DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

AUG 13 2012

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 958899-7413

Dear Mr. Douglas:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the California Department of Health Care Services' (DHCS) revised "Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims Based on Certified Public Expenditures (Supplement 1)" of the "Low Income Health Program (Attachment G)" for California's "Bridge to Reform Demonstration (No. 11-W-00193/9)."

Our review indicates that the submitted revisions to Supplement 1 of Attachment G are approvable. This is effective for the time period of October 1, 2011 through October 31, 2015 unless otherwise indentified in Supplement 1 of Attachment G, attached for your reference.

If you have any questions regarding the terms of this approval, please contact your project officer, Ms. Alexis E. Gibson. She can be reached by phone at (410) 786-2813, or by email at Alexis.gibson@cms.hhs.gov

Sincerely,

for Allison B. Orris, Acting Director
Division of State Demonstrations & Waivers

Attachment

cc: Gloria Nagel, ARA, CMS San Francisco Regional Office
Alexis E. Gibson, Esquire, CAHPG

Attachment G – Supplement 1
Low Income Health Program

SUPPLEMENT 1: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program—Claims Based on Certified Public Expenditures

The purpose of this Attachment G–Supplement 1 is to set forth the cost claiming guidelines and payment process for services provided by Participating Entities under the Low Income Health Program (LIHP), when the claim for federal financial participation (FFP) is based on Certified Public Expenditures (CPEs). The following guidelines must be met in order to ensure FFP.

A Participating Entity may provide services under the LIHP that are claimed based on CPEs, and may also provide services under the LIHP that are paid on the basis of actuarially sound capitation rates. The cost claiming for services reimbursed on the basis of CPEs will be governed by this Attachment G–Supplement 1. The cost claiming for services reimbursed on the basis of actuarially sound capitation rates will be governed by Attachment G–Supplement 2.

The LIHP costs being claimed under this protocol are limited to the costs incurred under the Participating Entity's executed contract(s) with the Department of Health Care Services (DHCS) (*i.e.,* the LIHP Contract, and the LIHP-Mental Health (LIHP-MH) Contract, if mental health services are provided through a carved-out delivery system that is separate from the LIHP) and in accordance with Attachment G, entitled *"Low Income Health Program,"* of the Special Terms and Conditions (STCs) of California's Section 1115(a) *Bridge to Reform Demonstration.* Each Participating Entity will receive as payment for services rendered to LIHP enrollees, FFP received by the State based on the CPEs for that Participating Entity's LIHP. All references to interim, quarterly or reconciled payments to a LIHP refer to the FFP received by the State based on the CPEs for that Participating Entity's LIHP.

Unless expressly discussed below, the LIHP costs being claimed under this methodology will be determined in accordance with Attachment F, entitled *"Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool,"* of the STCs of the *Bridge to Reform Demonstration*, and in accordance with the methodologies for claiming hospital and non-hospital costs that have been approved by the Centers for Medicare & Medicaid Services (CMS).

Unless expressly discussed below or in the documents referred to above, the Participating Entity and the Department of Health Care Services (DHCS) must follow Medicare cost principles in identifying eligible costs.

I. Methods for Delivery, Cost Reporting, and Payment for LIHP Services

Each Participating Entity will enter into a contract(s) with DHCS to provide services under the LIHP program. The contract(s) will identify the covered services that the Participating Entity will provide under the LIHP and the method of payment for such services.

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The method of reporting certain costs of providing LIHP services depends on whether or not the Participating Entity operates one or more Designated Public Hospitals (DPHs). All costs will be claimed in accordance with OMB Circular A-87 and Attachment F, as applicable. The HCCI allocation will be set forth in the LIHP contracts with DHCS and will be the maximum level of SNCP funding that will be available to pay for expenditures for HCCI enrollees in each Participating Entity's LIHP during the DY. There is no cap on funding for the MCE program.

A. DPH-Based LIHP

Participating Entities that operate a DPH (DPH-Based LIHP)will include the costs of providing health care services to LIHP enrollees on the *Interim Hospital Payment Rate Workbook* (Workbook), established pursuant to Attachment F of the STCs.

DPH-Based LIHPs will report the costs of providing those inpatient hospital, outpatient hospital, and non-hospital services, including those services approved in Attachment D of the STCs, entitled *"Additional Cost Elements for Government-Operated Hospitals Using Certified Public Expenditures (CPEs),"* to LIHP enrollees on the Workbook. The Workbook is completed using each hospital's most recently filed or audited Medi-Cal 2552-96 cost report for the period, as applicable. The LIHP inpatient days, inpatient and outpatient charges, and the resulting costs are calculated on Schedules 1, 1A and lB of the Workbook. Additional costs of LIHP services, as allowed under Attachment D of the STCs, are identified on Schedules 4 and 5 of the Workbook. Such costs include expenditures made by, or costs incurred by the DPH or by the governmental entity that operates the DPH.

DPH-Based LIHPs that provide services to LIHP enrollees through one or more contracts (Subcontract(s)) will report their contract costs on the Workbook as specified in Section III.E below. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

DHCS will make interim quarterly payments to DPH-Based LIHPs based on the estimated expenditures data included in Schedule 2A of the Workbook in accordance with the Interim Quarterly Payments for the Expenditure Year section below. DPH-based LIHPs will estimate costs for the expenditure year by utilizing volume and trend adjustment factors contained in the Workbook, based on estimated changes to factors such as enrollment, network provider contracts and DPH cost of providing services. DHCS will reconcile the interim quarterly payments as specified in the Interim Review and Reconciliation Process section below. Also, in accordance with the Final Reconciliation and Settlement and Payment/Recovery for the Expenditure Year section below, DHCS will perform a final reconciliation and settlement, and payment/recovery, after the claiming period using the hospital's Medi-Cal 2552-96 cost report for that same claiming period, as finalized by the Audits and Investigations Division (A&I) of DHCS, for the purposes of Medicaid reimbursement.

