DHCS
TOBY DOUGLAS
DIRECTOR

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

EDMUND G. BROWN JR.
GOVERNOR

November 7, 2013

Mr. Robert Nelb
Project Officer
Division of State Demonstrations and Waivers
Center for Medicaid and CHIP Services, CMS
7500 Security Boulevard, Mail Stop S2-02-26
Baltimore, MD 21244-1850

Ms. Angela Garner
Deputy Director
Division of State Demonstrations and Waivers
Center for Medicaid and CHIP Services, CMS
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Lane Terwilliger, Esq.
Technical Director
Center for Medicaid, CHIP, and Survey and Certification, CMS
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Ms. Gloria Nagle, PhD, M.P.A
Associate Regional Administrator
Division of Medicaid & Children's Health Operations
Centers for Medicare and Medicaid Services, Region IX
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RE: California Bridge to Reform Demonstration (No. 11-W-00193/9) Amendment Tribal Health Programs Uncompensated Care / California Rural Indian Health Board (CRIHB) Facility Payment Demonstration

Dear Mr. Nelb, Ms. Garner, Ms. Terwilliger, and Ms. Nagle:

The State of California proposes to amend the Special Terms and Conditions (STC) and Expenditure Authority of Waiver 11-W-00193/9, California Section 1115 "Bridge to Reform" Demonstration, pursuant to STC paragraph 7. The proposed amendment

would permit the Department of Health Care Services (DHCS) to make uncompensated care payments for optional services eliminated from the state plan provided by Indian Health Service (IHS) tribal health programs operating under the authority of Indian Self-Determination and Education Assistance Act (ISDEAA) to HIS-eligible Medi-Cal beneficiaries. This proposal is similar to a section 1115 amendment approved by the Centers for Medicare and Medicaid Services (CMS) in California in April 2013.

The State is requesting that this waiver amendment have an effective date of January 1, 2014, and an end date of December 31, 2014. The State is prepared to work diligently to respond to any questions or provide any information CMS may need in order to secure prompt approval of this amendment.

Background

The CRIHB is a tribal organization contracting under Indian Self-Determination and Education Assistance Act (ISDEAA) that provides medical assistance as a facility of the IHS through a subcontracting process with seven tribal health programs. Additionally the CRIHB serves as the central administrator for the Tribal Medicaid Administrative Activities (MAA) program through contracts with 17 Tribal Health Programs operating in California.

CRIHB subcontracts with most of the state's 33 tribal health programs in the Contract Health Service Delivery Area (CHSDA). These tribal health programs would be eligible to participate in the proposed facility payment demonstration project's provider network. The proposed demonstration would provide uncompensated care payments using the IHS encounter rate for Medi-Cal state plan primary care services and other optional services eliminated from the state plan.

For individuals enrolled in the Medi-Cal program, the proposed demonstration would only provide uncompensated care payments using the IHS encounter rate for optional services eliminated from the state plan.

IHS eligible individuals receiving care at these facilities would continue to receive acute care hospital and specialty care services as they do now through the IHS health service referral system. Services will continue to be provided in these tribal facilities to non-IHS beneficiaries according to the eligibility policy currently in place as established and authorized by Indian Health Care Improvement Act (IHCIA) by the individual tribal health program and as approved by the IHS.

Financing

Reimbursement for services provided to IHS eligible individuals will be provided at 100% federal matching assistance percentage.

For all services provided under the demonstration, the CRIHB would utilize a claiming protocol that would be administered by the CRIHB through a third party administrator arrangement that the CRIHB has with the tribal providers in the network. The CRIHB

network providers would submit certified claims through an encounter-based claiming protocol, which in turn will be rolled up and submitted to the state. The state would reimburse the CRIHB for the claims. Reimbursement would then be remitted to the CRIHB providers.

The CRIHB would be permitted to bill network providers a third party administration fee pursuant to a contract with CRIHB. The CRIHB would be eligible to receive reimbursement for administrative costs through the use of a CPE methodology. Claiming protocols will be developed during the forthcoming consultation process with CMS.

