waiver Populations** – Are individuals enrolled in the: (1) California Health Insuring Organizations; (2) Health Plan of San Mateo (3) Santa Barbara San Luis Obispo Regional Health Authority; (4) Two Plan Geographic Managed Care and

i. **Section 1931 Children and Related Populations** - Are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children

ii. **Section 1931 Adults and Related Populations** - Are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

iii. **Foster Care Children** - Are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

VII. DEMONSTRATION DELIVERY SYSTEMS

If the State chooses to use a managed care delivery system to provide benefits to the Demonstration populations (with the exception of LIHP populations), any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), or prepaid ambulatory health plans (PAHPs) [collectively referred to as managed care entities] is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438.

49. **Transition of existing 1915(b) waiver programs into the Demonstration**. Prior to this Demonstration, the State operated managed care programs under the authority of 1915(b) through four separate 1915(b) waivers:
    a. Health Plan of San Mateo (HPSM);
    b. Santa Barbara San Luis Obispo Regional Health Authority (SBSLORHA);
    c. Health Insuring Organizations (HIO); and
    d. Two Plan/Geographic Managed Care (GMC).

    Health Insuring Organizations are managed care delivery systems unique to California and operate under the authority of section 9517(c) of COBRA 1985, which was subsequently amended by section 4734 of OBRA 1990 and MIPAA 2008. HIOs are exempt from the managed care requirements of section 1932 of the Act (implemented through 42 CFR Part 438) because they are not subject to the managed care contract requirements of 1902(m)(2)(a). California state law identifies these as county-operated health systems (COHS). The 1915(b) waivers in subparagraph b. and c. operate under the HIO authority to deliver benefits to State plan populations; the HPSM is considered a COHS, but is not considered an HIO by Federal standards because it was implemented after 1985.

    The counties participating in the Two Plan offer a choice of two types of MCOs – a local initiative plan (a county-organized plan which includes local safety net providers and clinics) and a commercial plan. The counties participating in the GMC offer a choice of two or more MCOs.

50. **Managed Care Expansions**: The State has been granted the authority to operate managed care programs in the counties in Attachment M. Therefore, a Demonstration amendment is not required to implement expansions in these counties. However, any new service area expansions, proposed changes in Demonstration authorities, or changes in the populations included or excluded in the authorized counties will require an amendment to the Demonstration as outlined in STC 7, including updated Attachments L and M.

51. **Encounter Data Validation Study for New Health Plans.** When a managed care entity begins

serving the populations in STC 48. b., c., or d., in the Demonstration, the State will be responsible for conducting a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study will include validation through a sample of medical records of Demonstration enrollees.

52. **Submission of Encounter Data.** The State will submit encounter data to the Medicaid Statistical Information System (MSIS) as is consistent with Federal law, policy and regulation. The State must assure that encounter data maintained at managed care entities can be linked with eligibility files maintained at the State.

53. **Standard Transaction Formats for Transmission of Payment and Enrollment to Managed Care Entities.** The State must ensure that regular capitation payments and plan enrollment rosters provided to the managed care entities serving Demonstration populations are generated through an automated process that is compliant with the appropriate standard HIPAA ANSI X12 transaction file format. The State must transition to utilizing Version 5010 of the 820 standard for capitation payments, and the 834 standard for enrollment rosters by the January 1, 2012. FFP under this Demonstration may be at risk if these electronic standards are not implemented by the HIPAA-mandated compliance date.

54. **Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State will provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right as a corrective action to withhold FFP (either partial or full) for the Demonstration until the contract compliance requirement is met.

55. **Capitation Payments**. The State must ensure that regular capitation payments made to the Medicaid health plans that are covered under this Demonstration are done through an automated process that is compliant with the standard HIPAA ANSI X12 820 electronic transaction format. The State must transition to utilizing Version 5010 of the 820 standard transaction by the compliance date of January 1, 2012. Likewise, the State must ensure that regular plan enrollment rosters are provided to the Medicaid health plans covered under this Demonstration through an automated process that is compliant with the standard HIPAA ANSI X12 834 electronic transaction format. The State must transition to utilizing Version 5010 of the 834 standard transaction by the compliance date of January 1, 2012. FFP under this Demonstration may be at risk if these electronic standards are not implemented by the HIPAA-mandated compliance date.

56. **Network Adequacy.** The State must ensure that each managed care entity has a provider network that is sufficient to provide access to all covered services in the contract covered for the Demonstration populations identified in STC 47. b., c., and d., No later than 30 days prior to enrollment of Demonstration populations and annually thereafter, the State must provide to CMS for review and approval the following:
    a. The anticipated Demonstration population enrollment;
    b. Expected service utilization based on the Demonstration population's characteristics and health care needs;
    c. The number and types of primary care and specialty providers needed to provide covered services to the Demonstration population;
    d. The number of network providers accepting the new Demonstration population; and
    e. The geographic location of providers and Demonstration population, considering distance, travel time, transportation, and disability access.

57. **Network Requirements.** The State must through its health plans deliver adequate primary care, including care that is delivered in a culturally competent manner that is sufficient to provide access to

covered services to the low-income population, and coordinate health care services for Demonstration populations.

a. **Special Health Care Needs** - Enrollees with special health care needs must have direct access to a specialist as appropriate for the individual's health care condition.
b. **Out of Network Requirements** - The State through its health plans must provide Demonstration populations with the corresponding Demonstration program benefits described within these STCs and must adequately cover these benefits and services out of network in a timely fashion, for as long as it is necessary to provide them, at no additional cost to the enrollee.
c. **Timeliness** - The State through its health plans must comply with timely access requirements and ensure their providers comply with these requirements. Providers must meet State standards for timely access to care and services, considering the urgency of the service needed. Network providers must offer office hours at least equal to those offered to the health plan's commercial line of business enrollees or Medicaid fee-for-service participants, if the provider accepts only Medicaid patients. Contracted services must be made available 24 hours per day, seven days per week when medically necessary. The State, through the health plan contracts must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
d. **Credentialing** - The State through its health plans must demonstrate that the health plan providers are credentialed. The State must also require these health plans to participate in efforts to promote culturally competent service delivery.
e. **Demonstrating Network Adequacy -** Annually the State must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area.
    (1) The State must provide supporting documentation that must show that the health plan offers an adequate range of preventive, primary, and specialty services care for the anticipated number of enrollees in the service area. The network must contain providers who are sufficient in number, mix, and geographic distribution to meet the anticipated needs of enrollees.
    (2) The State through its health plans must submit this documentation when it enters into a contract.
        (a) The State must submit this documentation any time that a significant change occurs in the health plan's operations that would affect adequate capacity and services.
        (b) Significant changes include changes in services, benefits, geographic service area, or payments or the entity's enrollment of a new population.

f. **Certification** – Prior to enrollment and annually, the State is required to certify to CMS that each health plan has complied with State standards for service availability and must make all documentation available to CMS upon request.

VIII. OPERATION OF DEMONSTRATION PROGRAMS

A. Low Income Health Program

58. **Eligibility and Enrollment Processes -** For both the MCE and HCCI programs, eligible individuals may not be otherwise eligible for Medicaid or CHIP, must be non-pregnant, and must meet income eligibility standards that are determined on a county-by-county basis, with variation in the eligibility standards between counties within ranges established under this Demonstration. An individual determined eligible in one participating county who moves to another participating county will be disenrolled by the county in which the individual is no longer a resident, and may apply in the county to which the individual becomes a resident.
    a. **Definitions** -

i. **MCE Applicants** – are non-pregnant individuals between 19 and 64 years of age who are not enrolled in Medicaid or CHIP and who appear to have family incomes at or below 133 percent of the FPL (or less based on participating county standards) who have completed an application in a participating county and who have not had an eligibility determination.

ii. **MCE Recipients**

A. **New MCE Recipients -** Are individuals between 19 and 64 years of age who have family incomes at or below 133 percent of the FPL (or less based on participating county standards) are not enrolled in Medicaid or CHIP and who have been determined to be eligible for enrollment into a participating county program; and

B. **Existing MCE Recipients -** Includes certain individuals whose income is at or below 133 percent of the FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver at the effective date of this Demonstration, but who do not meet the income eligibility requirements under the Demonstration for the Low Income Health program in their county of residence.

iii. **HCCI Applicants** - are non-pregnant individuals between 19 and 64 years of age who appear to have family incomes above 133 through 200 percent of the FPL (or less based on participating county standards), are not enrolled in Medicaid or CHIP, do not have third party coverage, who have completed a written application for HCCI in a participating county and who have not had an eligibility determination.

iv. **HCCI Recipients**

A. **New HCCI Recipients** - Are individuals between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL(or less based on participating county standards), are not enrolled in Medicaid or CHIP, do not have third party coverage, and who have been determined to be eligible for enrollment into a participating county; and

B. **New HCCI Recipient Enrollment Limitation** – Within 60 days of Demonstration approval the State must provide to CMS for review and approval reasonable procedures and monitoring plans for assuring that MCE Applicants are enrolled prior to HCCI applicants. No FFP will be available for county plans that enroll new HCCI applicants at the exclusion of MCE applicants.

C. **Existing HCCI Recipients** - Includes certain individuals whose income is above 133 through 200 percent of the FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver" at the effective date of this Demonstration, but who do not meet the income eligibility requirements under the Demonstration for the Low Income Health Program in their county of residence.

v. **Initial Eligibility Determination –** the determination by a participating county as to whether an applicant meets the eligibility standards for the MCE or HCCI programs, using applicable methodologies or procedures in effect in the county under this Demonstration, As set forth below, a county may determine an individual eligible subject to a waiting list.

b. **Income Range for Eligibility**

i. **Baseline Income Limit Notice**. The State will provide to CMS within 60 days after Demonstration approval and with each newly participating county the following:

A. The actual upper income limit elected by the county for recipient eligibility for the:

1. MCE population - which must be at or below 133 percent of the FPL; and
2. HCCI population - which must be above 133 through 200 percent of the FPL.

B. Actual/projected enrollment for the county by:

1. MCE population; and
2. HCCI population.

C. The projected expenditure limit for the county's

1. MCE population: and
2. HCCI population.

D. Any county-specific eligibility standards, methodologies, or procedures in effect in determining how MCE and HCCI applicants become recipients.

ii. **Adjustments to the Income Limit** – In the event that, based on advance budget projections made by the county, funding will not be sufficient to continue to enroll applicants under the levels the county establishes in paragraph 58.b.i., the county may reduce the income limit for new applicants. Any reduction in income limits must ensure that lower income applicants remain eligible unless applicants with higher incomes are ineligible (as a result, upper income limits may not be reduced for MCE applicants unless the county no longer extends eligibility to HCCI applicants). As described in paragraph 60, eligibility levels for recipients will be maintained. In such cases, The State must submit a 90 day written notice to CMS describing the nature of the adjustment to the income limit, the start date of the adjustment(s), and the County's actual and projected enrollment.

c. **Enrollment Caps -** In cases where a county determines, based on advance budget projections that it cannot continue to enroll applicants without exceeding the funding available for the county program, the county can establish enrollment caps for the HCCI program. If, notwithstanding enrollment caps that totally close new enrollment in the HCCI program, the county estimates that it will still exceed available funding, the county can establish enrollment caps for the MCE population.

d. **Wait Lists for MCE and HCCI Applicants** - The State may employ county based wait lists when a county has established enrollment caps pursuant to the preceding paragraph, as a method of managing individual applicant enrollment into a county based HCCI or MCE program.

e. **Outreach for those on the Wait Lists -** The State will ensure that county based outreach is conducted for those individuals on a wait list, for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are still seeking coverage. Outreach materials will remind individuals they can apply for Medicaid and CHIP programs at any time.

59. **Eligibility Determinations.**
   a. Eligibility determinations for the MCE and HCCI populations will be made by individuals who are employed under merit system principles by the State or local governments, including local health departments. These employees will refer any applicant who may be eligible for either Medicaid or CHIP to the State or local government social services office for an eligibility determination. Any individual eligible for either Medicaid or CHIP is not eligible for enrollment into the MCE or HCCI program.
   b. Counties will develop eligibility income standards, methodologies and procedures for the MCE and HCCI populations. Such income standards, methodologies and procedures must comply with the requirements of section 42 USC 1396b(x) [Social Security Act section 1903b(x)] and 42 USC 1396a(a)(46)(B) [1902(a)(46)(B)] regarding documentation of immigration status.

60. **Eligibility Redeterminations -** Recipients enrolled in a MCE or HCCI program must have an eligibility redetermination at least once every 12 months.
   a. These eligibility redeterminations cannot be more restrictive during the redetermination period than those "in effect" during the period of the MCE or HCCI recipient's initial eligibility determination.
   b. Each redetermination must include a reassessment of the recipient's eligibility for Medicaid and CHIP. If upon a redetermination, a recipient is determined ineligible the recipient shall be disenrolled and referred to the county Medi-Cal office.

c. A MCE or HCCI enrollee may apply for eligibility under Medicaid or CHIP at any time for any reason. The State will determine eligibility for Medicaid and CHIP and enroll individuals in programs for which they are found eligible.

61. **Retroactive Eligibility.** Retroactive eligibility up to 3 months prior to the date of application may be extended to the MCE population, at county option, similar to the retroactive eligibility under the State plan.

62. **Disenrollment of Recipients.**
    a. **MCE population –** Recipients will be disenrolled:
        i. In accordance with Medicaid law and policy; or
        ii. If they no longer reside in the county participating in the MCE program.
    b. **HCCI population** – Recipients will be disenrolled if they:
        i. Exceed income limits allowed for the program at redetermination;
        ii. Voluntarily withdraw from the program
        iii. No longer reside in the County participating in the HCCI
        iv. Become incarcerated or are institutionalized in an IMD;
        v. Attain age 65;
        vi. Are no longer living; or
        vii. Obtain other health coverage.

63. **Standard Low Income Health Program Benefits** - consists of a core set of services and other add-on services allowable under Section 1905(a) of the Social Security Act, which are reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage, may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 CFR 440.230). FFP is available for such services through the authority granted in this Demonstration.
    a. **MCE population core benefits to the extent available under the California State Plan**:
        i. Medical equipment and supplies;
        ii. Emergency Care Services (including transportation);
        iii. Acute Inpatient Hospital Services;
        iv. Laboratory Services;
        v. Mental health benefits as described in STCs 64 and 65;
        vi. Prior-authorized Non-Emergency Medical Transportation (when medically necessary, required for obtaining medical care and provided for the lowest cost mode available);
        vii. Outpatient Hospital Services;
        viii. Physical Therapy;
        ix. Physician services (including specialty care);
        x. Podiatry;
        xi. Prescription and limited non-prescription medications;
        xii. Prosthetic and orthotic appliances and devices; and
        xiii. Radiology.

    b. **HCCI population core benefits**:
        i. Medical equipment and supplies;
        ii. Emergency Care Services;
        iii. Acute Inpatient Hospital Services;
        iv. Laboratory Services;

v. Outpatient Hospital Services;
vi. Physical Therapy;
vii. Physician services;
viii. Prescription and limited non-prescription medications;
ix. Prosthetic and orthotic appliances and devices; and
x. Radiology.

c. **Excluded Benefits** - Services and Benefits excluded from the MCE and HCCI core benefit plans include:
   i. Organ Transplants;
   ii. Bariatric surgery; and
   iii. Infertility related services (Eligible individuals requiring these services are to be seamlessly enrolled into the Family Planning, Access, Care and Treatment Program (F-PACT)).

d. **Enhancements to Core Benefits**. - Counties may provide benefits that include additional Medicaid eligible services above the minimum benefits and receive Federal funding. The State will submit such proposals to CMS for approval.

e. **Denial of Services** - The LIHP program may exclude from the core benefits those services listed above, except medically necessary emergency care services for MCE populations, that are rendered by providers that are not in the provider network for the LIHP program.

f. **Coverage of Out-of-Network Emergency Services**. Participating counties under the LIHP must provide coverage of emergency services provided in hospital emergency rooms for emergency medical conditions, and/or required post-stabilization care, regardless of whether the provider that furnishes the services is within the LIHP network.
   i. **Payment.** LIHP programs may pay for emergency services and post-stabilization services provided by out-of-network providers at 30 percent of the applicable regulatory fee-for-service rate under the State plan (less any supplemental payments), except that, with respect to inpatient hospital services, LIHP programs may pay 30% of the applicable regional un-weighted average of per diem rates paid to SPCP-contracted hospitals. The out-of-network provider must accept LIHP program payments made in accordance with these STCs as payment in full for the services rendered, and the LIHP recipient may not be held liable for payment.
   ii. **Out-of-network providers** must, as a condition for receiving payment for emergency services, notify the LIHP program within 24 hours of admitting the patient into the emergency room, and, with respect to post-stabilization care, meet the approval protocols established by the LIHP program.
   iii. **Definitions.**
      (1) **Emergency medical condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
         (a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
         (b) Serious impairment to bodily functions.
         (c) Serious dysfunction of any bodily organ or part.
      (2) **Emergency services** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under this title, and needed to evaluate or stabilize an emergency medical condition.
      (3) **Post-stabilization care services** means covered services related to an emergency medical condition that, subject to approval protocols, are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition.

g. **Funding of Out-of-Network Emergency Services**. In addition to the funding mechanisms described in paragraph 39 [CPE and IGT], the State may fund the nonfederal share of LIHP program payments for out-of-network emergency services with provider fee revenues that comply with section 1903(w).
h. **LIHP Plan Materials**. LIHP programs will include in plan materials information about their ability to receive emergency and/or post-stabilization services in out-of-network hospitals as well as their right to not be liable for payment for these services. LIHP programs will ensure that beneficiary id cards indicate to emergency providers that the LIHP program should be contacted for reimbursement and approval for post-stabilization services.
i. **Provider Bulletin**. The State will issue a provider bulletin indicating the requirement that providers must accept the LIHP out of network emergency service rates as reimbursement in full and are not permitted to balance bill patients.