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B. Non DPH-Based LIHP

Participating Entities that do not operate a DPH (Non DPH-Based LIHP) will determine their LIHP costs, for the purpose of establishing CPEs, through invoices that contain the actual costs of contracted services and, if applicable, the same cost-reporting protocols for services not provided through a contract but provided in clinics or other provider types operated by the Participating Entity (e.g. a county-owned clinic). Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

For services provided through a contract, Non-DPH-Based LIHPs will submit quarterly invoices or claims for reimbursement for LIHP services, to DHCS and DHCS will make quarterly payments to the Non-DPH-Based LIHPs based on such claims, in accordance with the Interim Quarterly Payments for the Expenditure Year section below. DHCS will reconcile the interim quarterly payments as specified in the Interim Review and Reconciliation Process section below, if appropriate. Also, in accordance with the Final Reconciliation and Settlement and Payment/Recovery for the Expenditure Year section below, DHCS will perform a final reconciliation and settlement, and payment/recovery after the claiming period using appropriate data, if appropriate.

For services not provided through a contract but provided through a facility operated by the Participating entity, if the Non DPH-Based LIHP provides services through a hospital that it operates, DHCS will base the final reconciliation and settlement, and payment/recovery, on the hospital's Medi-Cal 2552-96 cost report for that same claiming period, as finalized by the Audits and Investigations Division (A&I) of DHCS, for the purposes of Medicaid reimbursement and reported costs based on this cost report through a Workbook that includes the same elements as the Workbook used for the DPH-Based LIHPs.

II. Interim Quarterly Payments for the Expenditure Year

A.

1. DHCS will compute the interim quarterly payments for DPH-Based LIHPs on an annual basis using the Participating Entity's estimated total funds expenditures as estimated using the most currently filed Workbook adjusted by cost trend and utilization factors. DHCS will make interim quarterly payments in a manner consistent with the instructions herein.

   The interim quarterly payments will be separately identified for the MCE and HCCI enrollee populations. DHCS will make interim quarterly payments to the DPH-Based LIHPs within 45 days after the end of a calendar quarter, for services provided during that quarter.

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2. DHCS will make quarterly payments to the Non DPH-Based LIHPs, which are separately identified for the MCE and HCCI enrollee populations. DHCS will reimburse the Participating Entity the contract cost for services provided through a subcontract. For services provided through a hospital or other provider type operated by the Participating Entity, DHCS will determine quarterly interim payments using one-fourth of the annual estimated expenditures for the project year. DHCS will make the quarterly interim payments within 45 days of receipt of a complete approvable claim for services provided during that quarter.

3. For DPH-Based and Non DPH-Based LIHPs, the purpose of an interim quarterly payment for services provided to MCE enrollees is to provide an interim payment that will approximate the actual reimbursable LIHP program costs related to the services provided to eligible MCE enrollees that may be claimed by DHCS using the Participating Entity's CPEs.

   The interim quarterly payment for services provided to HCCI enrollees will be determined by DHCS under the same methodology as the interim payment for MCE enrollees, except that an interim quarterly payment will be limited to one-fourth of the annual HCCI allocation for the Participating Entity.

   The Participating Entity operating a DPH-Based LIHP or a Non DPH-Based LIHP operating all or part of its program through a hospital or other facility it operates will review its projected costs and utilization under the LIHP program each quarter, and will notify DHCS if there are material changes in such data. For this purpose, a "material change" means a change that would have the effect of increasing or decreasing the interim quarterly payment amount by at least 5%. DHCS will make appropriate adjustments to the interim quarterly payments as necessary to reflect material changes in costs. DHCS and the Participating Entity will collaborate in determining the appropriate adjustments to the interim quarterly payments based on auditable cost and utilization data.

   Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of services provided to LIHP enrollees. Documentation supporting other revenues received for the services furnished, and any other applicable non-patient care revenues to be offset, must be provided to DHCS upon request, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Documentation may include contracts, invoices and expenditure detail.

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B. Special Provisions Regarding Payments During the Extension Period (September 1, 2010 to October 31, 2010)

During the period from September 1, 2010 to October 31, 2010 (Extension Period), the DPH-Based entities and the Non-DPH-Based entities that participated in the Coverage Initiative (CI) under the Prior Demonstration will continue to be eligible to receive reimbursement under the CI pursuant to the Prior Demonstration.

Payments for services provided to CI enrollees during the period of September 1, 2010 to October 31, 2010 will be determined by DHCS based on Supplement 1 to Attachment G of the STCs under the Prior Demonstration. Payments for the Extension Period will be limited to one-sixth of the Participating Entity's allocation of CI funds for the CI year September 1, 2009 to August 31, 2010. The CI payments for the period of September 1, 2010 to October 31, 2010 will be charged to the HCCI allotment for Demonstration Year 6, as set forth in paragraph 3 of Attachment G.