Preliminary Cost Estimates for Proposal

Number of potential eligible beneficiaries:[1]		3129	x
IHS Global Encounter Rate for primary care services:[2]		$330.00	x
Average number of encounters per individual per year:[3]		3.0	
	=	$3,097,696	

Budget Neutrality

The total computable costs for the waiver amendment will be accounted for on the total computable "with waiver" side of budget neutrality. The projected cost of approximately $3 million would be equally distributed between demonstration years 9 and 10.

Waiver Authority

We believe the existing waivers for freedom of choice, statewideness, and comparability can encompass the proposed amendment. To the extent necessary, we ask that our authority to operate under these waivers extend to amendments contained in this request.

Special Terms and Conditions and Expenditure Authority

The proposed waiver amendment will impact the existing expenditure authority. Applicable changes to the Waiver Special Terms and Conditions and the Expenditure Authority document will be developed during the consultative period of the amendment.

Public Notice and Tribal Notice

- As required by STC Paragraph 14, DHCS released tribal notification of the proposal to amend the Section 1115 Waiver, on October 4, 2013.
- The amendment proposal to extend the program for the specified population was also presented at a DHCS Teleconference on October 22.

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[1]Census Bureau American Community Survey 2011. Analysis ran by "IHS eligible" by "no other coverage"

[2] 77 Federal Register No. 109, 33470 June 6, 2012, reimbursement Rate for Calendar year 2012

[3] List source Characteristics of the Medi-Cal Population Likely to Be Impacted by State Plan Amendment (SPA) Number 11-013 to Limit Beneficiaries to no more than Seven Physician Visits per Year, July 2012, *California California Research and Analytical Studies Branch.*

Questions and comments received regarding the proposed demonstration, along with DHCS responses, are posted on the DHCS Indian Health Program's website at: http://www.dhcs.ca.gov/services/rural/pages/tribal_notifications.aspx.

Thank you for your assistance and consideration. We are happy to assist you and your staff in any way as you review the proposed amendment. If you have any questions, please contact Danielle Stumpf, at (916) 440-7400.

Sincerely,

Toby Douglas
Director

Enclosures:

- Update to Attachment F Supplement 7
- Proposed STCs

Cc:

Mari Cantwell
Chief Deputy Director
Health Care Programs
Marianne.Cantwell@dhcs.ca.gov

Jennifer Brooks
Safety Net Financing Division
Jennifer.Brooks@dhcs.ca.gov

Hannah Walter
Safety Net Financing Division
Hannah.Walter@dhcs.ca.gov

Danielle Stumpf
Director's Office
Danielle.Stumpf@dhcs.ca.gov

Special Terms and Conditions (Proposed changes to the STCs)
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:

- Expand the number of Californians who have health care coverage;
- Strengthen and build upon the local health care safety net system, including disproportionate share hospitals, and county and community clinics;
- Improve access to high quality health care and health outcomes for individuals; and.
- 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.
On January 10, 2012 the State submitted an amendment to the Demonstration which was approved on March 31, 2012, to provide an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Medi-Cal beneficiaries enrolled in a managed care organization. The demonstration amendment will research and test whether individuals enrolled in CBAS who have an organic, acquired, or traumatic brain injury and/or chronic mental illness, maintain or improve the status of their health. Some beneficiaries who previously received adult day health care (ADHC) services (which will no longer be offered as an optional benefit under the State Plan) and, because a difference in the level of care criteria, will not qualify for CBAS services will instead receive a more limited "Enhanced Case Management" (ECM) benefit. ECM is a service that provides person centered planning including coordination of medical, social, and education supports.
Effective with the June 28, 2012 approval the State and CMS revised the demonstration to include the following amendments:

- *A Reallocation of Funds to Safety Net Uncompensated Care Pool* - On July 22, 2011 the State submitted an amendment to the Demonstration to increase authorized funding for the Safety Net Care Uncompensated Care Pool for Demonstration Year in DY 7 by the amount of authorized but unspent funding for the Health Care Coverage Initiative (HCCI) and Designated State Health Programs (DSHP) in DY 6.
- *A Reallocation of Funds to Safety Net Uncompensated Care Pool* - On May 2, 2012 the State submitted an amendment to the Demonstration to reallocate authorized funding for the Health Care Coverage Initiative (HCCI) to the Safety Net Care Uncompensated Care Pool for Demonstration Year (DY) 7;
- *HIV Transition Program in the Delivery System Reform Incentive Pool (DSRIP)* – On September 12, 2011, the State submitted a concept paper and on June 22, 2012, the State submitted a formal amendment to establish an HIV Transition Incentive Program within the Delivery System Reform Incentive Pool (DSRIP) under the Demonstration to establish "Category 5" HIV Transition projects to develop programs of activity that support efforts to provide continuity of quality care, care coordination, and coverage transition for LIHP enrollees with HIV; and
- Revisions to the budget neutrality agreement to correct errors in Demonstration expenditures.