64. **MCE Mental Health Benefit Criteria** - The MCE enrollee as described in paragraph entitled "Eligibility" must be diagnosed by a MCE participating provider, within their scope of practice, with a mental health diagnosis specified in the most recent version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.
    a. The enrollee must also have at least one of the following impairments as a result of the diagnosed mental disorder:
        i. A significant impairment in an important area of life functioning.
        ii. A probability of significant deterioration in an important area of life functioning.
    b. The intervention recommended by the enrolled provider, within their scope of practice, must be reasonably calculated to:
        i. Significantly diminish the impairment; or
        ii. Prevent significant deterioration in an important area of life functioning.
    c. In addition to the criteria listed above, for an inpatient admission for treatment of a diagnosed mental disorder, one or more of the following criteria may also apply:
        i. The impairment, symptoms or behavior:
            (1) Represent a current danger to self, others or property;
            (2) Prevent the enrollee from providing for, or utilizing food, shelter or clothing;
            (3) Present a severe risk to the enrollee's health and safety;
            (4) Require further psychiatric evaluation or medication treatment that cannot be provided on an outpatient basis.

65. **Mental Health Benefits for MCE enrollees** - The State must offer a minimum evidence-based benefits package for mental health services under the Demonstration, to promote services in community-based settings with an emphasis on prevention and early intervention.
    a. **Minimum Benefits Package** - Each county will provide the minimum level of mental health benefits to enrollees:
        i. Up to 10 days per year of acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.
        ii. Psychiatric pharmaceuticals.
        iii. Up to 12 outpatient encounters per year. Outpatient encounters include assessment, individual or group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment to an enrollee exists, the plan will optionally expand the service(s).
    b. **Benefits beyond the Minimum**. - Counties may provide benefits that include additional Medicaid eligible services above the minimum benefits and receive Federal funding. The State will submit such proposals to CMS for approval.
    c. **Option to carve out Mental Health Benefits**- Counties may opt to provide mental health services through a delivery system that is separate for the LIHP.

66. **Design of Behavioral Health Needs Assessment -** Upon Demonstration approval, the State shall work with CMS, SAMSHA, State Departments of Mental Health and Alcohol and Drug Programs to design an approach for a systems assessment to identify the services (including amount, duration, and scope) available throughout the State. This assessment design shall also include information on available service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

67. **Initial Behavioral Health Services Needs Assessment** - No later than March 1, 2012, The State will submit to CMS a comprehensive assessment, developed collaboratively with the State Departments of Mental Health and Alcohol and Drug Programs, of its current behavioral health system, anticipated growth needs to meet all Medicaid needs by 2014, including mental health and substance use services system. This assessment shall include an accounting of the services (including amount, duration, and scope) available throughout the State as of the assessment. This assessment shall also include information on available service delivery infrastructure, information system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization) current levels of behavioral health and physical health integration and other information necessary to determine the current state of behavioral service delivery in California.

68. **Behavioral Health Services - By October 1, 2012,** the State will submit a detailed plan, including how the State will coordinate with the Department of Mental Health and Alcohol and Drug Programs, to CMS outlining the steps and infrastructure necessary to meet requirements of a benchmark plan and ensure strong availability of behavioral health services statewide no later than 2014. This plan must be approved by CMS.

69. **Technical Assistance for Assessment and Plan -** CMS, in partnership with other Agencies of the Department of Health and Human Services, including the Substance Abuse and Mental Health Services Administration, will provide technical assistance in the development and conduct of the assessment(s), and the plan to ensure service delivery capacity sufficient to meet Federal requirements effective in 2014.

70. **Cost Sharing Parameters for the LIHP Population**.
    a. MCE related enrollment fees and premiums must be discontinued for enrollees with family income at or below133 percent of the FPL and newly participating MCE program counties must comply with Medicaid cost sharing limits for MCE and HCCI populations.
    b. **Effective July 1, 2011.** All cost-sharing must be in compliance with Medicaid requirements for State plan populations that are set forth in statute, regulation and policies and all HCCI enrollees must be limited to a 5% aggregate cost sharing limit per family.

71. **Delivery Systems for the LIHP Population.** If the State chooses to use a managed care delivery system to provide benefits to the LIHP population, any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care case management systems (PCCMs) [collectively referred to as managed care entities] is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, except as expressly noted below and consistent with the Demonstration waiver and expenditure authorities. A county based delivery system with a closed network of providers will be considered a managed care delivery system.

72. **Network Adequacy and Access Requirements for the LIHP Population**. The State must ensure that any managed care entity complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.
    a. Accessibility to primary health care services will be provided at a location within 60 minutes or 30 miles from each enrollee's place of residence. Primary care appointments will be made available within 30 business days of request during the period of the Demonstration term through June 30, 2012 and within 20 business days during the Demonstration term from July 1, 2012 through December 31, 2013. Urgent primary care appointments will be provided within 48 hours (or 96 hours if prior authorization is required) of request.
    b. Specialty care access will be provided at a minimum within 30 business days of request.
    c. Network providers must offer office hours at least equal to those offered to the health plan's commercial line of business enrollees or Medicaid fee-for-service participants. Services under the contract must be made available 24 hours per day, seven days per week when medically necessary. The State, through managed care entity contracts must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
    d. The State will establish alternative primary and specialty access standards for rural areas, service areas within a county with a population of 500,000 or fewer, other areas within a county that are sparsely populated, or other circumstances in which the standards are unreasonably restrictive.
    e. In an area of Los Angeles County where an uneven distribution of population resides across a large geographic area, the County shall, in instances where there is no network participation by other designated public hospitals or non-designated public hospitals, include coverage of inpatient hospital services at the nearest network hospital through the provision of appropriate transportation that is commensurate with patient need, is required for obtaining medical care and is provided at the lowest cost mode available.
    f. A plan will not be found to be in violation of 1902(a)(10)(A) with respect to the provision of federally-qualified health center services as long as it contracts with or otherwise offers services through at least one such health center.
    g. **Penalty Provisions Related to Network Readiness and Adequacy**. Failure to implement or operationalize the provisions listed in this STC will result in the loss of a percentage of the expenditure cap applicable to Safety Net Care Pool (SNCP) expenditures cap (not including HCCI expenditures) under the expenditure authorities. If the State fails to meet a provision, related to Network Adequacy and Access Requirements for the LIHP Population ,the annual expenditure authority cap will be reduced by the amount(s) listed in the table below for SNCP expenditures other than those reserved for the HCCI.

Deadline	Penalty Amount as a percentage of The Annual Safety Net Care Pool Expenditure (Total Computable)
Prior to Demonstration Enrollment	5.0 %
Nov, 1, 2011 and annually	5. 0%

    h. **Application of the Penalty**. The State's annual expenditures under the SNCP will be reduced in the proceeding DY to the extent described above. Thirty days after the close of the DY, the State's annual expenditures under the SNCP for that year will be determined. The reduction in expenditure authority shall be applied to sequential DYs, if the State has not met the required provisions. Once a requirement has been met, no further penalties associated

with that requirement will be imposed.

73. **LIHP Credentialing and Cultural Competence** - The State must ensure that providers of all managed care entities are appropriately credentialed for the services furnished, and must ensure that the managed care entities participate in efforts to promote culturally competent service delivery.

74. **Encounter Data.** Each county LIHP managed care delivery system in the Demonstration will be responsible for the collection and reporting of all data on services furnished to Demonstration enrollees through encounter data or other methods as specified by the State. The State will, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all outpatient, inpatient and physician services.

75. **Federal Financial Participation for the Medicaid Coverage Expansion (MCE) Population** - There will be no limit to the FFP in expenditures for the provision of services to MCE populations.

76. **Due Process** – By May 1, 2011, the State must implement standards and procedures for hearings and appeals by LIHP applicants and recipients. These standards and procedures shall not go into effect until approved by CMS. The State's proposed standards and procedures shall be submitted to CMS for review by January 1, 2011.
    a. **Scope** - the State must describe the standards and procedures for hearings and appeals from the following determinations under the LIHP:
        i. Denial, reduction or termination of eligibility;
        ii. Denial of enrollment and placement on a waiting list; or
        iii. Denial, reduction or termination of specific benefits.
    b. **Standards and Procedures** - must include, but are not limited to:
        i. Notices provided to individual applicant or recipient prior to an adverse action taking place, include content of the notice and timeframes the notice will be issued;
        ii. Requirement to maintain and reinstate services in appropriate circumstances per 42 CFR 431.230 and 231.
        iii. Hearing rights - To include, but not be limited to, right to a "de novo hearing," neutral arbiter, right to review case record, present evidence, and question or refute evidence (including to cross-examine witnesses)
        iv. Hearing decision and informing the applicant or recipient of the decision.
    c. **Expedited Process** - Any process the state may use to expedite hearings or appeals.
    d. **Recoupment** - The procedure the State may employ to recoup payments made pending an appeal that upholds a denial or termination of eligibility or benefits.
    e. **Federal Financial Participation (FFP)** – Once the State's unique hearings and appeals standards and procedures go into effect, FFP will be available in administrative costs to the State of operating the hearings and appeals system, and for medical assistance costs for benefits within the scope of the Demonstration to carry out the hearing decision. But no FFP will be available to the State for the administrative or medical assistance costs relating to judicial appeals challenging the adequacy of the hearing system (including remanded cases). Since the State will be exercising flexibility to deviate from the federal standards and procedures, the State will be at risk for defending its hearing and appeals system procedures and related substantive outcomes.

B. Managed Care Delivery Systems for Seniors and People with Disabilities (SPD) Populations Affected by the Demonstration

If the State chooses to use a managed care delivery system to provide benefits to the SPD population, any managed care delivery system which uses managed care organizations (MCOs), health-insuring organizations (HIOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care case management systems (PCCMs) [collectively referred to as managed care entities) is subject to all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, except as expressly noted below and consistent with the Demonstration waiver and expenditure authorities. Each of these STCs is in addition to standards established under other provisions of the STCs for this Demonstration, and nothing in this section waives any provision of Part 438 of Title 42 to the Code of Federal Regulations (CFR) and Section 1903(m) of the Social Security Act. Requirements related to tribal members apply to this section. Timelines included for CMS review (and approval as noted) reflect dates identified to the "Critical Path for SPD Enrollment" (See Attachment A). These STCS apply to the counties indicated in Attachment L – County List for SPD Enrollment.

77. Mandatory Enrollment of SPDs

a. **Enrollment** - The State may mandatorily enroll SPD in managed care programs to receive benefits. The mandatory enrollment of SPD individuals will apply to new or existing Medi-Cal when the plan or plans in the geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The State will provide updates through its regular meetings with CMS and submit regular documentation requested of its Readiness Review status.

b. **Choice** - For counties that do not operate a County Organized Health Systems (COHS), the State will ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 plans meeting all readiness requirements from which to choose. For counties that operate a COHS, the State need not ensure any choice of plans.

c. **Notice Requirement for a Change in Network** - The State will provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State may not mandatorily enroll the SPD population into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

d. **Enrollment and Contracting** - The State will not begin mandatory enrollment of the SPD population into a managed care plan prior to obtaining contract approval from CMS. The State will utilize appropriate risk adjustment in the development of its capitation payments and will set forth expectations for plans to ensure sufficient access, quality of care, and care coordination for beneficiaries. By April 1 2011 or with at least 60 days notice, prior to their effective date the State will submit contracts to CMS for approval.

e. **Advisory Committee** - The State will maintain for the duration of the Demonstration a managed care advisory group comprised of individuals and interested parties impacted by Medi-Cal managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of newly mandatorily enrolled individuals.

78. SPD Benefit Package

a. SPDs mandatorily enrolled in any managed care program within the State will receive from the managed care program the benefits as identified in Attachment M – Capitated Services List/Managed Care Benefit Package. The attachment must also indicate the services excluded from the benefit package; those services will be available outside of the managed care program. As noted in plan readiness and contract requirements, the State will assure that enrolled individuals shall have referral and access to State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and will also assure referral and coordination with services not included in the established benefit package.

b. Any addition or subtraction in Medicaid program benefits, such as home and community based services (HCBS), for any specific population added to the established benefit package will require an amendment to the Demonstration. Attachment M must also be updated and submitted when such a change is proposed.

79. Consumer Assistance

a. **Initial Outreach and Communication Strategy –** By December 2010 the State shall develop, and CMS shall review, an outreach and education strategy to explain the changes to individuals to be impacted by mandatory enrollment. The strategy shall describe the State's planned approach for advising individuals regarding health care options utilizing an array of outreach techniques (including in person as needed) to meet the wide spectrum of needs identified within the specific population. The strategy will further articulate the State's efforts to ensure that the individuals have access to information and human assistance to understand the new system and their choices, their opportunities to select a health plan or particular providers and to achieve continuity and coordination of care. The strategy will include a timeline for implementation. All updates or modifications to the outreach and education strategy shall be submitted to CMS for review throughout the Demonstration.

b. **CMS Review of Enrollee Communication** - The State will submit to CMS any written communication from the State to enrollees for review, before they are sent to beneficiaries. **Ongoing.**

c. **Ongoing Outreach and Communication Strategy -** The State shall provide to CMS by March 1, 2011 the State's communication strategy that reiterates options and articulates the rights of individuals impacted by mandatory enrollment as required by 42 CFR 438.The State shall submit its strategy describing the State's methodology for advising individuals utilizing an array of outreach techniques to meet the wide spectrum of needs identified within the population. The strategy will further articulate the State's efforts to ensure that the individuals have access to human assistance to understand the new system and their choices, their opportunities to select a health plan or particular provider and to achieve continuity of care and care coordination. On an ongoing basis the State will assure that enrollees be notified of changes that will have a major impact on their benefits or access no less than 30 days prior to the change.

d. **Sensitivity Training**. The State shall submit to CMS for review and approval, the State-proposed draft SPD Sensitivity Training curriculum, including anticipated target audience, by **November 1, 2010.** Updates or modifications to the curriculum shall be submitted to CMS throughout the Demonstration.
   i. All appropriate plan and State staff shall be trained using the *SPD Sensitivity Training Curriculum* by **March 2011.**

e. **Informing/Education Materials** - The State shall develop, and submit for CMS review informational and educational materials that meet the requirements of 42 CFR 438 by **November 1, 2010** to explain the changes in service delivery. Such materials must comport with 42 CFR 438., and be developed in collaboration with stakeholders. These materials must be sent to the CMS Regional Office for review in advance of mailings to beneficiaries. Information should include information on timeframes, enrollment choice options and types and availability of assistance.

The State shall submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain every facet of mandatory enrollment, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process. These would include directional memoranda to plans, online tools or other policy or guidance conveyance documents. Updates or modifications to the curriculum shall be submitted to CMS throughout the Demonstration.

f. Offers of individual assistance should be prevalent in documentation developed by the State and the plans including information on how to obtain in-person individual assistance through various means in an effort to minimize default assignments (e.g., assistance through enrollment broker, availability of a toll-free number, etc.).

i. **CMS Review** - The State will submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain every facet of mandatory enrollment, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process. These would include directional memoranda to plans, online tools or other policy or guidance conveyance documents. Updates or modifications to the curriculum will be submitted to CMS throughout the Demonstration.

ii. **Communication Follow-up** - Offers of individual assistance should be prevalent in documentation developed by the State and the plans.

g. **Readability and Accessibility**- All education materials, mail or electronic, should be available in languages, in formats, and at reading levels that will substantially meet the needs of the individuals impacted by the mandatory enrollment.

h. **Community Presentation**. The State shall submit to CMS, for review, the State's proposed "Community Presentation" by **February 1, 2011** and complete all "Community Presentations" **by May, 2011.** Forums or locations for these Presentations will be determined in collaboration with stakeholder groups.