C. Special Provisions Regarding Interim Payments for the Transition Period from November 1, 2010 Through June 30, 2011

DHCS will base the interim payments for those DPH-Based entities that participated in the CI under the Prior Demonstration for services provided to MCE enrollees during the period from November 1, 2010 through June 30, 2011 on the DPH-Based entity's costs as reflected in the most currently filed Workbook. Supplemental data will be requested by DHCS to appropriately reconcile expenditures reimbursed by the interim payments between MCE and HCCI enrollees as necessary. For those Non-DPH-Based entities that participated in the CI under the Prior Demonstration and provided services through subcontracts, DHCS will base the payments for services provided to MCE enrollees during the Transition Period on the Non DPH-Based entity's invoices.

The interim quarterly payment for services provided to HCCI enrollees will be determined by DHCS under the same methodology as the interim payment for MCE enrollees, except that an interim quarterly payment will be limited to the Participating Entity's unused allocation of HCCI funds for the period of September 1, 2010 through June 30, 2011.

III. Cost Reporting and Cost Determination

The Participating Entity's contract with DHCS will identify the types of services that it will provide under the LIHP. The Participating Entity will follow the instructions below in determining the costs of the services described below.

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For each cost category, the Participating Entity will separately identify the cost of services provided to the two populations covered under the LIHP, *i.e.*, the MCE and HCCI populations. The cost calculations will be based on appropriate data, such as days, charges, and/or units of service for MCE and HCCI enrollees.

Any revenue received from or on behalf of patients for the LIHP services are applied as offsets to arrive at uncompensated costs.

A. Non-Hospital Based Clinics, Including Public Health Clinics – For DPH-Based LIHPs (non-FQHCs)

The allowable cost for services provided to LIHP enrollees in a non-hospital based clinic that is owned or operated by a DPH-Based LIHP is based on a rate per visit (total costs divided by total visits).

Non-hospital based clinic costs are captured in the clinic records at each individual site, and the cost per visit is established through a clinic cost report. Clinic cost report data must be entered on the clinic cost finding forms that have been approved by CMS to establish the clinic rate and determine costs. Those DPH-Based LIHPs providing outpatient services to LIHP enrollees in a clinic setting that they own or operate and that is non-hospital based, must determine costs as specified in Supplement 2 to Attachment F of the STCs.

DPH-Based LIHPs will be reimbursed by DHCS for services based on the number of documented LIHP program visits times the established clinic rate for the specific service period.

DPH-Based LIHPs providing clinic services to LIHP enrollees through a subcontract will be reimbursed based on the cost of the subcontract reported on the Workbook in accordance with Section III.E. DPH-Based LIHPs will ensure that the services provided under a subcontract are allowable and will be claimed as specified in Attachment G and this Supplement 1. DPH-Based LIHPs must provide documentation to DHCS, upon request that is sufficient to support the subcontract costs, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Documentation may include contracts, invoices and expenditure detail. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

B. Non-Hospital Based Clinics, Including Public Health Clinics – For Non DPH-Based LIHPs

The allowable costs for services provided to LIHP enrollees in a non-hospital based clinic that is owned or operated by a Non DPH-Based LIHP is based on the same cost-reporting utilized for the uninsured as described in Attachment F Supplement 2.

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Non-hospital based clinic costs are captured in the clinic records at each individual site.

Non DPH-Based LIHPs providing clinic services to LIHP enrollees through a subcontract will be reimbursed based on the cost of the subcontract in accordance with Section III.E. Non DPH-Based LIHPs will ensure that the services provided under a subcontract are allowable and will be claimed as specified in Attachment G and this Supplement 1. Non DPH-Based LIHPs must provide DHCS, upon request, documentation sufficient to support the subcontract costs, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Documentation may include contracts, invoices and expenditure detail. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

C. Participating Entities Providing Services to LIHP Enrollees in Federally Qualified Health Clinics (FQHCs) – Hospital-Based and Non Hospital-Based

For FQHCs owned by the participating entity, DHCS and CMS, in collaboration with the affected Participating Entities, will work on revisions to this protocol or a separate protocol that will comply with the Waiver and other applicable federal requirements with the intention of completing this work within 60 days. Until such time that such a protocol is approved, participating entities will not be permitted to claim or receive federal financial participation for services provide in FQHCs owned by the participating entity.

1. FQHC Contractor Unrelated to Participating Entity

Participating entities that provide FQHC services to LIHP enrollees by contracting with an FQHC that is not owned by the Participating Entity, may use an alternative payment methodology pursuant to the Benefits Improvement and Protection Act of 2000, Section 702, and will be reimbursed based on the amount paid by the Participating Entity to the FQHC pursuant to the contract in accordance with Section III.D., below, which will be no less than the rate established pursuant to 42 U.S.C. sec. 1902(bb).

D. Participating Entities Providing Hospital and/or Non-Hospital Services to LIHP Enrollees under a Contract (Subcontract) for Services

DHCS will reimburse Participating Entities that provide services to LIHP enrollees through contracts with providers of services (subcontracts) based on the payments made by the Participating Entities to their subcontractors. Participating Entities will ensure that the services provided under a subcontract are allowable and can be claimed as specified in Attachment G of the STCs. Upon request by DHCS, Participating Entities must provide documentation sufficient to support their payments to subcontractors under the subcontracts, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R.