In addition, on October 30, 2012, the state submitted an amendment request approved on December 31, 2012 to transition the Healthy Families Program beneficiaries to the Medi-Cal program beginning on January 1, 2013. Children enrolled in the HFP will be transitioned into the Medi-Cal's Optional Targeted Low-Income Children's (OTLIC) Program), where they will continue to receive health, dental, and vision benefits. The OTLIC Program covers children with family incomes up to and including 250 percent of the federal poverty level.

On March 1, 2013 the state submitted a request to amend the demonstration to provide that the Department of Health Care Services (DHCS) shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to recognize the burden of uncompensated care costs and support the overall IHS and tribal health care delivery system. Payments will be based on the costs of qualifying uncompensated encounters, using the published Indian Health Service (IHS) encounter rate to determine cost. Qualifying uncompensated encounters will be primary care encounters furnished to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a California County Low Income Health Program (LIHP) and uncompensated costs of furnishing services that had been covered under Medi-Cal as of January 1, 2009 to such uninsured individuals and to Medi-Cal beneficiaries. The purpose of the demonstration would be to determine if these supplemental payments maintain or increase the availability of primary care services for Medicaid beneficiaries in 2014.

On April 29, 2013 the State submitted an amendment to the Demonstration to increase authorized funding for the Safety Net Care Uncompensated Care Pool for DY 8 and DY 9 by the amount of authorized but unspent funding for the Health Care Coverage Initiative (HCCI) in DY 8 and DY 9 respectively. If the available SNCP Uncompensated Care expenditures in DY 8 or DY9 are not sufficient to fully claim the reallocated funds, those funds will be made available for claiming in later demonstration years notwithstanding the total computable annual limits specified in STC **Error! Reference source not found.**.

On May 3, 2013 the state submitted a request to amend the demonstration pursuant to Assembly Bill 1467 (Chapter 23, Statutes 2012). The 2012-13 State budget authorized the expansion of Medi-Cal managed care to Medi-Cal beneficiaries residing in 28 California counties (hereafter referred to as the "2013 managed care expansion"). No earlier than September 1, 2013, approximately 102,000 Medi-Cal beneficiaries will transition from FFS to the COHS model of Medi-Cal managed care in 8 counties, and no earlier than November 1, 2013, approximately 176,000 Medi-Cal beneficiaries will transition from FFS to a non-COHS model of Medi-Cal managed care in the remaining 20 counties (subject to CMS approval of the applicable managed care contracts and the state's compliance with these special terms and conditions). Seniors and persons with disabilities in non-COHS counties will not be required to enroll in managed care, but they will have the option to enroll in managed care on an "opt-in" basis.

On November 7, 2013 the state submitted an amendment to the demonstration to extend through December 31, 2014, the supplemental payments to IHS and 638 facilities for uncompensated costs for optional Medi-Cal services, provided to IHS eligible Medi-Cal beneficiaries that were eliminated from Medi-Cal as of January 1, 2009.

III. GENERAL PROGRAM REQUIREMENTS

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.

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.

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.

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.

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.

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,

39. Safety Net Care Pool Expenditure.

b. SNCP Uncompensated Care. Expenditures may be made through the SNCP for uncompensated care provided to uninsured 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 **Error! Reference source not found.** "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 through 10. No FFP is allowed until the year 6-10 DSHP claiming protocol is approved by CMS.

iii. *Supplemental Payments to IHS and 638 Facilities.* The state shall make supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care and support the IHS and tribal 638 service delivery network. Supplemental payments shall be computed based on the uncompensated cost of primary care services furnished by such facilities to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low Income Health Program (LIHP) and uncompensated costs for services that were eliminated from Medi-Cal coverage in July 2009 pursuant to state plan amendment 09-001, furnished by such facilities to such uninsured individuals and individuals enrolled in the Medi-cal program.