80. Transition into Mandatory Managed Care and Enrollment Strategies

a. **Approaches to Affirmative Choices** - The State will implement mandatory managed care for all SPD populations affected by the Demonstration in:
   i. Any non- County Organized Health System (COHS) participating county by assuring that at least 2 plans are meeting the readiness requirements by **June 1, 2011**.
   ii. Any new non-COHS county cannot implement mandatory managed care for SPDs until the designated plan meets the same readiness requirements as described in paragraph 81
      a. Beginning **June 1, 2011**, SPD individuals in each county will be enrolled on a rolling basis over a 12 month period based on the date of their birth. The State may propose for CMS review and approval a plan for the enrollment of individuals living in Los Angeles County on a basis other than enrollment by the date of birth.

b. Through the outreach, enrollment and education strategy the State will articulate and establish clear methods for affirmative choice for individuals (e.g., online, in person, in writing, verbal with signature confirmation, by proxy or surrogate decision-maker, etc.). By **January 1, 2011**, these methods will be available for review by CMS.

b. **Approaches to Default**

i. For individuals who do not make an affirmative choice, and after repeated efforts (letter, followed by at least 2 phone calls) to encourage choice, the State will identify individual claims and data to make a default selection into a plan based on usual and known sources of care, including previous providers, and utilization history, including use of particular specialty providers data. Default enrollees will have the opportunity to see their existing providers for a period of 12 months after enrollment as described in paragraph 81.f. iii. The default shall not occur until education and outreach efforts are conducted (in person as needed) as noted above. The State must submit its default process rationale and design to CMS prior to initial enrollment. When an assignment cannot be made based on affirmative selection or utilization history, plan assessment shall be based on factors such as plan quality and safety net providers in a plan's network.

ii. By April 2011, the State will provide documentation and assurances for CMS review, that the infrastructure is in place at the State level, and across the plans, to effectively manage the default selection process prior to **June 1, 2011**.

iii. The State shall submit to CMS for review and approval the enrollment broker protocol and business rules for default process, and documentation requirements for failed affirmative selection leading to SPD default. Such protocol should, in circumstances where available data and utilization is insufficient to provide a clear, reasonable default selection, provide for pre-default assessment to determine individual needs. **November 1, 2010.**

iv. The State shall inform individuals of their opportunity to change plans at any time. **Ongoing.**

c. **Efforts to Ensure Seamless Transitions**

i. For each enrollee, the State shall provide the health plan data from Medi-Cal fee-for-service (FFS) paid claims, including that of other delivery systems billed through FFS, ICD codes, and available provider information. The State will provide CMS with its methodology for providing plans with a maximum of available data on Medi-Cal service utilization and provider utilization for SPD enrollee. This includes Medi-Cal administered services that are administered through sister agencies and takes into account the use of electronic health records (EHR) and Health Information Exchange as a source of clinical data on SPD enrollees as it becomes available. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.

ii. **By April 2010**, the State shall provide documentation that information technology systems and infrastructure are in place and can effectively manage the data exchange expectations set forth in this section to support smooth transition on **June 1, 2011**.

iii. The State shall provide data to plans to assist plans in identifying enrollees with complex, multiple, chronic or extensive health care needs or high risk enrollees upon assignment or enrollment.

iv. The State will work with CMS to establish a mechanism within its Money Follows the Person (MFP) Demonstration, "California Community Transitions," to increase opportunities for eligible individuals to access HCBS upon discharge from hospitals and nursing facilities as an alternative to institutional services.

81. Plan Readiness and Contracts

a. **Plan Readiness – Initial and Ongoing**
   i. The State shall consult with CMS to determine the final procedures for establishing and monitoring initial and ongoing network adequacy to serve the mandatorily enrolled SPDs that ensures compliance with 42 CFR 438 and the Knox Keene Act. The final methodology will be developed in consultation with CMS and will include such items as specialist to beneficiary ratios based on data from the COHS, geo-mapping of FFS providers versus network providers, minimum standards regarding access to specialty providers and their capacity to serve individuals, physical and programmatic accessibility of the plan (including completion of facility site reviews before readiness) or other strategies to ensure adequate network resources to meet the needs of the individuals to be served. **December 1, 2010.**
   ii. The State will provide support to CMS in its review and determination of appropriateness of all contract amendments including the provision of documentation. **Ongoing**.
   iii. The State will complete network certifications for each county. Each county network certification will be done across the geographic area covered by the county. **March 1, 2011**.
   iv. The State will submit any updates to the network adequacy procedures upon changes. **Ongoing.**

b. At any time, CMS may require mandatory enrollment freezes based upon review of State reports if it is evident that network adequacy targets are unmet. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that network adequacy is not met. Any available statutory or regulatory appeal procedures will apply. **Ongoing.**

c. The State will submit to CMS for review and approval a list of deliverables/submissions for readiness that is being requested from plans (presently and on regular intervals), and a description of State approach to analysis and verification. **November 1, 2010.**

d. The State shall submit to CMS its plan for ongoing monitoring of plans. Beginning in year one of mandatory enrollment, monitoring must occur quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter until the quarter ending **December 31, 2013.**

e. By April 1, 2011 the State will submit to CMS for review the State's contingency plan for addressing insufficient network issues.

f. Items Necessary for plan readiness:

   i. **Care Coordination** - The State shall submit to CMS their procedures for ensuring that each plan has sufficient resources available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the SPD population and include capacity to provide linkages to other necessary supports outside of each plan's benefit package (e.g., mental health and behavioral health services above and beyond the

benefits covered within the plan, personal care, housing, home delivered meals, energy assistance programs, services for individuals with intellectual and developmental disabilities and other supports necessary). The needs may be identified through the risk assessment process. Care shall be coordinated across all settings including services outside the provider network. **March 1, 2011.**

ii. **Standardized Assessments** - The State shall provide detailed information regarding the process to conduct health risk assessments for individuals at risk based on FFS data. **April 1, 2011.**

The State shall direct the plans to engage in a preliminary assessment/screen of needs of enrolled individuals within 44 days of enrollment. **Ongoing.**

The State shall ensure minimum assessment/screen components to be included in any assessment/screen administered by the plans to enable comparability and standardization of elements considered and included in all plan assessments. **Ongoing.**

iii. **Care Continuity** – Initial and Ongoing - The State shall ensure that the plans have mechanisms to provide continuity of care to SPD enrolled individuals in order to furnish seamless care with existing providers for a period of at least 12 months after enrollment-and established procedures to bring providers into network.

The State shall submit to CMS the policies and procedures that will establish and maintain a statewide, standardized exception process for an extended period of care continuity for individuals with significant, complex or chronic medical conditions. **May 1, 2011**.

iv. **Person-Centered Planning and Service Design** - The State ensures that all contracts will include an assurance that the plans will have protocols in place to require person-centered planning and treatment approaches for each enrollee by the end of the first year of the Demonstration. While definitions and models of person-centered planning vary, the protocols shall, at a minimum, address the following: 1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.

v. **Specialty Healthcare Sufficient Provider Pool** - The State shall ensure that each plan has a sufficient supply and continuum of providers to meet the unique needs of the population to be served as required by 42 CFR 438..206-207, the Knox Keene Act and other applicable state law and regulation. Such adequacy analysis can be based upon COHS plans *data.*

vi. **Geographic Accessibility** - The State shall ensure that each plan has an accessible network (including specialty providers) with reasonable geographic proximity to the individuals enrolled as required by State statute and regulations, including the Knox Keene Act, taking into account the location of FFS providers, means of transportation ordinarily used by SPD enrollees, and taking into consideration community standards as necessary, including time and distance standards.

vii. **Physical Accessibility** - The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility.

viii. **Interpreter Services - Information Technology** - The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care.

ix. **Transportation – Specialized** - The State will ensure that each plan has non-emergency medical transportation available in sufficient supply and accessibility so that individuals have easily accessible and timely access for scheduled and unscheduled medical care appointments.

x. **Fiscal Solvency (SPD-specific considerations)** - The State shall ensure a plan's solvency prior to implementing mandatory enrollment and shall continue to monitor on a quarterly basis.

xi. The State shall continue to ensure that all capitation rates developed for the Medicaid managed care program are actuarially sound and adequate to meet population needs pursuant to 42 CFR 438.6 (c).

xii. **Transparency** - The State shall require that plan methods for clinical and administrative decision-making are publicly available in a variety of formats, as well as elements of contractual agreements with the State related to benefits, assessments, participant safeguards, medical management requirements, and other non-proprietary information related to the provision of services and supports to SPDs.

The State shall require that each plan utilize its community advisory committee, and that the plans engage in regular meetings with its stakeholder advisory committees.

xiii. **Timing** - The State will ensure that plans are able to serve individuals, including specialty providers, within reasonable and specified timeframes for appointments, including expanded appointment times as needed to meet the individuals' particular needs.

xiv. **Access to non-network specialty providers** - The State shall ensure that plans provide enrolled members timely access to non-network specialty providers as required by 42 CFR 438, State statute and regulations and the Knox Keene Act.

Submit final plan readiness specifications to CMS for Review and Approval beginning in November, 2010.

82. **Contract Requirements** - Each of the elements noted in 81a. above as essential to determine plan readiness will be included in the State's contracts with each of the plans in a manner that ensures consistency of services, operations, participant rights and safeguards, quality and access to services. In addition to these elements, the State will ensure that each plan contract contains:

a. Transition Services and Care Coordination requirements to address discharge planning and transition requirements to ensure that:
    i. Discharge planning occurs with individuals, or their representatives, as applicable, starting from the time individuals are admitted to a hospital or institution; and
    ii. Appropriate care, services and supports are in place in the community before individuals leave the hospital or institution. The State will encourage statewide use of a uniform discharge planning checklist (see Attachment B).
b. Linkage expectations for linking beneficiaries to providers using claims data or other data sources, such as electronic health records (EHRs) and Health Information Exchange (HIE) as a source of clinical data on SPD enrollees. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements. (including mechanisms for regular monitoring).
c. Expectations regarding plan obligation to link individuals to services outside of plan benefit packages.
d. Requirements for Person-Centered Planning/Consultation, including uniform approach to be used by all plans as required in Plan Readiness Section.
e. Each plan shall be required to submit service encounter data, for individuals enrolled, as determined by the State and as required by 42 CFR 438 and 1903 of the Act as amended by the Affordable Care Act.. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion by January 2012.
f. The State must ensure that the notices to beneficiaries are standardized and meet all Federal and State legal requirements.
g. The State must ensure that a uniform Grievance System is in place and monitored by the State for enrolled individuals in each plan that includes a grievance process, an appeal process and access to the State's Fair hearing process as defined in the Medicaid statutory and regulatory requirements per 42 CFR 438 subpart F. This includes, but is not limited to the following:
    i. Protocols for receiving, tracking and resolving grievances (complaints)
    ii. Protocols for what to include in a Notice of Action when a service request is denied or reduced
    iii. Protocols for receiving tracking and responding to Member Appeals including Notice of Decision including State Fair Hearing Request instructions
h. Grievance and appeal procedures must comply with Medicaid statutory and regulatory requirements per 42 CFR 438.400-424, Medi-Cal statutory and regulatory requirements and the Knox-Keene Act as applicable.
i. SPDs will be substantially involved in plan advisory groups and committees.
j. Quality improvement committees will include SPDs.
k. Provisions outlining when out-of-network care be provided.
l. Comprehensive health assessments for SPDs.
m. Coordination of carved out services based on FFS data.

Submit draft contract modification language for existing plans and newly contracting plans to CMS. November 1, 2010.

83. **Information Technology** - The State will submit to a plan to CMS to ensure that the State has information technology available and operational that can meet all requirements set forth in these SPD STCs. April 1, 2011.

84. **Health Home Service Delivery Model** - The State will ensure that any health home delivery model developed through the Demonstration will comport with Section 1945 of the Social Security Act (the Act), and any applicable Federal future regulation or guidance on its implementation.

Enhanced FMAP for health home services will only be available through the Demonstration, including for the Low Income Health Program, if the program design meets all applicable requirements of Section 1945 of the Act.

The State will assure a mechanism for tracking appropriate health home services to receive the enhanced FMAP.

The State will submit detailed information on health home program design in a manner specified by CMS for approval prior to the State's implementation of the design.

85. **Participant Rights and Safeguards**

    a. **Information** - All information provided to enrollees, inclusive of and in addition to educational materials, enrollment and disenrollment materials, benefit changes and explanations and other communication, will fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

    b. **Disenrollment** - Individuals should be informed of opportunities no less than annually for disenrollment and ongoing plan choice opportunities regularly an in a manner consistent with 42 CFR 438 and other requirements set forth in the Demonstration terms and conditions.

86. **Quality Oversight and Monitoring** - In addition to all quality requirements set forth in 42 CFR 438, the State will ensure the following:

    a. **Encounter Data** - The State shall require each plan to submit comprehensive encounter data at least monthly, on all service utilization by seniors and persons with disabilities, in a manner that enables the State to assess performance by plan, by county, and Statewide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State shall ensure sufficient mechanisms and infrastructure in place for the collection, reporting, and analysis of encounter data provided by the plans. The State shall have a process in place to monitor that encounter data on SPDs from each plan is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require a contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion by January 2012. The State will provide summaries of this data in its regular meetings with CMS regarding the implementation of the Demonstration. Such data will be submitted as required in Section 1903 of the Social Security Act as amended by the Affordable Care Act.

    b. **Measurement Activities** - The State will collect data and information on the following measures to ensure ongoing monitoring of individual well being and plan performance. The State will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

       The State will submit a plan for CMS approval with timelines and capacity for developing and implementing additional HEDIS and QIP measures specific to the SPD population (as opposed to the general HEDIS and QIP measures). **April 1, 2011**

c. In addition to HEDIS and Existing CAHPS tools currently utilized, the State will consider the use of OASIS measures or other measures. The State shall also require the mandatory utilization of measures related to:
    i. Avoidable Hospitalizations
    ii. Hospital Readmissions
    iii. Emergency Room Utilization
    iv. Outcome measures related to person-centered care planning and delivery

    Initial performance measurement requirement changes relevant to the new mandatory SPDs will be added to the State's existing requirements to be effective in January 2012 and further changes will be made annually in subsequent years. The State will continue to collect and report performance measurement results for all managed care plan members and begin reporting statistically significant stratified results for mandatory SPDs once these members have had one year of continuous enrollment in managed care.

d. **Stratification and Analysis by County and Plan** - For all data collected from MCOs, and COHS the State will be able to stratify information by population, plan, and county. The State must also ensure that the data is collected in a manner that enables aggregation and reporting to ensure comprehensive plan oversight by the State of the counties and the plans.

87. **Notice of Change in Implementation Timeline** - The State must notify CMS of any potential changes in the implementation and deliverables timelines as specified above and in the "Critical Path" document below

88. **Withholding Approval** - At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that implementation timelines are not being met. Any available statutory or regulatory appeal procedures will apply.

89. **Applicability to Existing COHS Plans** – The State will ensure that COHS Plans formerly operating under 1915(b) authority prior to approval of this Demonstration or those COHS plans expanding in 2011 (Ventura, Marin and Mendocino counties) will meet the requirements in these STCs within a 2-year period after approval of this Demonstration , or provide to CMS its methodology for ensuring that the beneficiary protections, assessment, monitoring, and reporting requirements in this Section are being met by the State and contracted health plans.

90. **Applicability to Future COHS Expansions** – The State will ensure that any new COHS expansions that are implemented subsequent to this Demonstration with the exception of those COHS plans (Ventura, Marin and Mendocino counties) will meet the terms in this Section (B), or provide to CMS its methodology for ensuring that the beneficiary protections, assessment, monitoring, and reporting requirements in this Section are being met by the State and contracted health plans.

C. California Children's Services (CCS)

91. **CCS Pilot Programs Approval** - With at least 180 days-notice and after CMS approval the State may submit a plan to test up to four health care delivery models for children enrolled in the California Children's Services (CCS) Program. The plan shall include provisions to ensure adequate protections for the population served, including a sufficient network of appropriate providers and timely access to out of network care. The plan shall also include specific criteria for evaluating the models. These

CCS pilot models shall be eligible for FFP from the Date of CMS approval through December 31, 2015.

92. **CCS Pilot Program Protocol -** The overarching goal of the CCS pilot project is for the State to identify the model or models of health care delivery for the CCS population that results in achieving the desired outcomes related to timely access to care, improved coordination of care, promotion of community-based services, improved satisfaction with care, improved health outcomes and greater cost-effectiveness. CMS will evaluate the submitted pilot projects based on the criteria included in the plans and the following:

    a. A Program Description – inclusive of eligibility, benefits, cost sharing;
    b. Demonstration Program Requirements - inclusive of eligibility, enrollment, benefits, and cost-sharing;
    c. Budget/Allotment Neutrality projections
    d. Outcomes for -
        i. Ensuring that the CCS population has access to timely and appropriate, high quality and well-coordinated medical and supportive services that are likely to maintain and enhance their health and functioning and meet their developmental needs.
        ii. Increasing patient and family satisfaction with the delivery of services provided through the CCS program.
        iii. Increasing satisfaction with both the delivery of and the reimbursement of services among providers who serve the CCS population.
        iv. Improving the State's ability to measure and assess those strategies that are most and least effective in improving the cost-effectiveness of delivering high-quality, well-coordinated medical and supportive services to the CCS population.
        v. Increasing the use of community-based services as an alternative to inpatient care and emergency room use.
        vi. Reducing the annual rate of growth of expenditures for the CCS population.
    e. Use up to four models of care for care delivery:
        i. An Enhanced Primary Care Case Management (EPCCM) Program;
        ii. A Provider-based Accountable Care Organization (ACO);
        iii. A Specialty Health Care Plan (SHCP); and
        iv. Utilization of existing Medi-Cal Managed Care Plans.

