

## Low Income Health Program (LIHP) Frequently Asked Questions (FAQs) - Additional April 25, 2011

Topic	No.	Question	Answer
Behavioral Health Services	1	What are behavioral health services?	Behavioral health services include mental health and substance abuse services.
Benefits	2	What benefits do the existing and new enrollees receive prior to the implementation of LIHP by the current ten counties?	The existing enrollees and those enrolled between November 1, 2010 and the implementation date of the new LIHP, may continue to receive the benefits provided under the Medi-Cal Hospital/Uninsured Care section 1115 Demonstration until the county implements the LIHP no later than July 1, 2011. Also the counties with existing Health Care Coverage Initiative (HCCI) enrollees may begin transition to the new minimum core benefits allowed under the California Bridge to Reform Demonstration (BTR Demonstration) pursuant to paragraphs 63-65 of the Special Terms and Conditions (STCs). If a current county's transition to the BTR Demonstration, prior to implementation of their LIHP contract, includes benefits not provided under the previous HCCI contract, these new benefits should be reflected in their HCCI contract amendment.
Benefits	3	To what extent are dental and vision services included as required minimum core benefits for a LIHP?	Dental and vision services are included to the extent allowed under emergency care, acute inpatient hospital, outpatient hospital, and/or physician service categories. The services are also subject to limitations contained in Medi-Cal, the California Medicaid State Plan, Section 1905(a) of the Social Security Act, applicable state statutes, regulations, and LIHP utilization controls.
Benefits	4	Are there any limits to what health care services can be added above the minimum core set of services and minimum evidence-based benefits package for mental health services?	Additional services must be approved by CMS and should be allowable under Section 1905(a) of the Social Security Act.

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Topic	No.	Question	Answer
Capitation Rates	5	How will reimbursement work for capitated rates? Is there a minimum and a maximum rate that must be paid (both prior to and after July 1, 2011)? Is it the prospective payment system (PPS) rate? Is the rate for all services including mental health services? Will the rates need to be approved by an actuary prior to implementation of the rate?	Reimbursement is on a quarterly basis after capitated rates and the cost claiming protocols are approved and LIHP contracts are fully executed. There is no prescribed rate. The capitated rate should include all allowable costs for services, including mental health services unless they are carved out. In consultation with the local LIHP, DHCS shall determine actuarially sound per enrollee capitation rates for LIHPs that are adequate and sufficient to ensure access to services for enrollees and to at least cover the projected cost of care. Each local LIHP shall submit a detailed proposal to DHCS outlining proposed methodologies and rates that have been certified by county-employed or county-retained actuaries using state and federal Medicaid principles and standards. The proposed methodology must be identified generally in the funding and claiming protocols for the LIHP that must be approved by CMS before they are implemented.
Claiming	6	Regarding the Health Home Service Delivery Model, can case management now be claimed as a Health cost instead of an administrative cost?	Not at this time, however, DHCS is exploring and assessing the feasibility of the Health Home Service Delivery Model in the LIHPs. It is possible that the model will be able to be implemented in the LIHP at a future date.
Claiming	7	By July 1, 2011, the state will demonstrate to CMS that counties meet the new Medicaid Coverage Expansion (MCE) coverage requirements and that expenditures related to this coverage can be claimed as federal financial participation (FFP) under the MCE. For those counties with existing HCCI enrollees meeting this timeframe, FFP claimed from the date of Demonstration approval will be treated as MCE expenditures. By July 1, 2011, if a county is able to demonstrate full compliance with MCE coverage requirements, please confirm that all services provided to eligible MCE enrollees can be claimed against the FFP for MCE for the dates of service commencing November 1, 2010 (and not subject to allocation limits). Will counties need to submit new/revised invoices to claim against the MCE (as these services may have been claimed against the Safety Net Care Pool (SNCP) limits during the year for revenue flow)? What is the State timeline for development of the MCE invoice procedure and how quickly can counties expect payment?	If a county with existing HCCI enrollees is in full compliance with all MCE requirements by July 1, 2011, the county costs incurred for providing health care services to MCE eligible enrollees can be claimed for federal reimbursement under the MCE program category for services rendered back to November 1, 2010. The claiming process for adjusting the federal reimbursement of these costs from the SNCP to the MCE program category will be outlined in the cost claiming protocols to be developed by DHCS for review and approval by CMS. DHCS will be submitting the draft LIHP cost claiming protocols to CMS soon. Upon CMS approval, and DHCS authorization, the counties can submit the required cost documentation to DHCS for claiming the federal reimbursement.