Supplemental payments for uninsured individuals will end effective December 31, 2013. Supplemental payments will be made to IHS and 638 facilities for uncompensated care payments for optional Medi-Cal services eliminated from the state plan, using the IHS encounter rate through December 31, 2014. The supplemental payments will be for services provided to IHS eligible individuals enrolled in the Medi-Cal program. Participating tribal facilities shall maintain policies for furnishing services to non-IHS beneficiaries that are in place as of January 1, 2013. Payments shall be based on the approved methodology set forth in Attachment F – Supplement 7.

iv. *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

Notwithstanding the total computable annual limits specified above, reallocated funds in the amount of $176 million and $146 million, from the HCCI component from DY6 and DY7 of those years, respectively, will be added to the total computable annual limit listed above for DY7. If the available SNCP Uncompensated Care expenditures in DY7 are not sufficient to fully claim the reallocated funds, those funds will be made available for claiming in later demonstration years, notwithstanding the total computable annual limits specified above.

Notwithstanding the total computable annual limits specified above, reallocated funds in the amount of $97 million and $26 million, from the HCCI component from DY8 and DY9 of those years, respectively, will be added to the total computable annual limit listed above for DY8 and DY9, respectively. If the available SNCP Uncompensated Care expenditures in DY8 or DY9 are not sufficient to fully claim the reallocated funds, those funds will be made available for SNCP Uncompensated Care expenditures in later demonstration years notwithstanding the total computable annual limits specified above.

The annual limit the State may claim FFP for DSHP is limited to the programs listed below and shall not exceed $400,000,000 FFP per year for a 5 year total of $2,000,000,000 FFP.

The annual limit for the IHS uncompensated care cost shall be $15,461,000 TC per year (DYs 8 and 9) for a 2 year total of $30,922,000 TC.

The annual limit for the extension of the IHS uncompensated care cost claiming for the period January 1, 2014 through December 31, 2014 shall be $1,550,000 TC in each DY 9 and DY 10 for a 1 year total of $3,100,000 TC.

Attachment F – Supplement 7

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

The methodology outlined below has been approved for structuring supplemental payments to IHS and 638 facilities from the date of CMS approval of the amendment to this demonstration submitted by the state on ~~March 1~~ April 5, 2013 through December 31, ~~2013~~ 2014 as required by STC 38.b.iii. Using the methodology described below the state shall make supplemental payments to Indian Health Service (IHS) and tribal facilities to account for the uncompensated costs of furnishing primary care services to uninsured individuals with incomes up to 133 percent of the Federal Poverty Level (FPL) who are not enrolled in a Low Income Health Program (LIHP) and the uncompensated costs of furnishing services that were eliminated from the state plan pursuant to state plan amendment 09-001to individuals enrolled in the Medi-~~cal~~ Cal program and uninsured individuals with incomes up to 133 percent of the FPL who are not enrolled in a LIHP. As of December 31, 2013, uncompensated costs for services provided to uninsured individuals will no longer be claimable. Beginning January 1, 2014 through December 31, 2014 only eliminated Medi-Cal optional services for IHS eligible Medi-Cal beneficiaries will be reimbursed to IHS and tribal 638 facilities.

Beginning January 1, 2014, IHS and 638 facilities may claim for services provided to IHS eligible Medi-Cal beneficiaries that were originally eliminated in SPA 09-001, and which are not covered by Medi-Cal.

Provider Claiming Methodology

A. Claiming for April 5, 2013 through December 31, 2013

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters by utilizing a tracking document or other electronic means to record the following:
    a. The service provided;
    b. Whether the service was provided to an IHS eligible individual;
    c. Whether the service was provided to an uninsured individual;
    d. Whether the service was provided to a Medi-Cal beneficiary; and
    e. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating facilities shall have procedures to determine if individuals are Medi-Cal eligible or uninsured, and if uninsured to determine their income level (which could include a protocol based on self-attestation) and whether they are enrolled in LIHP.
5. Participating IHS and tribal 638 facilities shall maintain existing policies for pursuing third party liability, and shall have procedures to ensure that individuals who have a source of third party liability are not considered uninsured.
6. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying uncompensated encounters, broken down by type of qualifying uncompensated service (primary care or formerly optional Medi-Cal), type

of individual (uninsured or Medi-Cal individual) and status of individual as IHS-eligible (Indian or Alaskan Native).

7. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third party payments received for Medi-Cal beneficiaries for qualifying uncompensated care. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
8. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a Quarterly Summary Aggregate Encounter Report (Exhibit 1) specifying the number of qualifying uncompensated encounters for each IHS/Tribal 638 facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated encounters.
9. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

B. Claiming for January 1, 2014 through December 31, 2014

1. Participating IHS and tribal 638 facilities shall enter into a billing agent agreement with the California Rural Indian Health Board (CRIHB) consistent with the requirements of 42 C.F.R. 447.10.
2. Participating facilities shall track qualifying uncompensated encounters for optional services eliminated from the state plan by utilizing a tracking document or other electronic means to record the following:
    a. The qualifying optional Medi-Cal service provided;
    b. Whether the service was provided to an IHS eligible individual;
    c. The service date.
3. Qualifying encounters shall not include encounters for which any payment was made under Medi-Cal at the IHS published rate.
4. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the number of qualifying Medi-Cal optional service encounters and status of individual as IHS-eligible (Indian or Alaskan Native).
5. Participating IHS and tribal 638 facilities shall submit to CRIHB, on a quarterly basis, the amount of third party payments received for Medi-Cal beneficiaries for qualifying uncompensated care of the eliminated optional Medi-Cal benefits. Third party payments received after the end of the quarter shall be reported as a prior period adjustment.
6. CRIHB will process the reports from participating IHS and tribal facilities and submit to DHCS, within 60 working days after the end of each quarter, a Quarterly Summary

Aggregate Encounter Report (Exhibit 1.B) specifying the number of qualifying uncompensated optional service encounters for each IHS/Tribal 638 facility, broken down as reported by each facility. The submission will also include a summary page totaling the aggregate qualifying uncompensated optional service encounters as well as the aggregate supplemental payments due based on the applicable IHS encounter rate offset by any third party payments received by each facility for the qualifying uncompensated optional service encounters.

7. In support of the Quarterly Aggregate Encounter Rate, CRIHB shall submit a certification, signed by the Executive Director of CRIHB that the information contained therein is current, complete, and accurate.

State Payment Process

1. The state shall make supplemental payments to each participating facility through CRIHB within 30 days of receipt of each quarterly report, based on the reported uncompensated care costs as calculated by multiplying qualifying uncompensated encounters by the appropriate IHS published rate, offset by any third party payments received by each IHS/Tribal 638 facility for uncompensated encounters involving Medi-Cal beneficiaries, including third party payments reported as a prior period adjustment. If third party payments are reported as a prior period adjustment after the supplemental payment period, the state will offset other Medi-Cal payments to the facility by the amount of such payments.
2. The state shall terminate supplemental payments if the cap for the SNCP is met.
3. The CRIHB must maintain, and upon request provide DHCS, documentation sufficient to support the claims for supplemental payments.
4. CRIHB will disburse the supplemental payments received from the state to each IHS facility in accordance with its agreement with each facility, but no later than 20 business days after receipt from the state.
5. The State may claim federal matching funding for supplemental payments to IHS and tribal 638 at the 100 percent FMAP rate only to the extent that the supplemental payments reflect uncompensated care furnished to IHS eligible individuals.

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

Exhibit 1: Aggregate Encounter Report

A. Claiming for April 5, 2013 through December 31, 2013

Facility Name	IHS Eligible Individuals	
	Uninsured: non-LIHP/non-Medi-Cal	Medi-Cal beneficiaries
Total Number of Encounters		
	X	**x**
IHS Encounter rate		
Total Expenditures		
Less: Any other payments received		
Total Net Expenditures		

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool IHS and 638 Facilities Uncompensated Care Payment Methodology

B. Claiming for January 1, 2014 through December 31, 2014

Facility Name	IHS Eligible Medi-Cal beneficiaries
Total Number of Encounters	
	x
IHS Encounter rate	
Total Expenditures	
Less: Any other payments received	
Total Net Expenditures	