IX. OTHER ADMINISTRATIVE REQUIREMENTS

93. **Medicaid Management Information System (MMIS).** In accordance with Title II (Administrative Simplification) provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the State must adopt the American Standards Committee X12 Group Version 5010 standard electronic transaction format and the International Classification of Diseases, 10th Revision (ICD-10) standard electronic code set by January 1, 2012 and October 1, 2013, respectively as a condition of the State continuing to receive 90% and 75% Federal financial participation for the design, development, implementation, and operations of the State's new Medicaid Management Information System (MMIS). FFP for the State's MMIS may be at risk if these standards are not implemented by the HIPAA-mandated compliance date.

94. **National Correct Coding Initiative (NCCI)**. In accordance with Section 6507 of the 2010 Affordable Care Act - Mandatory State Use of National Correct Coding Initiative (NCCI), the State must incorporate all five CMS-defined NCCI methodologies into its existing and new Medicaid Management Information System (MMIS) and edit claims against these five NCCI methodologies for claims filed on or after October 1, 2010. The State must submit an Advanced Planning Document no

later than March 1, 2011, to CMS for review and approval in order to effectively deactivate any NCCI edits after March 31, 2011. The State will not have the flexibility to deactivate any NCCI edits after March 31, 2011 due to lack of operational readiness.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

95. **Quarterly Reports.** The State will provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, and to separately identify expenditures provided through the California's Bridge to Reform Demonstration under section 1115 authority which are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. The CMS will provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI (Monitoring Budget Neutrality).

96. **Reporting Expenditures under the Demonstration.** In order to track expenditures under this Demonstration, California will report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM).

    a. All Demonstration expenditures claimed under the authority of Title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, costs settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.c. For any other costs settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on Lines 9 and 10.c., as instructed in the SMM. The term "expenditures subject to the budget neutrality cap," is defined in paragraph 97.

    b. For each Demonstration year, twenty (20) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration expenditures. The specific waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets below:
        i. Safety Net Care Pool – Hospital Services [SNCP-Hosp.];
        ii. Safety Net Care Pool – Non-Hospital Services [SNCP – Non-Hosp.];
        iii. Family & Children – [Families];
        iv. Existing Seniors & People with Disabilities [Existing SPD];
        v. Newly Mandatory Seniors & People with Disabilities [Mandatory SPD];
        vi. Low Income Care / Medicaid Expansion [MCE]
        vii. Low Income Care / Health Care Coverage Initiative [SNCP - HCCI];
        viii. California Children Services [CCS – State Plan]
        ix. California Children Services - Designated State Health Program [CCS - DSHP]
        x. Genetically Handicapped Persons Program - Designated State Health Program [GHPP – DSHP]
        xi. Medically Indigent Adult Long Term Care - Designated State Health Program [MIALTC – DSHP]
        xii. Breast & Cervical Cancer Treatment Program - Designated State Health Program [BCCTP – DSHP]
        xiii. AIDS Drug Assistance Program - Designated State Health Program [ADAP- DSHP]

xiv. Expanded Access to Primary Care - Designated State Health Program [EAPC- DSHP]
xv. Department of Developmental Services - Designated State Health Program [DDS – DSHP]
xvi. Workforce Development Programs - Designated State Health Program [Work – DSHP]
xvii. Private and Non-Designated Government-Operated Hospital Payments [P/ND Govt. Hosp];
xviii. Designated Government-Operated Hospital Payments [D. Govt. Hosp]; and
xix. Delivery System Reform Incentive Pool [DSRIP - DSHP]
xx. County Mental Health Services [CMHS – DSHP]

97. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all expenditures, identified in paragraph 96.b.,(i - xx) except for (xvii-xviii). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

98. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration on Forms 64.10 Waiver and/or 64.10P Waiver. For each Demonstration year, 3 separate Forms CMS-64.10 Waiver and/or 64.10P Waiver must be completed to track, report, and identify administrative costs directly attributable to the Demonstration and those that are attributable to the Medicaid Coverage Expansion (MCE) and Health Care Coverage Initiative (HCCI) for each Low Income Health Program (LIHP) under the Demonstration. The specific waiver names to be used to identify these separate Forms CMS-64.10 Waiver and/or 64.910 Waiver appear in brackets below:
    a. Administrative Costs - General [Non-LIHP Admin.];
    b. Administrative Costs – Health Care Coverage Initiative [HCCI Admin.];
    c. Administrative Costs - Medicaid Coverage Expansion [MCE Admin]

99. **Administrative Costs Associated with Low Income Health Program.** For these costs, the State must distinguish between direct services provided under the LIHP (MCE and HCCI) and administrative activities to ensure there is no duplicate claiming for the LIHP program.

100. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2 year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

101. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. California must estimate matchable Medicaid expenditures (total computable and Federal share) subject to the budget neutrality cap and separately report these expenditures by quarter for each Federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the appropriate Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures

reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

102. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding and in accordance with paragraphs 33 entitled Certified Public Expenditures and paragraph 46 entitled Federal Financial Participation for the Health Care Coverage Initiative, CMS will provide FFP at the applicable Federal reimbursement rate as outlined below, subject to the limits described in Section XI:

a. Administrative costs, including those associated with the administration of the California's Bridge to Reform Demonstration.

b. Net medical assistance payments/expenditures and prior period adjustments paid in accordance with the approved State Plan.

c. Net Safety Net Care Pool expenditures during the operation of this Demonstration.

d. Expenditures associated with Low Income Health Program MCE subject to paragraph 35.a.5.

103. **Sources of Non-Federal Share.** The State certifies that State and local monies are used as matching funds for the Demonstration. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding must be compliant with section 1903(w) of the Act and any applicable regulations. Further, these sources and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies, any sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

104. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

105. **Cost-Claiming.** All costs will be claimed in accordance with OMB Circular A-87 as defined within Attachment F, and any other cost claiming methodologies or protocols approved by CMS under this Demonstration.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

106. **Budget Neutrality Effective Date.** All STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning November 1, 2010. Notwithstanding this effective date, expenditures made by California during the temporary extension period of September 1, 2010 through October 31, 2010 must be applied against Demonstration Year 6 (DY 6) expenditures.

107. **Limit on Title XIX Funding**. California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the

aggregate annual diverted upper payment limit determined for designated public hospitals in California. Spending under the budget neutrality limit is authorized for managed care population expenditures for the following groups – family and children, SPD, and CCS, public hospital expenditures and for spending under the SNCP. Spending under the SNCP is for uncompensated care, DSHP, HCCI and hospital investment/incentive pool. Attachment C lists the designated public hospitals. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for Monitoring Budget Neutrality. The data supplied by the State to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

108. **Risk.** California will be at risk for the per capita cost for Demonstration enrollees (Medicaid State plan or hypothetical populations) under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

109. **Budget Neutrality Annual Expenditure Limit.** For each DY, two annual limits are calculated.

a) **Limit A.** For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under section entitled General Reporting Requirements for each EG, including the hypothetical population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below;
ii. Starting in SFY 2011, actual expenditures for the Expanded Eligibility EG will be included in the expenditure limit for the California. The amount of actual expenditures to be included will be the actual Expanded Eligibility per member per month cost experience for DY 6-10;
iii. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration is specified below.

Eligibility Group (EG)	Trend Rate	DY 6 PMPM	DY 7 PMPM	DY 8 PMPM	DY 9 PMPM	DY 10 PMPM
		Mandatory State Plan Groups				
Families	5.30%	$150.40	$158.37	$166.76	$175.60	$184.91
Existing SPD	7.4%	$730.43	$784.48	$842.53	$904.88	$971.84
Mandatory SPD	7.4%	$730.43	$784.48	$842.53	$904.88	$971.84
CCS – State Plan	3.28%	$1,493.12	$1,542.10	$1,592.68	$1,644.92	$1,698.87
		Hypothetical Populations*				

MEC	5.00%	$300.00	$315.00	$330.75	$347.29	$0

*These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit.

b) **Limit B.** - The amount of the designated public hospital spending as determined in the chart below. Current State plan reimbursement is actual incurred cost as defined in the State plan. The State is prohibited from changing the reimbursement methodology or amounts of supplemental payments approved in the Medicaid State plan on November 1, 2010 that result in higher overall reimbursement without recalculating the Upper Payment Limit (UPL) for the period of the new or modified payments and adjusting the UPL diversion if necessary.

Total Computable IP Unspent Public Hospital Amounts	
DY 6	$396,364,787
DY 7	$443,813,467
DY 8	$518,660,641
DY 9	$675,984,270
DY 10	$863,054,068
5 Year Total	**$2,897,877,233**

i. The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality expenditure limits. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that California can receive for expenditures on behalf of Demonstration populations as well as Demonstration expenditures under the Safety Net Care Pool described in paragraph 35.

ii. California must present to CMS for approval MCO contract modifications to include an increase in PMPM amounts due to adjustments associated with the inpatient hospital provider tax. The with waiver and without waiver budget neutrality PMPM limits will be adjusted for each EG with an affected rate due to requirements in the Affordable Care Act based on the increases in contracts, if necessary.

iii. For purposes of determining the UPL, the FFS increased Medi-Cal utilization of the newly eligible beneficiaries beginning in 2014 has been included. Expenditures for these beneficiaries starting in FY2014 will receive increased FMAP. However for any expenditures under the SNCP that are funded by the portion of the UPL gap associated with their FFS utilization , the State's regular FMAP applies

110. **Composite Federal Share Ratio.** The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share Ratio. The Composite Federal Share Ratio is the ratio calculated by dividing the sum total of FFP received by California on actual Demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable Demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable Demonstration expenditures for the same period as reported on the same forms.

111. **Deficit Spending.** California will be allowed to make expenditures in DY 6 and 7 under the authority of the SNCP consistent with the limits described in paragraph 109 for each of the four

categories of SNCP spending notwithstanding budget neutrality limits determined for each of those years. SNCP spending in DY 8-10 are subject to the limitations in paragraph 109.

112. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the Demonstration as adjusted November 1, 2010, rather than on an annual basis. However, expenditure authorities in the Safety Net Care pool will be reduced in DY 8 through 10 if California is unable to achieve savings associated with the State plan EG included in the Demonstration as described below:

a. By July 15, 2012 California must submit to CMS an analysis of actual enrollment in the Mandatory SPD EG. If total member months in the Mandatory SPD EG fall below final enrollment projections for the 12 months of DY 7 as determined in the final budget neutrality projections in Attachment K by more than 10% for the period ending June 30, 2012, SNCP authority for expenditures DSHP or Incentive Pool will be reduced by $350 million dollars (Total Computable) in DY (July 1, 2012 - June 30, 2013 with respect to the categories described in paragraph b.ii., and b.iii.
b. By January 15, 2013 California must submit to CMS an analysis of actual enrollment in the Mandatory SPD EG. If total member months in the Mandatory SPD EG for the first 6 months of DY 8 fall below final enrollment projections as determined in the final budget neutrality projections in Attachment K by more than 10% for the period ending December 31, 2012, SNCP authority for expenditures DSHP or Incentive Pool will be reduced by $350 million dollars (Total Computable) in DY July 1, 2013 - June 30, 2014 with respect to the categories described below in paragraph b.ii., and b. iii.

    i. California must provide a savings analysis associated with State plan EGs by July 31, 2012. If in the aggregate after analyzing each State plan EG, the aggregate PMPM savings falls below projections by more than 10 % as measured by actual expenditures through July 1, 2012, CA must submit a corrective action plan by November 1, 2012 reducing expenditures in the SNCP for DY July 1, 2013 - June 30, 2014 and DY July 1, 2014 - October 31, 2015 to ensure budget neutrality by the end of the Demonstration. The corrective action plan must reduce spending in the SNCP with reductions in categorical spending in the programs described below and should include any reductions in SNCP spending associated with clauses i and ii above.
    ii. Designated State Health Programs (DSHP)
    iii. Delivery System Reform Incentive Pool

c. If California must submit a corrective action plan, CMS will monitor budget savings on July 1, 2013, January 1, 2014, July 1, 2014 and January 1, 2015 to ensure that the Demonstration will be budget neutral by the end of DY 10. If the Demonstration spending as amended by the corrective action plan is not projected to be budget neutral, CA must further limit SNCP spending in DY 9 and DY 10 by August 1, 2013 and August 1, 2014
d. If actual enrollment and expenditures for EG in DY 8 or 9 produces savings that demonstrate that California is within 5% of their projected budget neutrality savings, California may submit an amendment seeking to restore SNCP spending authority as long as the amendment demonstrates that the State will be budget neutral by the end of DY 10.

113. **Restoring SNCP Spending Authority** - If actual enrollment and expenditures for EG in DY 8 or 9 produces savings that demonstrate that California is within 5% of their projected budget neutrality savings, California may submit an amendment seeking to restore SNCP spending authority as long as the amendment demonstrates that the State will be budget neutral by the end of DY 10.

114. **Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of the Demonstration period, the excess Federal funds must be returned to CMS using the methodology outlined in paragraph 110, composite Federal share ratio. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

Attachment A – Reserved For "Critical Path for SPD Enrollment" form

Attachment B – Reserved For "SPD Discharge Planning Checklist" form

Attachment C – Government Hospitals to be Reimbursed on a Certified Public Expenditure Basis

State Government-operated University of California (UC) Hospitals

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
6 Santa Monica UCLA Medical Center (aka – Santa Monica UCLA Medical Center & Orthopedic Hospital)

Non-State Government-operated

Los Angeles County (LA Co.) Hospitals

1. LA Co. Harbor/UCLA Medical Center
2. LA Co. Olive View Medical Center
3. LA Co. Rancho Los Amigos National Rehabilitation Center
4. LA Co. University of Southern California Medical Center

Other Government-Operated Hospitals

1. Alameda County Medical Center
2. Arrowhead Regional Medical Center
3. Contra Costa Regional Medical Center
4. Kern Medical Center
5. Natividad Medical Center
6. Riverside County Regional Medical Center
7. San Francisco General Hospital
8. San Joaquin General Hospital
9. San Mateo County General Hospital
10. Santa Clara Valley Medical Center
11. Ventura County Medical Center

Attachment D
Additional Cost Elements for
Government-Operated Hospitals Using Certified Public Expenditure (CPE) Methodology
(For Purposes of Adjusting the CMS 2552-96 Cost Report)

Hospital Cost Element	Medi-Cal Payment			
	Regular Medi-Cal Inpatient CPE	**SNCP UCC**	**DSH UCC**	**Offset DSH Limit**
a) Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing. [1]	No	Yes	No	No
(b) Provider component of provider-based physician costs not reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable OMB Circular A-87 requirements.	No	No	No	No
(a) Costs of interns and residents in accredited programs.	Yes	Yes	Yes	Yes
(b) Costs of training and supervision provided by teaching physicians not reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable OMB Circular A-87 requirements.	No	No	No	No
(a) Non-physician practitioner costs	No	Yes	No	No
(b) For contracted therapy services, these costs will not be subject to Publication 15-1, Section 1400, limitations (but will be subject to applicable OMB Circular A-87 requirements.)	No	No	No	No
Non-hospital-based clinics that are under the hospital's license and are classified in the Cost Report as "Non-reimbursable Clinics"	No	Yes	No	No
Public hospital pensions	No	Yes	No	No
Administrative costs of the hospital's billing activities associated with physician services billed and received by the hospital.	No	Yes	No	No
Patient and community education programs, excluding cost of marketing activities	No	Yes	No	No
Investigational and "off-label" drugs	No	Yes	No	No
Dental services – Inpatient only	Yes	No	Yes	Yes

Attachment D
Additional Cost Elements for
Government-Operated Hospitals Using Certified Public Expenditure (CPE) Methodology
(For Purposes of Adjusting the CMS 2552-96 Cost Report)

Telemedicine services	No	No	No	No
(a) Drugs and supplies provided to non-Medi-Cal patients in non-inpatient or non-outpatient settings	No	Yes	No	No
(b) Drugs and supplies provided to non-Medi-Cal patients in inpatient and outpatient settings	No	Yes	Yes	Yes
Costs associated with securing free drugs for indigent persons	No	Yes	No	No

Hospital Cost Element	**Medi-Cal Payment**			
	Regular Medi-Cal Inpatient CPE	**Safety Net Care Pool UCC**	**DSH UCC**	**Offset DSH Limit**
Patient transportation	No	No	No	No
Services contracted to other providers, including services to treat uninsured patients	No	Yes	No	No
The actual cost incurred by the hospital for physicians' private offices, less the fair market value rent paid by the physicians.	No	No	No	No

The Inpatient Hospital Component (formerly called the Selective Provider Contracting Program and operated under section 1915(b)(4) of the Social Security Act) allows the State to selectively contract with hospitals for acute inpatient hospital services (excluding emergency services) and to limit beneficiary freedom of choice to those hospitals that agree to contract with the California Medical Assistance Commission for Medi-Cal (CMAC). It is jointly administered by the California Department of Health Care Services and CMAC.