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Part 413. Documentation may include contracts, invoices and expenditure detail. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

Cost associated with providing LIHP program services through a subcontract may include negotiated amounts or rates, such as a cost per visit, or rate based on fee schedule. The basis for reimbursement of the services provided pursuant to the subcontract will be established in the payment provisions of the subcontract, and the Participating Entity will report CPEs and be reimbursed based on payments to the subcontractors.

Costs associated with providing LIHP program services through a subcontract may be incurred under an agreement by the Participating Entity to reimburse the subcontractor based on the subcontractor's allowable costs. The total funds expenditures reported for such services will be the amount paid by the Participating Entity to the subcontractor pursuant to the subcontract.

E. Participating Entities Providing all Healthcare Services under a Contract (Subcontract) to a Managed Care Plan

This section E of the protocol is subject to change upon CMS review and approval of the rates, if such review and approval is determined to be necessary.

DHCS will reimburse Participating Entities that provide services to LIHP enrollees through contracts with health plans (subcontracts) based on the payments made by the Participating Entities to their subcontractor health plan. Participating Entities will ensure that the services provided under a subcontract are allowable and can be claimed as specified in Attachment G of the STCs. Upon request by DHCS, Participating Entities must provide documentation sufficient to support their payments to subcontractors under the subcontracts, consistent with the documentation standards applicable to Medicare reasonable cost determinations. See 42 C.F.R. Part 413. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

Cost associated with providing LIHP program services through a subcontract with a managed care plan may include contractually provided rates per member per month (PMPM) as adjusted by contractual risk sharing and pay for performance arrangements. The basis for reimbursement of the services provided pursuant to the subcontract will be established in the payment provisions of the subcontract, and the Participating Entity will report CPEs and be reimbursed based on payments to the subcontractors. The Participating Entity will return to DHCS the federal share of any federally reimbursed payment to the subcontractor that is recovered as a result of contractual risk sharing and pay for performance arrangements. DHCS will return these funds to CMS on the CMS-64 form within the required timeframe.

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The total funds expenditures reported for such services will be the amount paid by the Participating Entity to the subcontractor on a PMPM basis pursuant to the subcontract and all subsequent adjustments for risk sharing and pay for performance.

Participating Entities will reimburse subcontracting health plans on a PMPM basis paid to subcontracting health plan for LIHP enrollees. The Participating Entity may reimburse using two separate PMPM rates, one for people previously eligible for Participating Entity coverage and a second for newly eligible people with HIV transferring from the state AIDS Drug Assistance Program (ADAP) or the Ryan White program.

Each PMPM is a single payment with three components. After receiving the PMPM payment, the subcontracting health plan will be required to place each component in a separate interest bearing investment account for Healthcare Costs, Administrative Costs, and Pay for Performance (P4P).

The Healthcare Costs will include the cost of all outpatient, inpatient, primary care, and specialty claims that are paid to providers, including county providers. Funds placed in the Healthcare Costs account will be visible to the Participating Entity, traceable to an audit, and restricted in use by contract terms to healthcare costs approved by Participating Entity. All investment income for the funds in this account will be posted to this account. For the first 6 months of the LIHP, the Participating Entity will begin payment with a higher PMPM rate so that a Reserve Account can be built to address the uncertainties of the new LIHP. The Participating Entity will adjust the rate at least every six months in an effort to set a PMPM rate that is comparable with the cost of healthcare services. The Participating Entity takes full risk for the healthcare costs.

Administration Costs will be based on a contractually provided percentage of healthcare costs. All costs for member services, network development, utilization management, claims adjudication, grievances and appeals, are covered in this percentage. The subcontractor will be entirely at risk for the Administration costs. This Administration Cost will not include the Participating Entity's cost of administering the LIHP, such as eligibility determinations, program administration, and oversight of the subcontractor, which will be separately claimed under administrative claiming protocols.

Pay for Performance (P4P) will be based on a contractually provided percentage of healthcare costs and will not exceed 105% of the PMPM. The subcontracting health plan is at full risk for these measures as well. Any funds paid in the PMPM for performance standards not met, will be returned to the Participating Entity. The Participating Entity will return to DHCS the Federal share of the returned funds. DHCS will return those funds to CMS on the CMS-64 form within the required timeframe.

Final Reconciliation/Recovery

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Healthcare expenditures will be reconciled to PMPM payments and interest will be deposited in the Healthcare account. Unspent funds, including interest, will be returned to Participating Entity and Participating Entity will return to DHCS the federal share of any federally reimbursed payment to the subcontracting health plan. DHCS will return these funds to CMS on the CMS-64 form within the required timeframe. In the event that this account has a deficit the Participating Entity will reimburse the subcontracting health plan for this amount and certify this expense. DHCS will reimburse the Participating Entity the federal share of this payment.

Through this reconciliation process, the Participating Entity and the federal government will only pay for the actual healthcare expenditures made by the subcontracting health plan on behalf of the LIHP.

After the Healthcare account is adjusted, payments for Administration and P4P will be reconciled to actual Healthcare costs. The final payment to the subcontracting health plan for Administration costs will be equal to the contractual percentage; however, the amount paid to the subcontracting health plan cannot be less than a contractually provided minimum dollar amount PMPM. The final payment to the subcontracting health plan for P4P costs will be equal to the contractual percentage less any funds returned to the Participating Entity for failure to meet a performance standard.