This Demonstration incorporates the State's descriptions and assurances with respect to Beneficiary Access and Program Monitoring, as described in Chapters II and III of the "Selective Provider Contracting Program Federal Waiver Renewal" document dated September 2001. The State will ensure the Inpatient Hospital Component of this Demonstration will not substantially impair access to quality inpatient hospital services and will not restrict access to emergency services.

The State must modify this protocol as well as any portion of the approved Medicaid State Plan that utilizes certified public expenditures (CPEs) to reflect any changes in CPE regulations or policy that CMS may release.

I. SUMMARY OF MEDI-CAL 2552-96 COST REPORT AND STEP-DOWN PROCESS

Worksheet A
The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:
(i) overhead;
(ii) routine;
(iii) ancillary;
(iv) outpatient;
(v) other reimbursable; and,
(vi) non-reimbursable.

Worksheet A also includes A-6 reclassifications (moving cost from one cost center to another) and A-8 adjustments (which can be increasing or decreasing adjustments to cost centers). Reclassifications and adjustments are made in accordance with Medicare reimbursement principles.

Worksheet B
Allocates overhead (originally identified as General Service Cost Centers, lines 1-24 of Worksheet A) to all other cost centers, including the non-reimbursable costs identified in lines 96 through 100.

Worksheet C
Computation of the cost-to-charge ratio for each cost center. The total cost for each cost center is derived from Worksheet B, after the overhead allocation. The total charge for each cost center is determined from the provider's records. The cost-to-charge ratios are used in the Worksheet D series (see the apportionment process of ancillary and other non-routine cost centers).

Worksheet D
This series (including D-1) is where the total costs from Worksheet B are apportioned to different payer programs. Apportionment is the process by which a cost center's total cost is allocated to a specific payer or program or service type. For example, an apportionment is used to arrive at Medicare hospital inpatient routine and ancillary cost, Medicare hospital outpatient cost, as well as Medicaid hospital inpatient routine and ancillary cost, and Medicaid hospital outpatient cost, etc.

(i) Under the apportionment process for each routine service cost center, a per diem is computed by dividing the cost center's reimbursable cost by the cost center's total patient days. The resulting per diem is multiplied by the number of program days to arrive at program cost.
(ii) Under the apportionment process for each ancillary/outpatient /other non-routine reimbursable cost center, the cost-to-charge ratio from Worksheet C for each cost center is multiplied by the program charge for that cost center to arrive at program cost.

Worksheet E

This series contains the settlement worksheets that compute actual reimbursement and account for interim payments. The Medicaid costs computed from the Worksheet D series are transferred to Worksheet E-3, Part III (Title 19) for Medicaid.

NOTES:

(i) States making CPE-funded payments for non-hospital-based costs under section 1115(a)(2) waiver authority, must develop/identify a separate cost reporting tool and receive CMS approval for such cost reporting prior to claims for Federal matching funds.

(ii) For purposes of utilizing the Medi-Cal 2552-96 cost report to determine Medicaid reimbursements described in the subsequent instructions, the following terms are defined:

> The term "finalized Medi-Cal 2552-96 cost report" refers to the cost report that is settled by the Department of Health Care Services (DHCS), Audits and Investigations (A&I) with the issuance of a Report On The Cost Report Review (Audit Report).
>
> 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 5 months after the end of the cost reporting period.
>
> Nothing in this document 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.

(iii) 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 document. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

II. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE MEDICAID HOSPITAL COSTS

To determine a governmentally-operated hospital's allowable Medicaid costs and associated Medicaid reimbursements when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Interim Medicaid Inpatient Hospital Payment Rate

The purpose of an interim Medicaid inpatient hospital payment rate is to provide an interim payment that will approximate the Medicaid inpatient hospital costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim Medicaid inpatient hospital payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

Attachment F

Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming

1. The process of determining the allowable Medicaid inpatient hospital costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.

2. To determine the interim Medicaid payment rate, the State should use the most recently filed Medi-Cal 2552-96 cost report, follow the Medi-Cal 2552-96 cost report apportionment process as prescribed in the Worksheet D series to arrive at the total Medicaid non-psychiatric inpatient hospital cost.

   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, since Medi-Cal does not separately reimburse for Graduate Medical Education costs via a per-resident amount methodology. If the costs have been removed, the State should add allowable interns and residents costs 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. The State is to only add back allowable interns and residents costs that are consistent with Medicare cost principles. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as GME under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

   For hospitals that remove Medicaid inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), the State will make necessary adjustments to 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 identified in Attachment D to the Special Terms and Conditions. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

   Additionally, the State 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 18 months after the Fiscal Year Ending (FYE) of the cost report, the State 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.

   Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already 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 Step number 3 below.

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

4. The Medicaid per day amount computed in Step number 3 above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. 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:

   (i) 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 spending year.
   (ii) 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 or reflected on the Medi-Cal 2552-96 cost report for the spending year.

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

5. An audit factor may be applied 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. Such percentage must be identified to CMS.

Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim Medicaid payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. If, at the end of the interim reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

The State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers as explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document. The State will also adjust the cost for inpatient dental as explained in Step 2 for those hospitals that used such adjustment to create the interim Medicaid payment rate.

In computing the Medicaid non-psychiatric inpatient hospital cost on the most recently filed Medi-Cal 2552-96 cost report, the State should update the Medicaid program data (such as Medicaid days and charges) on the cost report worksheet D series with Medicaid program data generated -from its MMIS/claims system for the respective cost reporting period. As explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, data generated from the MMIS/claims system will not be complete, and steps to verify the data will be taken by the State 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.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid

inpatient hospital non-psychiatric cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid non-psychiatric inpatient hospital per diem) under this interim reconciliation process. Adjustments made to the MMIS data mentioned above may address outstanding Medicaid claims for which the hospital has not received payment. The State will take steps to ensure that payments associated with the pending claims, when paid, for Medicaid costs included in the current spending year cost report are properly accounted.

An audit factor may be applied 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. Such percentage must be identified to CMS.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

Each governmentally-operated hospital's interim payments and interim adjustments in a spending year will also be subsequently reconciled to its Medi-Cal 2552-96 cost report for that same spending year as finalized by A&I for purposes of Medicaid reimbursement. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

The State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers as explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document. The State will also adjust the cost for inpatient dental as explained in Step 2 for those hospitals that used such adjustment to create the interim Medicaid payment rate.

In computing the Medicaid non-psychiatric inpatient hospital cost from the finalized Medi-Cal 2552-96 cost report, the State should update the Medicaid program data (such as Medicaid days and charges) on the finalized cost report Worksheet D series with 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.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be included in the total Medicaid payments (along with the interim Medicaid payments based on the Medicaid non-psychiatric inpatient hospital per diem) under this final reconciliation process.

III. CERTIFIED PUBLIC EXPENDITURES – DETERMINATION OF ALLOWABLE SAFETY NET AND DSH COSTS FOR HOSPITALS

To determine a governmentally-operated hospital's allowable Safety Net Care Pool (SNCP) costs and the associated SNCP reimbursements and to determine a hospital's allowable uncompensated care costs eligible for disproportionate share hospital (DSH) reimbursement when such costs are funded by a State

through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Safety Net Care Pool (SNCP) Payments to Hospitals

The purpose of interim SNCP payments is to provide an interim payment that will approximate the SNCP costs eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim SNCP payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instruction below.

1. The process of determining the allowable SNCP costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.

2. The total allowable SNCP hospital cost should be computed by using the most recently filed Medi-Cal 2552-96 cost report.

   The State will make necessary adjustments to 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 SNCP cost elements identified in Attachment D to the Special Terms and Conditions.

   As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

   In the cost report apportionment process in Worksheet D series, auditable uninsured program data (days and charges) will be used to determine uninsured hospital cost. This data will be submitted to the State by the hospitals based on data from the hospital's records. Only program data for medical services eligible for SNCP should be included in the apportionment process in the Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

   The costs described in this document eligible under the SNCP relate strictly to individuals with no source of third party insurance coverage for the inpatient and outpatient hospital services they receive that would have been benefits eligible for federal reimbursement under Title XIX had these individuals been eligible Medi-Cal beneficiaries, and those costs identified in Attachment D of the Special Terms and Conditions. The determination of other costs eligible for SNCP funding (e.g., clinic costs, medical care costs incurred by the State or counties) will be addressed in a separate methodology within the protocol document.

   The program data should be for the period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.

   Any SNCP-eligible cost that is not reported on the hospital cost report or that the State believes should not be subject to the cost report apportionment process must be identified separately to and approved by CMS.

Any self-pay payments made by or on behalf of uninsured patients to the hospital for services of which the costs are already included in the SNCP cost computation described above should be offset against the computed SNCP-eligible costs. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only, or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

3. The net SNCP cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net SNCP costs may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:

   ii. Inpatient and outpatient 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 spending year.

   iii. Inpatient and outpatient 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 or reflected on the Medi-Cal 2552-96 cost report for the spending year.

   Such costs must be properly documented by the hospital and are subject to review by the State and CMS.

4. The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

5. The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

   i. Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
   ii Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
   iii. Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments
   iv. Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
   v. Total non-hospital costs funded by SNCP payments.

   An audit factor may be applied 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. Such percentage must be identified to CMS.

6. Interim SNCP payments can be made based on the SNCP certifiable expenditures as computed above. The interim payments can be on a quarterly or other periodic basis approved by CMS. There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Interim Reconciliation of Interim SNCP Payments to Hospitals

Each governmentally-operated hospital's interim SNCP certifiable expenditures will be reconciled based on its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total SNCP certifiable expenditures determined under the interim reconciliations. If, at the end of the interim reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheet) to account for the SNCP cost elements (Attachment D to the Special Terms and Conditions).

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

Also, in computing the uninsured hospital cost on the most recently filed Medi-Cal 2552-96 cost report, the State should use auditable uninsured program data (such as days and charges) for the Worksheet D series apportionment process. Only program data for medical services eligible for SNCP should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Any self-pay payments made by or on behalf of uninsured patients to the hospitals for services of which costs are included in the SNCP cost computation described above should be offset against the computed SNCP costs under the interim reconciliation process. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;

(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

An audit factor may be applied 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. Such percentage must be identified to CMS.

Final Reconciliation of Interim SNCP Payments to Hospitals

Each governmentally-operated hospital's interim SNCP certifiable expenditures (and any interim adjustments) will also subsequently be reconciled based on its Medi-Cal 2552-96 cost report as finalized by A&I for purposes of Medicaid reimbursement for the respective cost reporting period. The State will adjust, as necessary, the aggregate amount of interim SNCP funds claimed based on the total certifiable SNCP expenditures determined under the final reconciliations. If, at the end of the final reconciliation process, it is determined that SNCP funding was over-claimed, the overpayment will be properly credited to the federal government.

The State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheet) to account for the SNCP cost elements (Attachment D to the Special Terms and Conditions).

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers.

Also, in computing the uninsured hospital cost on the finalized Medi-Cal 2552-96 cost report, the State should use auditable uninsured program data (such as days and charges) for the Worksheet D series apportionment process. Only program data for medical services eligible for SNCP should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Any self-pay payments made by or on behalf of uninsured patients to the hospitals for services of which costs are included in the SNCP cost computation described above should be offset against the computed SNCP costs under this final reconciliation process. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or a unit of local government (e.g., state-only, local-only, or joint state-local health programs) to a hospital for inpatient and outpatient services provided to indigent patients shall not be considered a source of third party payment.

The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to

unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Disproportionate Share Hospital (DSH) Payments

The purpose of an interim DSH payment is to provide an interim payment that will approximate the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs ("shortfall") eligible for Federal financial participation claimed through the CPE process. This computation of establishing interim DSH payment funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

1. The process of determining the allowable DSH costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.

2. The total Medicaid managed care and Medicaid psychiatric inpatient and outpatient hospital shortfall and the uninsured hospital inpatient and outpatient costs should be computed by using the most recently filed Medi-Cal 2552-96 cost report.[1]

   As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

   In the cost report apportionment process in the Worksheet D series, auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges) will be used to compute the hospital's eligible DSH cost. This data will be submitted to the State. Only hospital inpatient and

[1] No shortfall related to fee-for-service Medicaid inpatient hospital and /or Medicaid outpatient hospital services is anticipated based on the certification of public expenditures up to total Medicaid inpatient and Medicaid outpatient hospital costs.

outpatient program data for medical services eligible for DSH should be included in the apportionment process in Worksheet D series. The program data should be from the period which corresponds to the most recently filed Medi-Cal cost report. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Uninsured individuals are individuals with no source of third party insurance coverage for the inpatient hospital and outpatient hospital services they receive and as defined in governing federal statute and regulation.

3. All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost from Step number 2 above to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

4. The net DSH cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net DSH costs may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:

   (i) Inpatient and outpatient hospital costs not reflected in 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 spending year.
   (ii) Inpatient and outpatient hospital costs incurred and reflected in the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

   Such costs must be properly documented by the hospital and are subject to review by the State and CMS.

   An audit factor may be applied 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. Such percentage must be identified to CMS.

5. The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 86.05% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

6. Interim DSH payments can be made based on the eligible DSH expenditure computed above. The interim payments can be on a quarterly or other periodic basis, but such payments must account for all revenue offsets. There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Interim Reconciliation of Interim DSH Payments

Each governmentally-operated hospital's interim DSH certifiable expenditures will be reconciled based on its filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. The State will adjust, as necessary, the aggregate amount of interim DSH funds claimed based on the total DSH certifiable expenditures determined under the interim reconciliations. If, at the end of the interim reconciliation process, it is determined that DSH funding was over-claimed, the overpayment will be properly credited to the federal government.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents' costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

In computing the Medicaid managed care and Medicaid psychiatric shortfall and the uninsured hospital inpatient and outpatient cost based on the most recently filed Medi-Cal 2552-96 cost report, the State should use auditable Medicaid managed care, Medicaid psychiatric and uninsured program data (days and charges) for the Worksheet D series apportionment process. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in the Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a

hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 86.05% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

An audit factor may be applied 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. Such percentage must be identified to CMS.

Final Reconciliation of Interim DSH Payments

Each governmentally-operated hospital's interim DSH certifiable expenditures (and any interim adjustments) will subsequently be reconciled based on its Medi-Cal 2552-96 cost report as finalized by A&I for purposes of Medicaid reimbursement for the respective cost reporting period. The State will adjust, as necessary, the aggregate amount of interim DSH funds claimed based on the total DSH certifiable expenditures determined under the final reconciliations. If, at the end of the final reconciliation process, it is determined that DSH funding was over-claimed, the overpayment will be properly credited to the federal government.

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and resident's costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

In computing the Medicaid managed care and Medicaid psychiatric shortfall and the uninsured hospital inpatient and outpatient cost based on the finalized Medi-Cal 2552-96 cost report, the State should use auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges) for the Worksheet D series apportionment process. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

Attachment F

Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming

All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 86.05% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

(i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
(ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
(iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
(iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
(v) Total non-hospital costs funded by SNCP payments.

NOTES:

(i) All disproportionate share hospital (DSH) payments, funded through certified public expenditures or otherwise, are subject to the State of California's aggregate DSH allotment.
(ii) Based on the State of California's proposal to certify total Medicaid inpatient and outpatient hospital costs (non-managed care), there would be no fee-for-service Medicaid inpatient and/or outpatient hospital cost "shortfall" for purposes of the hospital-specific DSH limits.
(iii) For California's DSH hospitals that qualify for 175% DSH payment under the Benefits, Improvements, and Protections Act of 2000, during waiver years one and two, for the specific purpose of computing 175% of the OBRA 1993 hospital-specific uncompensated care cost (UCC) limit, UCC is computed without an offset for Safety Net Care Pool (SNCP) claims made for the uninsured. However, the combination of SNCP funds and DSH funds that are claimed will not exceed 175 percent of UCC (for those hospitals subject to the 175 percent authority), to ensure no duplication of claiming. For purposes of the preceding sentence, each hospital's SNCP certifiable expenditures (excluding costs that are ineligible for DSH claiming) that are actually used by the State for claiming SNCP funds shall be counted against the above hospital-specific claiming limits, rather than the amounts actually distributed to the hospital by the State.
(iv) Claims that are based on CPEs of qualifying UCC (determined as described in this document) may be submitted for Federal reimbursement from a combination of SNCP and DSH funds, at the State's discretion. The State may also claim federal DSH funds with respect to DSH payments made to hospitals equivalent to costs between 100 and 175 percent of eligible UCC, regardless of whether the combined amount of DSH and SNCP funds have been claimed

based on CPEs to 100 percent of the hospital's UCC, provided that 100 percent of UCC has been certified as actually expended. There will be no duplication of UCC claimed for SNCP and DSH reimbursement.

Attachment F – Supplement 1
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)

SCNP Payments – Physician and Non Physician Professional Services

To determine a government-operated hospital's allowable physician and non-physician professional service costs eligible for SNCP reimbursement when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation.

The purpose of interim SNCP payments for physician and non-physician practitioner professional costs is to provide an interim payment that will approximate the SNCP costs eligible Federal financial participation through the CPE process. This computation of establishing interim physician and non-physician practitioner professional services payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instruction below.

The government-operated hospitals identified in Attachment C and the government operated entities with which they are affiliated, including their affiliated government-operated physician practice groups, are eligible providers.

The eligible SNCP costs are uncompensated costs incurred by each provider described above for the furnishing of physician and non-physician professional services to uninsured individuals in accordance with STCs Items 43 – 50.

Eligible professional costs are reported on the designated hospitals' Medi-Cal 2552 cost report and, in the case of the University of California (UC) hospitals, the UC School of Medicine physician/non-physician practitioner cost report as approved by the Centers for Medicare & Medicaid Services.

1. Non-UC Provider Steps

    a. The professional component of physician costs are identified from each hospital's most recently filed Medi-Cal 2552 cost report Worksheet A-8-2, Column 4. These professional costs are:

        1. Limited to allowable and auditable physician compensations that have been incurred by the hospital;
        2. For the professional, direct patient care furnished by the hospital's physicians in all applicable sites of service, including sites that are not owned or operated by an affiliated government entity;
        3. Identified as professional costs on Worksheet A-8-2, Column 4 of the cost report of the hospital claiming payment (or, for registry physicians only, Worksheet A-8, if the physician professional compensation cost is not reported by the hospital on Worksheet A-8-2 because the registry physicians are contracted solely for direct patient care activities (i.e., no administrative, teaching, research, or any other provider component or non-patient care activities));
        4. Supported by a time study, accepted by Medicare for Worksheet A-8-2 reporting purposes, that identified the professional, direct patient care activities of the physicians (not applicable to registry physicians discussed above); and
        5. Removed from hospital costs on Worksheet A-8.

SCNP Payments – Physician and Non Physician Professional Services

b. The professional costs on Worksheet A-8-2, Column 4 (or Worksheet A-8 for registry physicians) are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for uninsured physician professional cost determination purposes. There will be revenue offsets to account for revenues received for services furnished by such professionals to non-patients (patients whom the hospital does not directly bill for) and any other applicable non-patient care revenues that were not previously offset or accounted for by the application of time study.

c. Reimbursement for other professional practitioner service costs that have also been identified and removed from hospital costs on the Medi-Cal cost report. The practitioner types to be included are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

d. To the extent these practitioners' professional compensation costs are not included in Worksheet A-8-2, Column 4, but are removed from hospital costs through an A-8 adjustment on the Medi-Cal cost report, these costs may be recognized if they meet the following criteria:

1. the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services;
2. for all non physician practitioners there must be an identifiable and auditable data source by practitioner type;
3. a CMS-approved time study must be employed to allocate practitioner compensation between clinical and non-clinical costs; and
4. the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the hospital does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. The compensation costs for each non-physician practitioner type are identified separately.

SCNP Payments – Physician and Non Physician Professional Services

e. Professional costs incurred for freestanding clinics (clinics that are not recognized as hospital outpatient departments on the 2552) are separately reimbursable as clinic costs and therefore are not included in this protocol.

f. Hospitals may additionally include physician support staff compensation, data processing, and patient accounting costs as physician-related costs to the extent that:

1. these costs are removed from hospital inpatient and outpatient costs because they have been specifically identified as costs related to physician professional services;
2. they are directly identified on ws A-8 as adjustments to hospital costs;
3. they are otherwise allowable and auditable provider costs; and
4. they are further adjusted for any non-patient-care activities such as research based on physician time studies.

If these are removed as A-8 adjustments to the hospital's general service cost centers, these costs should be stepped down to the physician cost centers based on the accumulated physician professional compensation costs. Other than the physician and non-physician practitioner compensation costs and the A-8 physician-related adjustments discussed above, no other costs are allowed.

g. Total billed professional charges by cost center related to physician services are identified from hospital records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from hospital records. Los Angeles County hospitals, due to their all-inclusive billing limitations, do not have itemized physician or non-physician practitioner charges. Therefore, these hospitals are to use the hospital RVU system to apportion professional costs to uninsured services under the SNCP claiming; this is the same RVU system as that used by Los Angeles County hospitals for Medicare and Medi-Cal cost reporting purposes. Where charges are mentioned in this paragraph and later paragraphs in this subsection, Los Angeles County will use its RVUs.

h. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-f of subsection 1 by the total billed professional charges for each cost center as established in paragraph g of subsection 1. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-f of subsection 1 by the total billed professional charges for each practitioner type as established in paragraph g of subsection 1.

i The total professional charges for each cost center related to eligible uninsured physician services, billed directly by the hospital, are identified using auditable hospital financial records. Hospitals must map the charges to their cost centers using information from their hospital billing systems. Each charge may only be mapped to one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the eligible uninsured professional charges, billed directly by the hospital, are identified using auditable hospital financial records.

SCNP Payments – Physician and Non Physician Professional Services

Hospitals must map the charges to non-physician practitioner type using information from their hospital billing systems. Each charge may only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

j. The total uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratio for the cost center as established in paragraph h of subsection 1.

For each non-physician practitioner type, the total uninsured costs related to non-physician practitioner professional services are determined by multiplying total uninsured charges as established in paragraph i of subsection 1 by the respective cost to charge ratios as established in paragraph h of subsection 1.

k. The total uninsured costs eligible for SNCP claiming are determined by subtracting all revenues received for the uninsured physician/practitioner services from the uninsured costs as established in paragraph j of subsection 1. The amount of the SNCP interim payment will be based on the costs for the period coinciding with the latest as-filed cost report; the data sources for uninsured claims are from the auditable hospital records. All revenues received (other than the SNCP professional payments being computed here in this section) for the uninsured professional services will be offset against the computed cost; these revenues include payments from or on behalf of patients and payments from other payers. The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only.

l. The uninsured physician/practitioner amount computed in paragraph k of subsection 1 above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The uninsured amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

1. Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

2. Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the hospital and subject to review by the State and CMS. The result is the uninsured physician/practitioner amount to be used for interim SNCP payment purposes.

SCNP Payments – Physician and Non Physician Professional Services

2. UC Provider Steps

a. The physician compensation costs are identified from each UC School of Medicine's trial balance and reported on a CMS-approved UC physician/practitioner cost report. These professional compensation costs are limited to identifiable and auditable costs that have been incurred by the UC School of Medicines' physician practice group(s) for the professional patient care furnished in all applicable sites of service, including services rendered at non-hospital physician office sites operated by the UC practice groups and at sites not owned or operated by the UC for which the UC practice group bills for and collects payment.

The physician compensation costs are reduced by National Institute of Health (NIH) grants to the extent the research activities component is not removed via physician time studies.

b. On the UC physician cost report, these physician compensation costs net of NIH grants as applicable, reported by cost centers/departments, are then allocated between clinical and non-clinical activities using a CMS-approved time-study. Prior to July 1, 2008, the UCs may use a CMS-approved benchmark RVU methodology in lieu of the CMS-approved time study to allocate UC physician compensation costs between clinical and non-clinical activities only. The result of the CMS-approved time study (or the benchmark RVU methodology before July 1, 2008) is the physician compensation costs pertaining only to clinical, patient care activities.

c. The physician clinical costs are subject to further adjustments and offsets, including any necessary adjustment to bring the costs in line with Medicare cost principles. However, Medicare physician reasonable compensation equivalents are not applied for uninsured professional cost determination purposes. There will be offset of revenues received for services furnished by such professionals to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

d. Reimbursement for non-physician practitioner compensation costs will also be included. The practitioner types to be included on the UC physician/practitioner cost reports are:

(1) Certified Registered Nurse Anesthetists
(2) Nurse Practitioners
(3) Physician Assistants
(4) Dentists
(5) Certified Nurse Midwives
(6) Clinical Social Workers
(7) Clinical Psychologists
(8) Optometrists

e. These non-physician practitioner compensation costs are recognized if they meet the following criteria:

SCNP Payments – Physician and Non Physician Professional Services

(1) the practitioners must engage in the direct provision of care in addition to being Medicaid-qualified practitioners for whom the services are billable under Medi-Cal separate from hospital services;
(2) the non-physician practitioner compensation costs are derived from an identifiable and auditable data source by practitioner type;
(3) a CMS approved time study will be employed to allocate practitioner compensation between clinical and non-clinical costs;
(4) the clinical costs resulting from the CMS-approved time study are subject to further adjustments and offsets, including adjustments to bring the costs in line with Medicare cost principles and offset of revenues received for services furnished by such practitioners to non-patients (patients for whom the UC does not directly bill for) and other applicable non-patient care revenues that were not previously offset or accounted for by the application of the CMS-approved time study.

The resulting net clinical non-physician practitioner compensation costs are allowable costs. Each non-physician practitioner type is reported in its own cost center on the UC physician/practitioner cost report.

f. The above physician or non-physician practitioner compensation costs must not be duplicative of any costs claimed on the UC hospital cost reports.

g. Additional costs that can be recognized as professional direct costs are costs for non-capitalized medical supplies and equipments used in the furnishing of direct patient care.

h. Overhead costs will be recognized through the application of each UC's cognizant agency-approved rate for indirect costs. The indirect rate will be applied to the total direct cost, calculated above, based on each center/department's physician and/or non-physician practitioner compensation costs determined to be eligible for Medicaid reimbursement and identifiable medical supply/equipment costs to arrive at total allowable costs for each cost center.

Other than the direct costs defined above and the application of an approved indirect rate, no other costs are allowed.

i. Total billed professional charges by cost center related to physician services are identified from provider records. Similarly, for each non-physician practitioner type, the total billed professional charges are identified from provider records.

j. A physician cost to charge ratio for each cost center is calculated by dividing the total costs for each cost center as established in paragraphs a-h of subsection 2 by the total billed professional charges for each cost center as established in paragraph i of subsection 2. For each non-physician practitioner type, a cost to charge ratio is calculated by dividing the total costs for each practitioner type as established in paragraphs a-h of subsection 2 by the total billed professional charges for each practitioner type as established in paragraph i of subsection 2.

SCNP Payments – Physician and Non Physician Professional Services

k. The total professional charges for each cost center related to eligible uninsured physician services, billed directly by UC, are identified using auditable UC financial records. UCs must map the claims to their cost centers using information from their billing systems. Each charge must be mapped to only one cost center to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

For each non-physician practitioner type, the eligible uninsured professional charges, billed directly by the UC, are identified using auditable UC financial records. UCs must map the claims to non-physician practitioner type using information from their billing systems. Each charge must only be mapped to one practitioner type to prevent duplicate mapping and claiming. These charges must be associated with services furnished during the period covered by the latest as-filed cost report.

l. The total uninsured costs related to physician practitioner professional services are determined for each cost center by multiplying total uninsured charges as established in paragraph k of subsection 2 by the respective cost to charge ratio for the cost center as established in paragraph j of subsection 2.

For each non-physician practitioner type, the total uninsured costs related to non-physician practitioner professional services are determined by multiplying total uninsured charges as established in paragraph k of subsection 2 by the respective cost to charge ratios as established in paragraph j of subsection 2.

m. The total uninsured costs eligible for SNCP claiming are determined by subtracting all revenues received for uninsured physician practitioner services from the uninsured costs as established in paragraph l of subsection 2. The amount of the SNCP interim payment will be based on the costs for the period coinciding with the latest as-filed cost report; the data sources for uninsured claims are from the auditable UC records. All revenues received (other than the SNCP professional payments being computed here in this section) for the uninsured professional services will be offset against the computed cost; these revenues include payments from or on behalf of patients and payments from other payers. The total SNCP certifiable expenditures as computed above should be reduced by 13.95% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only.

n. The uninsured physician/practitioner amount computed in paragraph m above can be trended to current year based on Market Basket update factor(s) or other medical care-related indices as approved by CMS. The uninsured amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:

(1) Physician/practitioner costs not reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would be incurred and reflected on the physician/practitioner cost report for the spending year.

(2) Physician/practitioner costs incurred and reflected on the filed physician/practitioner cost report from which the interim supplemental payments are developed, but which would not be incurred or reflected on the physician/practitioner cost report for the spending year.

Such costs must be properly documented by the UCs and subject to review by the State and CMS. The result is the uninsured physician/practitioner amount to be used for interim SNCP payment purposes.

Interim Reconciliation of Physician and Non-Physician Practitioner Professional Services Payments to Hospitals

The physician and non-physician practitioner SNCP payments determined under subsections 1 and 2, which are paid for services furnished during the applicable state fiscal year, are reconciled to the as-filed Medi-Cal 2552 and UC physician/practitioner cost reports for the same year once the cost reports have been filed with the State. The UC physician/practitioner cost report should be filed, reviewed, and finalized by the State in a manner and timeframe consistent with the Medi-Cal hospital cost report process. If, at the end of the interim reconciliation process, it is determined that a provider received an overpayment, the overpayment will be properly credited to the federal government; if a provider was underpaid, and the provider will receive an adjusted payment amount. For purposes of this reconciliation the same steps as outlined for the interim payment method are carried out except as noted below:

1. For the determinations made under paragraphs a through h of subsection 1 and paragraphs a through j of subsection 2 of Section C, the costs and charges from the as-filed physician/practitioner cost report for the expenditure year are used.

2. For the determinations made under paragraph i of subsection 1 and paragraph k of subsection 2, uninsured professional charges for covered services furnished during the applicable fiscal year are used. The State will perform those tests necessary to determine the reasonableness of the uninsured physician/practitioner charges from the as-filed physician/practitioner cost report. Only eligible uninsured data related to the furnishing of physician/practitioner professional medical services should be used in the apportionment process.

3. For the determinations made under paragraph k of subsection 1 and paragraph m of subsection 2, uninsured professional services furnished during the applicable state fiscal year are used.

Final Reconciliation of Physician and Non-Physician Practitioner Professional Services Payments to Hospitals

Once the Medi-Cal 2552 and the UC physician/practitioner cost report for the expenditure year have been finalized by the State, a reconciliation of the finalized costs to all SNCP payments made for the same period will be carried out, including adjustments for overpayments and underpayments if necessary. The same method as described for the interim reconciliation will be used except that the finalized Medi-Cal 2552 and UC physician/practitioner cost amounts and updated uninsured data will be substituted as appropriate. If, at the end of the final reconciliation process, it is determined that a hospital received an overpayment, the overpayment will be properly credited to the federal government.

Attachment F – Supplement 2
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)

Determination of Allowable SNCP Costs for Services Provided to Uninsured Individuals in Government Owned and Operated Non-hospital Clinics

The following shall apply to determine the allowable costs of providing services to uninsured individuals in government owned or operated non-hospital clinics (i.e., clinics that are not hospital outpatient departments), for purposes of calculating certified public expenditures that may be used to claim federal financial participation (FFP) from the Safety Net Care Pool (SNCP).

A. Cost Finding Methodology – General Provisions

1. Costs, as determined under this Supplement, will be computed in accordance with Title 42 of the Code of Federal Regulations (CFR) Part 413; the Provider Reimbursement Manual (CMS Pub. 15-1); and other applicable federal directives that establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the uninsured program, except as expressly modified in this Supplement.

2. The allowable SNCP non-hospital clinic costs determined under this methodology include direct, ancillary, physician/non physician practitioner, and overhead costs, which are incurred in providing health care services that are not identified as hospital services under the Special Terms and Conditions and applicable State law to uninsured beneficiaries in eligible facilities, and determined to be allowable under the regulations and publications specified above.

3. Allowable non-hospital clinic costs will be derived from the clinic's general ledger and reported on the approved clinic cost reporting forms. General ledger supporting schedules which group costs into direct service and overhead cost centers will accompany the filed clinic cost reports. Direct service costs and overhead expenses will be reported on separate cost center lines, and non-allowable costs will either be reclassified to non-reimbursable cost centers or removed through discrete adjustments. Reclassifications and adjustments to the working trial balance, including the assignment of costs to non-reimbursable cost centers, or and the discrete disallowance of expenses, will be recorded on supporting schedules which will be submitted with the approved cost reporting forms.

4. Clinic overhead costs will be equitably allocated to non-allowable activities based on the use of such overhead costs by the non-allowable activities.

5. The allowable costs for non-hospital clinic services provided to uninsured patients will be based on the clinic's cost report which includes data for visits. The clinic cost report will determine the per-visit cost for a patient. For the purposes of determining the per-visit cost, a "visit" is defined as a face-to-face encounter between a clinic patient and health professional pursuant to paragraph F, below, for which the services provided have been documented.

6. The per-visit cost will be multiplied by the number of uninsured visits to determine the total uninsured costs for the clinic.

7. The total uninsured costs for the non-hospital clinics computed above must be offset by any payments received by the clinic from or on behalf of the patient for such uninsured clinic services. For purposes of the preceding sentence, payments and other funding and subsidies made by a state or local government (e.g., state-only, local-only, or joint state-local health programs) for services provided to indigents shall not be offset.