Any payments due the Participating Entity, including interest, will be returned to Participating Entity and Participating Entity will return to DHCS the federal share of any federally reimbursed payment to the subcontracting health plan. DHCS will return these funds to CMS on the CMS-64 form within the required timeframe. In the event that the Participating Entity has reimbursed subcontracting health plan for additional Healthcare costs, the Participating Entity will provide additional reimbursement to the subcontracting health plan for Administration and P4P based on the contractually provided percentages and the Participating Entity will certify this expense. DHCS will reimburse the Participating Entity the federal share of this payment.

F. Participating Entities Providing Mental Health Services to LIHP Enrollees

The costs of mental health services whether provided through a carved-out delivery system that is separate from the LIHP, or through the LIHP, will be determined as set forth below.

The costs of inpatient and outpatient mental health services provided to LIHP enrollees by DPH-Based LIHPs at a DPH will be determined in accordance with Attachment F of the STCs and reported on the Workbook.

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The costs of mental health services provided to LIHP enrollees by DPH-Based LIHPs, other than mental health services provided at the DPH, including mental health services provided under a subcontract, will be determined in accordance with Attachment F–Supplement 4, and will be reported in Schedule 5 of the Workbook.

The costs of inpatient and outpatient mental health services provided to LIHP enrollees by Non DPH-Based LIHPs at a hospital operated by the Non DPH-Based LIHPs will be determined in accordance with the cost finding methodology for the Medi-Cal 2552 cost report.

The costs of mental health services provided to LIHP enrollees by Non DPH-Based LIHPs, other than mental health services provided at a hospital operated by the Non DPH-Based LIHP, including mental health services provided under a subcontract, will be determined in accordance with the cost finding methodology in a new supplement to Attachment G.

Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of mental health services provided to LIHP enrollees. Documentation supporting other revenues received for the services furnished, and any other applicable non-patient care revenues to be offset, must be provided upon request. .

G. Participating Entities Providing Substance Use Disorder/Drug Rehabilitation Services to LIHP Enrollees

1. DPH-Based LIHP

If provided as an add-on service pursuant to the LIHP Contract, the costs of outpatient substance abuse and drug rehabilitation services (substance abuse services) provided to LIHP enrollees by DPH-Based LIHPs at a DPH will be determined in accordance with Attachment F of the STCs and reported on the Workbook.

The costs of other substance abuse services provided by Participating Entities to LIHP enrollees will be determined using specific service codes that will capture utilization data for LIHP program participants as captured in the Alcohol and Drug Program Cost Reports required under the California Code of Regulations, Title 9. The cost related to the LIHP program will be based on a ratio of total substance abuse services costs and total utilization, times LIHP program utilization. Utilization data used to apportion cost to the LIHP program will be based on the appropriate apportionment measures for the respective provider types and services. The Participating Entity will be reimbursed for substance abuse services through interim quarterly payments based on the documented substance abuse costs times the calculated ratio to determine program services costs for the specific service period.

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Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of substance abuse services provided to LIHP enrollees. Documentation supporting other revenues received for the services furnished, and any other applicable non-patient care revenues to be offset, must be provided upon request.

For those DPH-Based Participating Entities providing substance abuse services to LIHP enrollees through a subcontract, the Participating Entities will be reimbursed based on their subcontract costs as discussed above. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

2. Non DPH-Based LIHP

a) Participating Entities that provide substance abuse services that are claimed based on invoices for actual cost will determine their costs in accordance with Section I.B of this Supplement.

b) For those Participating Entities providing substance abuse services to LIHP enrollees through a subcontract, the Participating Entities will be reimbursed based on their subcontract costs as discussed above. Services provided through a contract will be limited to those covered in the Entity's LIHP contract.

H. Costs Incurred by Participating Entities for Emergency and Post-Stabilization Services Furnished by Out Of Network Providers to LIHP Enrollees

Participating Entities that operate their LIHP program through a closed provider network are generally not required to pay for services that are provided outside their approved delivery system. Under limited circumstances, however, LIHPs that operate a closed provider network may be required to pay for medically necessary emergency care services and required post-stabilization care for MCE enrollees. Participating Entities are required to pay for out-of-network emergency and post-stabilization services only if the out-of-network provider furnishes timely notice to the LIHP of the patient's emergency room visit and adheres to the LIHP's protocol for approval of post-stabilization services.

The allowable cost for out of network emergency and post-stabilization services provided to MCE enrollees is the amount paid by the Participating Entity to the out-of-network provider. For covered inpatient hospital services furnished in state, the Participating Entity must pay at least 30% of the applicable regional unweighted average of per diem rates paid to Selective Provider Contracting Program contracted hospitals, which rates are published annually by DHCS Medi-

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Cal Managed Care Division in its MMCD All Plan Letters to All Medi-Cal Managed Care Health Plans (for example, MMCD All Plan Letters 11-016 and 11-017). For covered inpatient hospital services furnished out of state, the Participating Entity must pay at least 30% of the statewide per diem average of contract rates as of December 1 of the prior calendar year for acute inpatient hospital services provided by California hospitals with at least 300 beds, or 30% of the hospital's actual billed charges, whichever is less. For mental health services provided by out-of-network providers, the Participating Entity may pay 30 percent of the average rate that is paid by the mental health plan in the county of the LIHP enrollee's residence. For covered services other than mental health services, the Participating Entity must pay the out-of-network provider at least 30% of the applicable regulatory fee-for-service rate (excluding any supplemental payments).

DPH-Based LIHPs will report the costs of emergency and post-stabilization services furnished by out of network providers on Schedule 4 of the Workbook.