8. The net uninsured costs computed above will be reduced by 13.95 percent to account for non-emergency care furnished to unqualified aliens.

9. Interim SNCP certified expenditures for non-hospital clinic services will be determined for each fiscal period pursuant to the steps outlined above using the most recently available clinic cost report (if appropriate trended to the current year based on Market Basket update factor(s) or other health care related indices as approved by CMS), that are submitted to the State in conjunction with the Interim Hospital Payment Rate Workbook.

B. Interim Reconciliation

1. The certified expenditures for non-hospital clinic services for each fiscal period will be subject to an interim reconciliation. Allowable costs will be computed pursuant to the steps described in subparagraphs A.1 through A.8, above, using cost, visit, and payment data from each clinic's as-filed cost report and other supplemental data for the applicable fiscal period that are submitted to the State in conjunction with the Interim Hospital Payment Rate Workbook.

2. The State may, if appropriate, make adjustments to costs reported on the as-filed cost report based on the results of the most recently completed audit, settlement or appeal determination of a prior year cost report.

3. The State will adjust the amount of SNCP funds claimed and any overpayment will be credited to the federal government.

C. Final Reconciliations

1. The certified expenditures for non-hospital clinic services for each fiscal period will be subject to a final reconciliation. Allowable costs will be computed pursuant to the steps described in subparagraphs A.1 through A.9, above, using cost, visit, and payment data from the clinic's cost report for the applicable fiscal period and other supplemental data for the period submitted in conjunction with

the Interim Hospital Payment Rate Workbook that is finalized by the State during its audit and settlement process..

2. The State will adjust the amount of SNCP funds claimed and any overpayment will be credited to the federal government.

D. Eligible Clinic Reporting Requirements

The governmental entity that reports on behalf of any eligible non-hospital clinic must do all of the following:

1. Report costs annually on cost reporting forms approved by the State. The clinics will use clinic cost reporting forms that are modeled on the CMS approved Federally Qualified Health Center (FQHC) cost reporting form, and that have been approved by the State and CMS.

2. Complete the cost report which is due five months after the fiscal period in order to submit the annual workbook and cost certification to the State in a timeframe specified by the State.

3. Provide evidence supporting the cost report and the cost determination as specified by the State.

4. Keep, maintain and have readily retrievable, such records as specified by the State to fully disclose reimbursement amounts to which the eligible clinic is entitled, and any other records required by CMS.

E. Definition of Visit

1. For the purposes of determining the per-visit cost pursuant to paragraph A, above, a "visit" is defined as a face-to-face encounter between a clinic patient and a physician, physician assistant, nurse practitioner, clinical psychologist, or licensed clinical social worker, hereafter referred to as a "health professional." For purposes of this paragraph E, "physician" includes the following:

   (a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.

   (b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.

   (c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license.

(d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license.

(e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting within the scope of his/her license.

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

3. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

   (a) When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, two visits may be counted.

   (b) When the clinic patient is seen by a dentist and sees any one of the following providers: physician (as defined in subparagraphs (1)(a) through (1)(e), above), physician assistant, nurse practitioner, clinical psychologist, or licensed clinical social worker, two visits may be counted.

Attachment F – Supplement 3
Funding and Reimbursement Protocol for
Claiming Against the Safety Net Care Pool (SNCP)

Attachment F - Supplement 3: Reserved for State submission of claiming protocol for DY 6-10 DSHPs in accordance with paragraph 37b.

Attachment G

Reserved for State submission of Demonstration Year 6-9 claiming protocol for the Medicaid Coverage Expansion and Health Care Coverage Initiative per paragraph 43.

Attachment H - Accounting Procedures

The following Accounting Procedures have been developed to ensure that no over claiming of expenditures occur and to provide for accurate reporting of mandated reports as required by CMS for the Demonstration. The Safety Net Financing Division's (SNFD) Hospital Contracts Unit (HCU), within the Inpatient Contract and Monitoring Section (ICMS), is responsible for preparing quarterly and annual reconciliation of program expenditures.

I. STATE-ONLY PROGRAMS - Reserved for State submission of accounting procedures for DY 6-10 DSHPs per paragraph 17.

II. CERTIFIED PUBLIC EXPENDITURES

CPEs are expenditures certified by counties, university teaching hospitals, or other governmental entities within a state, as having been spent on the provision of covered services to Medi-Cal beneficiaries and uninsured individuals. CPEs are eligible for reimbursement at the federal medical assistance percentage in effect on the date the service is provided.

Cost Submission

At least annually, designated public hospitals (DPHs) send to SNFD an estimate of their CPEs for the project (current) year, accompanied by an attestation of the costs. The CPEs are derived from the Medi-Cal 2552-96 cost report, a Workbook developed by SNFD, and other documentation to support the estimated CPEs. These CPEs are used to establish an interim per diem rate of reimbursement for the costs of providing inpatient care to Medi-Cal beneficiaries, and to determine DSH payments, and payments from the SNCP. In addition, the data is used as the basis of a tentative settlement made for inpatient services rendered to Medi-Cal beneficiaries.

1. Review Process
   SNFD reviews all data submitted for accuracy and compliance with established procedures, and performs tests for reasonableness. If discrepancies or inconsistencies are identified, SNFD works directly with the DPH staff to resolve issues and correct data.

2. Interim Payment Process

   Establish Inpatient Interim Rates
   SNFD establishes the inpatient interim rate for each DPH based on the most current filed Medi-Cal 2552-96 and Workbook. SNFD instructs Provider Enrollment Division (PED) to update the Provider Master File (PMF) to reflect the new interim rates. The new interim rates are not retroactive and are applied to all claims for services rendered effective with the update.

   Determine Interim Payment
   SNFD reviews the most current filed Medi-Cal 2552-96 cost report and Workbook filed by each DPH for the purpose of determining a tentative settlement. The tentative settlement is made to settle on an interim basis all claims paid to date to reflect the difference between the interim rate paid and actual costs. The actual claims paid are based on the most current Medi-Cal claims payment data generated by California's fiscal intermediary. Based on the review and application of the current payment data, SNFD generates a notice of tentative settlement to each DPH that includes schedules supporting the calculation and a copy of the payment data. A copy of the notice is forwarded to A&I for preparation of an action notice authorizing California's fiscal intermediary to pay or recover the tentative

settlement amount. California's fiscal intermediary will prepare a Statement of Account Status which will inform the hospital of the date of payment or instructions for repayment.

3. Final Reconciliation Process
   The final audit report of the Medi-Cal 2552-96 cost report generated by A&I will be used as the basis for final determination and settlement of the CPEs. SNFD will instruct A&I to prepare an action notice informing California's fiscal intermediary of the final settlement. California's fiscal intermediary will issue a Statement of Account Status which will incorporate the previous tentative settlement and inform the DPH of any further payment or recovery.

III. INTERGOVERNMENTAL TRANSFERS (IGTs)

IGTs are transfers of public funds between governmental entities, such as from a county to the State. One source of the funding used for the transfer is local tax dollars. SNFD reviews the source of funding for each IGT that is proposed by a governmental entity to ensure that it meets state and federal requirements for permissible transfers.

Pre-Transfer

For IGTs used as the non-federal share of DSH payments, DHCS and the State Treasurer's Office (STO) are notified by the county or governmental entity, prior to the transfer of funds to ensure all arrangements are complete.

For IGTs used as the non-federal share of the supplemental payments under the provisions of section 14166.12 of the California Welfare and Institutions (W&I) Code, DHCS, the California Medical Assistance Commission (CMAC), and STO are notified by the county, or governmental entity, prior to the transfer of funds to assure that all arrangements are complete.

Transfer

1. IGTs used as the non-federal share of DSH payments.
   The amounts of the IGTs are determined by the data submitted to DHCS by the DPHs. Staff of the DSH Payment Unit will coordinate the amount and timing of transfers from the DPHs to STO.

2. IGTs used as the non-federal share of the supplemental payments.
   CMAC coordinates with HCU on the amount and timing of IGTs to the STO under the provisions of section 14166.12 of the W&I Code.

Post-Transfer

For all IGTs, the county, or governmental entity, notifies DHCS after the transfer is complete. The transfer is verified and documented, and DHCS deposits the transferred amount into the appropriate funds for payments.

IV. SAFETY NET CARE POOL PAYMENTS

DPHs receive SNCP payments for hospital and clinic costs associated with health care services provided to uninsured individuals.

Payment Processes

The SNFD Program payment computation includes automated verification that the federal SNCP allotment, quarterly interim payments and the total SNCP funding level are not exceeded.
The payment process includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation occurs based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to the Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

V. DISPROPORTIONATE SHARE HOSPITAL PROGRAM

DHCS disburses $1.0325 billion of the federal DSH allotment to eligible DPHs and non-designated public hospitals (NDPHs) annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the California Medicaid State Plan (State Plan), are eligible to receive DSH program funding. The State Plan defines DPHs and NDPHs, specifies the funding level, and describes the distribution methodology.

The non-federal share of DSH payments to DPHs is comprised of CPEs and IGTs. DPHs use CPEs to claim DSH funding for up to 100 percent of their uncompensated care costs, and use IGTs to claim DSH funding for up to 175 percent of their uncompensated care costs, as permitted by the Omnibus Budget Reconciliation Act of 1993. By contract, the nonfederal share of DSH payments to NDPHs is the State General Fund.

Annually, the DSH Share Hospital Eligibility Unit submits a DSH Program audit report to CMS as required by the Social Security Act. The DSH Share Hospital Payment Unit (DSHPU) performs a final reconciliation of total DSH hospital-specific payments to ensure that funding provided during and after the project year does not exceed appropriate funding levels established by actual hospital uncompensated care costs, as required by the State Plan.

The DSH Program payment computations include automated verification that the federal DSH allotment, appropriate IGT funds invoiced for DSH payments, and the total DSH Program funding level are not exceeded.

The DSHPU protocol and procedures include quality audits to ensure that correct data is used appropriately and that correct amounts are disbursed to the appropriate hospitals.

A. DESIGNATED PUBLIC HOSPITALS

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source.

The check write memorandum includes a payment authorization notice (PAN) and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. For payments using IGTs as the non-federal share of the payments, the PAN provides Accounting with authorization to use the federal DSH allotment and IGT funds from the Medicaid Inpatient Adjustment Fund. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for DPHs includes three phases.

Phase One
Four quarterly interim payments are disbursed to hospitals during and immediately after the program year.

Phase Two
Interim reconciliation is based on hospital cost reports filed five months after the end of the fiscal year. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

Phase Three
The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute an additional payment to a hospital or recover an overpayment amount.

EDS prepares the check write computer file for submission to SCO.

B. NON-DESIGNATED PUBLIC HOSPITALS

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal DSH allotment).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting with authorization to use the General Fund and federal DSH allotment. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal share sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for NDPHs includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information.

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover any overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

C. PRIVATE HOSPITALS

DHCS disburses approximately $465 million of DSH replacement funding to eligible private hospitals annually. Hospitals that satisfy federal criteria specified in the Social Security Act and determined by the State Plan, are eligible to receive DSH replacement funding. The State Plan defines private hospitals, specifies the funding level, and describes the funding distribution methodology. In addition to the DSH replacement funding, DSH-eligible private hospitals receive their pro rata share of payments from a defined pool within the annual DSH allotment.

Check Write Memorandum

The DSHPU generates a check write memorandum addressed to California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% federal Medicaid funding).

The check write memorandum includes a PAN and a memorandum to Accounting. The DSHPU uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting with authorization to use the State General Fund and federal Medicaid funds. The memorandum provides instructions for Accounting to draw federal funds using the appropriate non-federal sources.

Signature Authorization

The DSH Program signature authorization document includes the DSHPU Chief and the DSH Financing & Non-Contract Hospital Recoupment Section Chief.

Payment Process

The payment process for private hospitals includes two phases.

Phase One
During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. Bimonthly payments are made based on tentative data. The first payment of the year is based on the prior year's data. As more current data becomes available, a recalculation is made and payments are adjusted based on current information

Phase Two
Before the final payment is made, hospitals are given the opportunity to review the data used to calculate payment amounts. Final adjustments to payments are made in this phase after all discrepancies have been resolved. Appropriate adjustments are made to either distribute the final installment or recover an overpayment amounts.

EDS prepares the check write computer file for submission to SCO.

VI. PRIVATE HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the Selective Provider Contracting Program (SPCP) to provide acute inpatient hospital care to Medi-Cal patients. Eligible private hospitals receive supplemental payments funded with State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Private Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to the Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VII. NON-DESIGNATED PUBLIC HOSPITAL SUPPLEMENTAL PAYMENTS

CMAC negotiates contract amendments with hospitals participating in the SPCP to provide acute inpatient hospital care to Medi-Cal patients. Eligible NDPHs receive supplemental payments funded with State General Funds and federal funds.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for supplemental payments from the Non-designated Public Hospital Supplemental Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

VIII. DISTRESSED HOSPITAL FUND PAYMENTS

CMAC negotiates contract amendments with participating SPCP hospitals that meet criteria for distressed hospitals. These hospitals must serve a substantial volume of Medi-Cal patients, be a critical component of the Medi-Cal program's health care delivery system, and be facing a significant financial hardship that may impair ability to continue their range of services for the Medi-Cal program.

The non-federal share of distressed hospital fund payments is funded by State Treasury funds that are 20% of the July 2005 balance of the prior supplemental funds (PFSs), accrued interest on the PFSs, and any additional amounts appropriated by the Legislature.

Payment Determination

Approximately two times per year, CMAC forwards to HCU the contract amendments for payments from the Distressed Hospital Fund. Each contract amendment indicates the amount and date to be paid.

Payment Process

HCU prepares a payment package for signatures. The package is reviewed by a peer for verification prior to routing to management for signatures. Each package includes:

(i) A memorandum addressed to Financial Management Branch Chief requesting authorization for payment.
(ii) An invoice for the signatures of the Chiefs of ICMS and HCU.
(iii) A copy of the support documents.

After internal signatures are obtained, HCU will:

(i) Make a photocopy of payment package for program files.
(ii) Record data on an internal spreadsheet, (including amount, date paid, and annual totals).

The payment packages are submitted to Accounting. Accounting processes the payment request, and submits it to SCO. After the payment is made, Accounting will send a claim schedule to HCU for confirmation.

IX. CONSTRUCTION/RENOVATION REIMBURSEMENT PROGRAM (SB 1732)

In 1989, Senate Bill (SB) 1732 was enacted to establish the Construction/Renovation Reimbursement Program (also known as the SB 1732 program) (Welfare and Institutions Code 14085.5). Under this program, reimbursement is provided to eligible hospitals for the debt service costs incurred on revenue bonds used to finance eligible hospital construction project(s).

Invoice Submission

Invoices are submitted by participating hospitals to HCU no more than twice each year. The invoices consist of the following:

(i) A cover letter from the hospital's Chief Financial Officer, or other appropriate representative.
(ii) A reimbursement request that includes bond debt service payment (principal and/or interest).
(iii) Support documents verifying payment by the hospital to the debt holder.

Review Process

HCU verifies inclusion and accuracy of all required documents in the invoice package.

Payment Process

HCU calculates reimbursement amounts on a spreadsheet by:

(i) Determining the amount of debt service paid.
(ii) Deducting interest earned in the hospital's SB 1732 account.
(iii) Calculating the reimbursable amount based on the eligible portion of the construction project and the Medi-Cal Utilization Rate percentage.

HCU prepares a reimbursement payment package, which is reviewed and approved by the ICMS Chief, and submits it to California's fiscal intermediary. .

HCU sends a notification letter to each eligible hospital and a copy of the notification letter is forwarded to CMAC.

California's fiscal intermediary forwards payment requests to SCO and sends copies of the payment requests to HCU.

SCO mails the payment to the hospital.

X. SELECTIVE PROVIDER CONTRACTING PROGRAM

The SPCP was established in 1982 and operated under a two-year section 1915(b) waiver until August 31, 2005. On September 1, 2005, CMS approved the continuation of a restructured SPCP under California's new five-year section 1115 Medi-Cal Hospital/Uninsured Care Demonstration. The SPCP allows DHCS to selectively contract with acute care hospitals to provide inpatient hospital care to Medi-Cal beneficiaries. Under the SPCP, CMAC negotiates contract terms and conditions and per diem rates with participating hospitals on behalf of DHCS. This program has resulted in millions of dollars of savings each year which offset expenditures in this Demonstration to assist in achieving budget neutrality.

The non-federal share of SPCP payments is funded by amounts from the State General Fund.

Contract Process

CMAC forwards proposed contract(s)/amendment(s) to HCU for review. After review, final proposed contracts/amendments are presented at a CMAC meeting for approval by the Commissioners. The approved contracts/amendments are signed by authorized hospital representatives and submitted by CMAC to HCU for processing. The HCU analyst prepares contract/amendment packages for processing and obtains the signature of DHCS's delegated Contract Officer (SNFD Chief) to fully execute the contracts/amendments.