Non DPH-Based LIHPs will be reimbursed based on quarterly invoices for the cost of emergency and post-stabilization services furnished by out of network providers and supporting documentation.

I. Costs Incurred for Providing Services to LIHP (MCE) Enrollees Determined Eligible by DHCS and Who are Only Eligible While Admitted as Hospital Inpatients

FFP is available for the health care services provided for specific LIHP enrollees under the MCE component of the program who are eligible only while they are admitted as an inpatient in a medical institution, pursuant to Medicaid policy and regulations. [1] A Participating Entity may report State expenditures for inpatient hospital services provided to specific LIHP enrollees whose eligibility is determined by DHCS and who are enrolled in the Participating Entity's LIHP.

DHCS will determine eligibility based on the following: (a) whether the individual's county of last legal residence operates or participates in a LIHP, (b) whether the individual meets the income standards of the MCE component of the Participating Entity's LIHP; and (c) whether the individual meets all other eligibility criteria for enrollment in the Participating Entity's LIHP.

Expenditures for costs incurred from providing inpatient hospital services by the state agency that is responsible for providing medical services to the individual will be reported to the

[1] Sections I and J of this Protocol provide additional detail regarding claiming for services rendered to inmates who receive care in a medical institution, as outlined in DHCS's letter to Gloria Nagle, Associate Regional Administrator for CMS Region IX, dated February 24, 2011, at pages 4-6.

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Participating Entity and fully documented by that agency. The responsible state agency determines when medical care is needed, contracts with the hospitals for services for the individuals, and arranges for payment using funds allocated from the state agency. For each LIHP enrollee the state agency will send a quarterly invoice to the Participating Entity indicating the amount expended by the state agency for allowable inpatient hospital services. The state agency will certify that the information on these invoices is true and accurate and that the expenditure is eligible for FFP, and will transmit the certification to the Participating Entity.

Upon receipt of the invoices and certifications, the Participating Entity may submit the expenditures certified by state agency as part of the Participating Entity's claim to DHCS. The Participating Entity will separately identify those expenditures as being the expenditures of the state agency. In addition to the certifications received from the state agency, the Participating Entity will submit a statement signed by the Participating Entity's designated representative that the Participating Entity's claim is based on the expenditures submitted and certified by the state agency. The state agency shall provide sufficient information to allow the Participating Entity to comply with the requirements of 42 C.F.R. §§ 438.604 and 438.606. DHCS will submit the claim for FFP based on the expenditures reported by the Participating Entity for services provided to these LIHP enrollees. DHCS will pay the FFP to the contributing state entity directly.

DPHs that provide inpatient hospital services to the subject individuals may report in their Workbooks the costs of providing those services and any additional allowable expenditures for services that are provided to the enrollees during the time in which the enrollee is an inpatient in the DPH including physician, laboratory, pharmacy and other services, but only to the extent that such costs exceed the amount paid to the DPH by the contributing state entity for that service.

DPHs will make appropriate adjustments to expenditures reported in their Workbooks to ensure that there is no duplicate claim for FFP. DPHs will not report expenditures for services provided to the subject individuals that are not allowable for claiming.

J. Costs Incurred for LIHP (MCE) Enrollees Determined Eligible by the Participating Entity and Who are Only Eligible While Admitted as Hospital Inpatients

FFP is available for health care services provided for specific individuals enrolled in the LIHP under the MCE component who are eligible only while they are admitted as an inpatient in a medical institution, pursuant to Medicaid policy and regulations. [1]A Participating Entity (or the DPH with which it is affiliated) may submit the cost of inpatient hospital services provided to these individuals if they are determined eligible by the Participating Entity and enrolled in the Participating Entity's LIHP. The Participating Entity (or the DPH with which it is affiliated) may also report any additional expenditure allowable for claiming that are provided to these

enrollees during the time in which these individuals are inpatients in the acute care hospital, including physician, laboratory, pharmacy and other services. The Participating Entity shall submit these in accordance with the applicable provisions of this Attachment G, Supplement 1. The Participating Entity will determine whether the individual meets the county residency requirements and whether the individual is eligible for enrollment in the LIHP under the MCE component of the program. If the individual is determined to be eligible, the Participating Entity will enroll the individual for the limited purpose of reporting allowable expenditures for services provided while the individual is admitted as an inpatient in an acute care hospital. The Participating Entity will not report expenditures for services provided to the individual that are not allowable for claiming.

K. Total Funds Expenditures of other Governmental Entities

Participating Entities may report the total funds expenditures incurred by other governmental entities, including a governmental entity with which a LIHP is affiliated, or any other eligible public entity that voluntarily incurs expenditures, in providing services under the LIHP to MCE and HCCI enrollees for which the Participating Entity is responsible. The other governmental entity will submit a report of its total funds expenditure and the services provided under the LIHP, to the Participating Entity, along with an attestation signed by the entity's designated representative certifying that such costs are allowable and meet all federal requirements. The other governmental entity will report costs in a manner and format consistent with Attachment F and this Attachment as utilized by DPHs. The Participating Entity will submit a claim to DHCS that is accompanied by an attestation signed by the Participating Entity's designated representative that it has reviewed such costs, that to the best of its knowledge such costs are allowable and meet all federal requirements, and that the Participating Entity is relying on the other governmental entity's attestation.