Notification Process

HCU notifies PED of new per diem rates and/or new Current Procedural Terminology codes, revenue codes, and Health Care Procedure Coding System codes, to update the Provider Master File with the hospital- specific information. This file is used by California's fiscal intermediary to process and pay claims submitted by all Medi-Cal providers, including those participating in the SPCP.

Distribution Process

HCU distributes fully executed contracts/amendments to the following:

(i) Contracted hospital
(ii) CMAC Executive Director
(iii) Medi-Cal Field Office
(iv) A&I

XI. CMS-64 QUARTERLY EXPENSE REPORT

After the end of every quarter, Accounting summarizes all payments and claims made relating to the Demonstration during the quarter and sends the summary to SNFD to verify the payment period, amount and funding source. After the confirmation, Accounting prepares and submits the CMS-64 Quarterly Expense Report to CMS.

Attachment H - Accounting Procedures

Attachment I

Quarterly Report Guidelines

In accordance with Section, paragraph 20, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 30 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – State of California Bridge to Health Reform Demonstration 11-W-00193/9)

Title Line Two - Section 1115 Quarterly Report
Demonstration Reporting Period:

Example:
Demonstration Year: 2 (9/1/10 - 11/30/10)

Introduction:

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information:

Please complete the following table that outlines current enrollment in each HCCI program under the Demonstration. The State should indicate "N/A" where appropriate.

Note:

Monthly enrollment data during the quarter and Demonstration Year to Date by:

i. County of participation the number of persons in the Medicaid Coverage Expansion Program ([MCE]) who are applicants, new recipients and existing recipients by FPL;
ii. County of participation the number of persons in the HCCI program ([SNCP – HCCI]) who are applicants, new recipients and existing recipients by FPL;
iii. County of participation the number of persons enrolled in the SPD program ([Existing SPD] or [Mandatory SPD]);
iv. County of participation the number of persons enrolled in the California Children Services Program based on Medi-Cal eligibility ([CCS – State Plan]) and DSHP ([CCS – DSHP]); and
v. County of participation the number of persons participating in any Demonstration programs receiving FFP.
vi. Monthly eligible member-month totals for [MCE], [Existing SPD], [Mandatory SPD], [CCS – State Plan], and [Families],

Member-Months: To permit full recognition of "in-process" eligibility, reported member month totals may be revised subsequently as needed. To document revisions to totals submitted in prior quarters, the State must report a new table with revised member month totals indicating the quarter for which the member month report is superseded. The term "eligible member months" refers to the number of months

in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

Demonstration Programs	**Month 1**	**Month 2**	**Month 3**	**Quarter**	**Current Enrollees** (to date)

Outreach/Innovative Activities:
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Developments/Issues:
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:
Identify any quality assurance/monitoring activity in current quarter.

Enclosures/Attachments:
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The State may also add additional program headings as applicable.

Date Submitted to CMS:

Attachment J – Administrative Cost Claiming Protocol

Reserve for State submission of modified LIHP administrative cost claiming protocol per paragraph 47.

Attachment K – Reserved Budget Neutrality Projections

Attachment L – Managed Care Enrollment Requirements in Transitioned 1915(b) Waivers

		Included Populations								
1915(b) Waiver	**County Included**	**Section 1931 Children**	**Section 1931 Adults**	**Blind/ Disabled Adults**	**Blind/ Disabled Children**	**Aged & Related Populations**	**Foster Care Children**	**Title XXI CHIP**	**BCCPT * Program**	**Children with accelerated eligibility**
HIO Waiver	**Santa Cruz**	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Monterey	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Merced	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Orange	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Solano	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Napa	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Sonoma	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
	Yolo	All populations are required to enroll in managed care					Req.	Req.	Req.	Req.
HPSM	**San Mateo**	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
SBSLORHA	**Santa Barbara**	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
	San Luis Obispo	All populations are required to enroll in managed care					Req.	Req [a]	Req.	Req.
Two-Plan/GMC Waiver	**Alameda**	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Contra Costa	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Fresno	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kern	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Kings	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Los Angeles	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Madera	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Riverside	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Sacramento	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Bernardino	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Diego	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Francisco	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	San Joaquin	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Santa Clara	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Stanislaus	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	
	Tulare	All populations are required to enroll in managed care					Vol.	Req.[b]	Vol.	

[a] non-State only Healthy Families

[b] CHIP expansion includes non-Healthy Families children in the percent of poverty program

*** BCCPT - Breast and Cervical Cancer Prevention Treatment Program**

Planned Expansions:

- **In July, 2011, Marin, Mendocino and Ventura counties plan to begin operation; all populations will be required to enroll in managed care**

Attachment L – Managed Care Enrollment Requirements in Transitioned 1915(b) Waivers

		Populations that may be excluded from enrollment in managed care									
1915(b) Waiver	**County Included**	**Dual Eligibles**	**Preg. Women**	**Other Insurance**	**Nursing Facility or ICF/MR Resident**	**Enrolled in Another Managed Care Program**	**Less than 3 Months Eligibility**	**HCBS Waiver-Enrolled**	**Special Needs Children (State Defined)**	**CHIP Title XXI**	**Retro Eligibility**
HIO Waiver	Santa Cruz					X				X[h]	
	Monterey					X				X[h]	
	Merced					X				X[h]	
	Orange					X				X[h]	
	Solano					X				X[h]	
	Napa					X				X[h]	
	Sonoma					X				X[h]	
	Yolo					X				X[h]	
HPSM	San Mateo					X				X[h]	
SBSLORHA	Santa Barbara					X				X[h]	
	San Luis Obispo					X				X[h]	
Two-Plan/GMC Waiver	Alameda	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Contra Costa	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Fresno	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kern	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Kings	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Los Angeles	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Madera	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Riverside	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Sacramento	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Bernardino	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Diego	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Francisco	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	San Joaquin	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Santa Clara	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Stanislaus	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
	Tulare	X[c]	X[d]	X[ef]	X	X[g]	X			X[i]	X
Planned Expansions	Marin***					X				X[h]	
	Mendocino***					X				X[h]	
	Ventura***					X				X[h]	

Notes:

[c] **State excludes enrollment of dual eligibles who are simultaneously enrolled in a Medicare Advantage plan, unless the Medicare Advantage plan also has a Medi-Cal managed care contract;**

[d] **These beneficiaries receive pregnancy related services only;**

[e] **State excludes individuals that have a share of cost or are ineligible for full-scope services;**

[f] **State excludes individuals who have been approved by the Medi-Cal Field Office or the CCS program for any major organ transplant that is a Medi-Cal FFS benefit, except kidney transplants;**

[g] **Individuals enrolled in mental health or dental health managed care programs are not considered to be enrolled in another managed care program**

[h] **State only Healthy Families;**

[i] **Except for non-Healthy Families children in the Percent of Poverty program.**

Attachment M-Geographic Distribution and Delivery System Model for Transitioned 1915(b) Waivers

1915(b) Waiver	Counties Included	Delivery System Model	Managed Care Organizations Participating
HIO Waiver	**Santa Cruz**	MCO/HIO	Central Coast Alliance
	Monterey	MCO/HIO	Central Coast Alliance
	Merced	MCO/HIO	Central Coast Alliance
	Orange	MCO/HIO	CalOPTIMA
	Solano	MCO/HIO	Partnership HealthPlan of California
	Napa	MCO/HIO	Partnership HealthPlan of California
	Sonoma	MCO/HIO	Partnership HealthPlan of California
	Yolo	MCO/HIO	Partnership HealthPlan of California
HPSM	**San Mateo**	MCO	Health Plan of San Mateo
SBSLORHA	**Santa Barbara**	MCO/HIO	CenCal
	San Luis Obispo	MCO/HIO	CenCal
Two-Plan/ GMC Waiver	**Alameda**	MCO	Alameda Alliance for Health , Anthem Blue Cross Partnership Plan
	Contra Costa	MCO	Contra Costa Health Plan, Anthem Blue Cross Partnership Plan
	Fresno	MCO	Health Net Community Solutions, Anthem Blue Cross Partnership Plan
	Kern**	MCO	Kern Family Health, Health Net Community Solutions
	Kings**	MCO	Cal Viva, Anthem Blue Cross (when implemented)
	Los Angeles *	MCO	L.A. Care Health Plan, Health Net Community Solutions
	Madera	MCO	Partnership HealthPlan of California
	Riverside *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	Sacramento	MCO; medical PAHP; dental	Anthem Blue Cross, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Bernardino *	MCO	Inland Empire Health Plan, Molina Healthcare of California Partner Plan
	San Diego	MCO	Care First, Community Health Group, Health Net Community Solutions, Kaiser Permanente , Molina Healthcare of California Partner Plan
	San Francisco	MCO	San Francisco Health Authority, Anthem Blue Cross Partnership Plan
	San Joaquin	MCO	Health Plan of San Joaquin, Anthem Blue Cross Partnership Plan
	Santa Clara	MCO	Santa Clara Family Health Plan, Anthem Blue Cross Partnership Plan
	Stanislaus	MCO	Anthem Blue Cross Partnership Plan, Health Net Community Solutions
	Tulare	MCO	Anthem Blue Cross Partnership Plan, Health Net Community Solutions

Note:

*** These counties allow beneficiaries in certain zip codes to enroll on a voluntary basis**

Planned Expansions:

- ****In February 2011, Kings and Madera County, Two Plan Expansion - authority as approved by the Tri-Country 1915b approval of 10/1/2010.**
- *****In July, 2011, Marin, Mendocino and Ventura counties plan to begin operation using an HIO model**

Attachment N-Capitated Benefits Provided in Transitioned 1915(b) Waivers (X= covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	X[1]	X[1]	X[1]
Acute Administrative Days	Intermediate Care Facility Services	Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization.	X	X	X
Adult Day Health Care (ADHC) Program	Services not covered under the State Plan	A licensed community-based day care program providing a variety of health, therapeutic, and social services to those at risk of being placed in a nursing home.			
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	X	X	X
California Children Services (CCS)	Services not covered under the State Plan	California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.			
Certified Family nurse practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioners who provides services within the scope of their practice.	X	X	X
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	X	X
Child Health and Disability Prevention (CHDP) Program	Services not covered under the State Plan	A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services.	X	X	X[4]
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)	Services not covered under the State Plan	A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.			
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	X[1]	X[1]	X[1]

Attachment N-Capitated Benefits Provided in Transitioned 1915(b) Waivers (X= covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	X	X
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.	X	X	X
Dental Services	Services not covered under the State Plan	Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.			
Drug Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries.			
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	X	X
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services	EPSDT	Preliminary evaluation to help identify potential health issues.	X	X	X
Erectile Dysfunction Drugs	Services not covered under the State Plan	FDA-approved drugs that may be prescribed if a male patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem.			
Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS)	Services not covered under the State Plan	A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.			
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the written prescription of a physician or optometrist.	X[1,3]	X[1,3]	X[1,3]
Federally Qualified Health Centers (FQHC)	FQHC	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).	X	X	X

Attachment N-Capitated Benefits Provided in Transitioned 1915(b) Waivers (X= covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	X	X	X
Home and Community-Based Waiver Services (Does not include EPSDT Services)	This is a multitude of services and is not listed in the State Plan as HCBS services	Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.			
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	X	X
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	X	X
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	X	X
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	X	X	X
Human Immunodeficiency Virus and AIDS drugs	Services not covered under the State Plan	Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual			

Attachment N-Capitated Benefits Provided in Transitioned 1915(b) Waivers (X= covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.	X	X	X
Indian Health Services	Services not covered under the State Plan	Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.	X	X	X
In-Home Medical Care Waiver Services and Nursing Facility Waiver Services	These are a multitude of services and are not listed as waiver services in the State Plan.	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	X	X
Intermediate Care Facility Services for the Developmentally Disabled	Intermediate Care Facility Services for the Developmentally Disabled	Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care	X	X	X

Attachment N-Capitated Benefits Provided in Transitioned 1915(b) Waivers (X= covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X	X	X
Intermediate Care Facility Services for the Developmentally Disabled-Nursing.		Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N) are covered subject to prior authorization by the Department for the ICF/DD-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/DD-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X	X	X
Intermediate Care Services	Intermediate Care Facility Services	Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X	X	X
Laboratory, Radiological and Radioisotope Services	Listed as Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner	X	X	X
Licensed Midwife Services	Listed as Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education.			
Long Term Care (LTC)	Services not covered under the State Plan	Care in a facility for longer than the month of admission plus one month.	X[5]	X[5]	X
Medical Supplies	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes	X	X	X
Medical Transportation Services	Transportation-Medical Transportation Services	Covers ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.	X	X	X
Multipurpose Senior Services Program (MSSP)	Services not covered under the State Plan	MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.			
Nurse Anesthetist Services	Listed as Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	X	X
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	X	X

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered.	X	X	X
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	X	X	X
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day to day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.			
Part D Drugs	Services not covered under the State Plan	Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.			
Pediatric Subacute Care Services	Nursing Facility Services and Pediatric Subacute Services (NF)	Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X	X	X
Personal Care Services	Personal Care Services	Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services.			
Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers medications including prescription and nonprescription and total parental nutrition supplied by licensed physician.	X	X	X
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited psychiatry services when rendered by a physician, and limited allergy treatments.	X	X	X
Podiatry Services	Listed as Other Practioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to prior authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X[1]	X[1]	X[1]

Attachment N-Capitated Benefits Provided in Transitioned 1915(b) Waivers (X= covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Prayer or Spiritual Healing	Any other medical care and any other type of remedial care under State Law	Prayer or spiritual healing services covered are limited to those allowed under Title XVIII of the Social Security Act.			X
Prosthetic and Orthotic Appliances	Prosthetic and Orthodic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	X	X
Psychology, Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services	Psychology Listed as Other Practitioners' Services and Psychology, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology Services	Psychology, physical therapy, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements	X[1,2*]	X[1,2]	X[1,2*]
Psychotherapeutic drugs	Services not covered under the State Plan	S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual			
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training	X	X	X
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	X	X
Renal Homotransplantation	Organ Transplant Services	Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers.	X	X	X
Requirements Applicable to EPSDT Supplemental Services.	EPSDT	Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services.	X	X	X
Respiratory Care Services	Respiratory Care Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	X	X	X
Rural Health Clinic Services	Rural Health Clinic Services	Covers primary care services by a physician or a non-physician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, supplies, equipment and drugs.	X	X	X
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	X	X	X

Attachment N-Capitated Benefits Provided in Transitioned 1915(b) Waivers (X= covered by plan. If service is not covered, plan is contractually required to provide care coordination to members)

Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Services provided in a State or Federal Hospital	Services not covered under the State Plan	California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.			
Short-Doyle Mental Health Medi-Cal Program Services	Short-Doyle Program	Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program.			
Skilled Nursing Facility Services	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X[5]	X[5]	X
Special Duty Nursing	Private Duty Nursing Services	Private duty nursing is the planning of care and care of clients by nurses, whether an registered nurse or licensed practical nurse.	X	X	X
Specialty Mental health services	Services not covered under the State Plan	Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.			
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[5]	X[5]	X
State Supported Services	Services not covered under the State Plan	State funded abortion services that are provided through a secondary contract.	X	X	X
Subacute Care Services	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X	X	X
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	X	X
Targeted Case Management Services Program	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.			

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Service	State Plan Service Category	Definition	Covered in GMC	Covered in Two-Plan	COHS
Targeted Case Management Services.	Targeted Case Management	Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.			
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	**X**	**X**	**X**
Tuberculosis (TB) Related Services	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.			

[1] Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; and 5) beneficiaries enrolled in the PACE. Services include: Chiropractic Services, Psychologist, Acupuncturist, Audiologist and Audiology Services, Optician and Optical Fabricating Lab, Dental*, Speech Pathology, Dentures, Eye glasses.

[2] Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider are not covered, except that Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.

[3] Fabrication of optical lenses not covered

[4] Not covered by CenCal

[5] Only covered for the month of admission and the following month

Attachment O – County Listing for SPD Enrollment

County Name	Plan Model			Do Section IX STCs Apply?
	Two-Plan	GMC	COHS	
Alameda	X			X
Contra Costa	X			X
Fresno	X			X
Kern	X			X
Kings*	X			X
Los Angeles	X			X
Madera*	X			X
Marin**			X	
Mendocino**			X	
Merced			X	
Monterey			X	
Napa			X	
Orange			X	
Riverside	X			X
Sacramento		X		X
San Bernardino	X			X
San Diego		X		X
San Francisco	X			X
San Joaquin	X			X
San Luis Obispo			X	
San Mateo			X	
Santa Clara	X			X
Santa Barbara			X	
Santa Cruz			X	
Solano			X	
Sonoma			X	
Stanislaus	X			X
Tulare	X			X
Ventura*			X	
Yolo			X	

* Kings, Madera, and Ventura County expansions are planned for February 1, 2011

** Marin and Mendocino expansions are planned for July 1, 2011

Attachment P – Reserved DSRIP Metrics

Attachment Q – Reserved DSRIP Protocol