IV. Interim Review and Reconciliation Process

The purpose of an interim review and reconciliation process is for DHCS to review LIHP program costs and payments for services provided to LIHP enrollees that may be claimed through the CPE process, to review the Participating Entity's expenditures to ensure that reported costs are accurate and allowable, and to reconcile the Participating Entity's expenditures under the HCCI to the Participating Entity's HCCI allocation. This interim computation of payments claimed as CPEs will be performed in a manner consistent with the instructions below. Costs that are claimed will be in a manner and form consistent with the contract terms and conditions, and be accompanied by an attestation signed by the Participating Entity's designated representative that the costs being claimed are allowable and meet all federal requirements.

Participating Entities must maintain and provide DHCS with documentation sufficient to support the cost of services provided to LIHP enrollees. Revenue offsets to account for other revenues

received for services furnished, and any other applicable non-patient care revenues that were not previously offset or accounted for, must be provided to DHCS. (*e.g.,* revenue paid by or on the behalf of the patient).

A. DPH-Based LIHPs

DPH-Based LIHPs and DHCS will reconcile the interim costs for LIHP enrollees based on each DPH's filed Medi-Cal 2552-96 cost report for the spending year in which interim payments were made. DHCS will adjust, as necessary, the total interim payments based on the total costs under the interim reconciliations. If, at the end of the interim reconciliation process, DHCS determines that the Participating Entity received an overpayment, DHCS will recover the overpayment from the Participating Entity and report the appropriate credit to CMS through the quarterly federal reporting process.

B. Non DPH-Based LIHPs

At the end of each LIHP program quarter, for those Participating Entities that have provided services to LIHP enrollees, DHCS will review the Participating Entity's quarterly utilization, expenditures, and other information submitted by the Participating Entity to ensure proper claiming, and reconcile the HCCI expenditures with the interim quarterly payment and the Participating Entity's allocation under the HCCI. Upon completion of the interim quarterly review and reconciliation, DHCS will adjust the interim quarterly payment accordingly.

After the end of each LIHP program year, for those Participating Entities that have provided services to LIHP enrollees, DHCS will review the Participating Entity's final expenditure data, and reconcile the expenditure data with the quarterly interim payments made to the Participating Entity. For Non-DPH Based LIHPs, an interim reconciliation will only be necessary for those services not provided through a subcontract but that were provided through the Participating Entity's own hospital or other facility

V. Final Reconciliation and Settlement, and Payment/Recovery, for the Expenditure Year

The purpose of a final reconciliation and settlement and payment/recovery is to finalize the LIHP program costs and payments for services provided to LIHP enrollees that may be claimed through the CPE process. DHCS will perform the final computation of payments claimed as CPEs in a manner consistent with the instructions below. Costs that are claimed must be in a manner and form consistent with the terms and conditions of the LIHP Contract and LIHP-MH Contract (if mental health services are provided through a carved-out delivery system that is separate from the LIHP) and must be accompanied by a certification signed by the Participating Entity's designated representative that the costs being claimed are allowable and meet all federal

requirements. For Non-DPH Based LIHPs, a final reconciliation will only be necessary for those services not provided through a subcontract but that were provided through the Participating Entity's own hospital or other facility.

Participating Entities must maintain and, upon request, provide DHCS with documentation sufficient to support the cost of services provided to LIHP enrollees, revenue offsets to account for other revenues received for services furnished, and any other applicable non-patient care revenues that were not previously offset or accounted for.

DHCS will perform the final reconciliation after the claiming period using the final cost determinations for the services provided, and other information submitted by the Participating Entity. For those Participating Entities providing services to LIHP enrollees at a hospital (including a DPH) operated by the Participating Entity, DHCS will perform a final reconciliation and settlement, and payment/recovery, after the claiming period using the hospital's Medi-Cal 2552-96 cost report for that same spending year as finalized by A&I for the purposes of Medicaid reimbursement.

DHCS will reconcile the Participating Entity's interim quarterly payments for services provided to MCE and HCCI enrollees to the final determination of the Participating Entity's costs for such services. If, at the end of the final reconciliation process, DHCS determines that the Participating Entity has been underpaid for services provided to LIHP enrollees, DHCS will claim for reimbursement of the additional amount due to the Participating Entity. If, at the end of the final reconciliation process, DHCS determines that the Participating Entity received an overpayment, DHCS will recover the overpayment from the Participating Entity and will return the overpayment to CMS on the CMS-64 form within the required timeframe.

VI. Impact of Safety Net Care Pool (SNCP) and Uncompensated Care Cost Computations

The costs of services provided to LIHP enrollees that are not covered by LIHP may be considered uncompensated care costs. Costs for hospital services may be eligible for reimbursement as disproportionate share hospital (DSH) payments and Safety Net Care Pool (SNCP) payments. (Note however that certain hospital costs are only allowed for SNCP and not allowed for DSH purposes, in accordance with Attachment D; therefore, any uninsured costs to be claimed for DSH payments must be adjusted accordingly to arrive at DSH eligible costs only.) The non-hospital costs may be eligible for reimbursement through SNCP payments.

In the event that a Participating Entity's costs of providing HCCI program services to HCCI enrollees exceed the amount of the Participating Entity's allocation for its HCCI program, those costs may be considered uncompensated care costs. Costs for hospital services may be eligible

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for reimbursement as DSH payments and SNCP payments. (Note however that certain hospital costs are only allowed for SNCP and not allowed for DSH purposes, in accordance with Attachment D; therefore, any uninsured costs to be claimed for DSH payments must be adjusted accordingly to arrive at DSH eligible costs only.) The non-hospital costs may be eligible for reimbursement through SNCP payments for uncompensated care costs. Total HCCI program costs will be reduced by the total HCCI claim allocable to the appropriate services setting and the net uncompensated care costs will be included, as appropriate, in the DSH and the SNCP payment calculations.

With respect to a Participating Entity that is a county, is not a DPH-Based LIHP, and which is affiliated with a DPH that is operated by a hospital authority (Alameda County), if the Participating Entity's costs of providing HCCI program services to HCCI enrollees exceed the amount of the Participating Entity's allocation for its HCCI program, the costs in excess of the allocation may be considered uncompensated care costs and may be reported in the Workbook for the DPH that is operated by the hospital authority affiliated with the county (Alameda County Medical Center) as eligible SNCP CPEs incurred by a governmental entity affiliated with the DPH.

Local Low Income Health Program: Participating Entity Claiming Protocol

CONTRACTOR NAME

Purpose: STC 43(a)(iii) requires the State of California to submit individual funding and claiming protocols to the Centers for Medicare and Medicaid Services (CMS) with respect to each county participating in the LIHP program. The purpose of this document is to fulfill the requirement set forth is Paragraph 43 (a)(iii) of the Special Terms and Conditions (STCs) of California's Section 1115(a) Bridge to Reform Demonstration (Demonstration) and describe how the LIHP will receive payment and how federal reimbursement will be claimed under the program. All claiming should be consistent with Attachments G and J, as authorized under the STCs of the Demonstration.

1. PROGRAM DESCRIPTION

The LIHP is a:

☐ Designated Public Hospital-Based LIHP (DPH-Based LIHP)

☐ Non-Designated Public Hospital-Based LIHP (Non DPH-Based LIHP)

The LIHP will claim payment for the covered services rendered to enrollees in accordance with the STCs of the Demonstration and the following claiming protocols:

- Attachment G,
- Supplement 1 to Attachment G: Cost Claiming Protocol for Health Care Services Provided Under the Low Income Health Program – Claims Based on Certified Public Expenditures, and/or

☐ The LIHP will claim payment for administrative activities under Attachment J of the STCs of the Demonstration.

2. ELIGIBILITY: POPULATION SERVED

The LIHP will cover the following population(s) indicated below (the MCE population will be claimed separately from the HCCI population):

MCE: ☐ Existing MCE ☐ New MCE

HCCI: ☐ Existing HCCI ☐ New HCCI

3. BASIS FOR CLAIMING

The LIHP will use the identified claiming protocols for claiming payment for the services rendered (Check all

that apply):

LIHP Services	Attachment G Protocol for Claiming Supplement 1 = Cost Basis (CPEs)

a. Health Care Services

☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

b. Substance Abuse Services

☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

Limited Service Populations-enrollees determined eligible by DHCS and who are only eligible while admitted as hospital inpatients.

☐ MCE ☐ Supp 1

Limited Service Populations-enrollees determined eligible by the participating entity and who are only eligible while admitted as hospital inpatients.

☐ MCE ☐ Supp 1

HIV/AIDS/Ryan White - Services provided to enrollees who meet the requirement in the definition of eligible individuals in Part B of the Ryan White Care Act, section 2616 (b)(1) of the Public Health Service Act (42 U.S.C. 300ff-26(b)(1).

☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

Out-of-Network Emergency and Post-Stabilization Services

☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

Other Excluded Services (if applicable)

_____ ☐ Supp 1
Description of Other Service

Mental Health Services

a. ☐ LIHP mental health services are provided through a carved out delivery system that is separate from the LIHP.

☐ MCE ☐ Supp 1

☐ HCCI ☐ Supp 1

OR

b. ☐ LIHP mental health services are provided through the LIHP.
☐ MCE ☐ Supp 1
☐ HCCI ☐ Supp 1

4. SOURCES OF LOCAL NON-FEDERAL SHARE
(Check all that apply.)

a. ☐ The LIHP will use public county funds, including county general funds, patient care revenue, and other provider revenue as the non-federal share.

b. ☐ As authorized by Paragraph 63.g. of the STCs, out-of-network emergency and post-stabilization services will be funded in part with provider fee revenues that comply with § 1903(w) of the Social Security Act. (See § 14169.7.5 of the Welfare & Institutions Code).

c. ☐ Other public entities will provide part of the non-federal share. Please include the name of each public entity that will provide part of the non-federal share and describe the LIHP's arrangement with the other public entity, as requested below. If you need additional space to describe the contributions of other public entities, please attach supplemental pages to the end of this protocol.

(1). Name of Other Public Entity: (Insert Name)

The Other Public Entity will provide the non-federal share, based on:

☐ CPEs

☐ IGTs

Describe the nature of the arrangement through which the other public entity will contribute the non-federal share and receive payment. The other public entity must certify that the non-federal share is from permissible sources as identified in Paragraph 39 of the STCs.

(Insert Description)

(2). Name of Other Public Entity: (Insert Name)

The Other Public Entity will provide the non-federal share, based on:

☐ CPEs

☐ IGTs

Describe the nature of the arrangement through which the other public entity will contribute the non-federal share and receive payment. The other public entity must certify that the non-federal share is from permissible sources as identified in Paragraph 39 of the STCs.

(Insert Description)

***This Participating Entity Claiming Protocol will be amended to allow for claiming under Attachment G – Supplement 2 upon CMS approval of that protocol.**