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Claiming	8	Is all mental health claiming for services provided to MCE and, if allowed, HCCI, through DHCS and not the Department of Mental Health?	Yes.
Cost sharing Limit	9	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 percent aggregate cost sharing limit per family. Does family include the number of people in the household or is it the number of people in the household who participate in LIHP?	The aggregate cost sharing limit imposed on a family is limited to 5 percent of a family's income (number of people in the household) not the number who participate in the LIHP.
Eligibility	10	Can an asset test be used for LIHP eligibility determinations?	An asset test can not be used as part of MCE or HCCI eligibility determinations.
Eligibility	11	How do we do the social security number verifications?	DHCS is developing a process for Medi-Cal Eligibility Data System (MEDS) access in the future, and will advise the counties of its progress. DHCS is targeting completion of this process by mid May.
Eligibility	12	What types of third party coverage are allowable for a MCE eligible individual?	The LIHP is intended to be the payer of last resort; that is, all other available third party resources must meet their legal obligation to pay claims before the LIHP pays for the care of a LIHP enrollee. Examples of third parties which may be liable to pay for services include, group health plans, self-insured plans, managed care organizations, pharmacy benefit managers, Medicare, court-ordered coverage, settlements from a liability insurer, workers' compensation, first party probate-estate recoveries, long-term care insurance, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.
Eligibility	13	Is the local LIHP required to use one standardized application form?	No.
Eligibility	14	Is an individual who is eligible for Medi-Cal, Children's Health Insurance Program (CHIP), or Access for Infants and Mothers (AIM) program eligible for LIHP?	No.
Emergency Services	15	Regardless of the network a county chooses, do the requirements to provide medically necessary emergency services apply to both populations?	Yes, emergency services within the network must be provided to both populations. However, note that out-of-network emergency services for medically necessary emergency services, are required to be provided to only the MCE population.

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Topic	No.	Question	Answer
Enrollment	16	Please clarify the STCs of the BTR Demonstration which state that no FFP will be available for counties that enroll new HCCI applicants at the exclusion of MCE applicants.	One of the requirements for receiving federal funding for the LIHP is that individuals eligible under the MCE component of the LIHP must have priority over individuals eligible for HCCI. An HCCI program can not be implemented if a MCE program is not implemented or if the MCE upper income limit is below 133 percent of the FPL. If both MCE and HCCI are implemented, individuals eligible for HCCI can be enrolled before those eligible for MCE are enrolled in the program. However, adequate resources must be available to enroll all eligible unenrolled MCE applicants if eligible individuals are enrolled in HCCI, An enrollment cap for MCE can not be established because the local funds were used for new HCCI enrollees.
FFP	17	Can local mental health and/or substance abuse resources be used as matching funds?	Local mental health and/or substance abuse resources used to provide services to the LIHP population can be federally reimbursed at the current Federal Medical Assistance Percentage (FMAP). LIHP is not a federal match program; it is a federal reimbursement program. This means that the county incurs the total cost for services provided to LIHP enrollees before receiving federal reimbursed.
FFP	18	Is there a local match requirement?	No. LIHP has no match requirement. The LIHP must incur the total funds expenditures and is reimbursed the federal share of the cost at the FMAP rate.
Funding	19	Will state general funds be included in the program?	No.
HCCI Not Implemented	20	If a current HCCI county does not implement HCCI, does the county need to comply with the new waiver requirements for existing HCCI enrollees such as due process and network adequacy?	If the current HCCI county does not implement the new HCCI program, the county must still comply with all the requirements under the new BTR Demonstration for the existing HCCI enrollees and those who were enrolled until February 14, 2011, including, but not limited to due process, cost sharing, minimum HCCI core benefits, and network adequacy.
IGTs	21	Will there be a State admin fee for any IGTs and if so, what amount?	There is no additional fee unless the LIHP requests expedited processing. The local LIHP must reimburse DHCS for the additional administrative costs that it incurs associated with the expedited processing. To the extent the number of IGTs requires additional staff, the local LIHP must reimburse the State for the additional staff costs. The local LIHPs must reimburse the State for all costs to administer the program. DHCS will develop a process for this reimbursement.

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Topic	No.	Question	Answer
Indigent Populations	22	Are the county medically indigent programs a component of the LIHP?	No.
Indigent Populations	23	Are county medically indigent participants eligible for the LIHP?	Yes, if they meet the eligibility criteria and are determined eligible for the LIHP.
Inmates Claiming	24	How do claims for State and county inmates eligible for MCE work?	DHCS and the California Prison Health Care Services (CPHCS) are currently collaborating on the claiming process for State and county inmates. DHCS will provide more details about this process as soon as it is finalized.
Inmates Claiming	25	AB 1628 requires the counties of the inmates' last legal residence to reimburse providers for inpatient hospital services of State inmates if the county participates in LIHP. These State inmates can be housed out of the county, would this be considered out-of-network services?	No, these services would be considered provided within the counties provider network through a contract between CPHCS and the county of last legal residence.
Mechanisms for Managing Costs	26	What mechanisms are available for local LIHPs to manage costs?	Mechanisms to manage costs include, but are not limited to the following: standard utilization management controls, benefits beyond the required minimums, and payment rates. In addition, costs can be controlled through additional steps that must be implemented in the following order; not implementing HCCI, modify upper income limit, and set enrollment caps. Enrollment caps should be used only as the last alternative when no other cost alternatives are available or feasible.
Medicaid Rules Waived in STCs	27	The MCE for eligible adults between 19 and 64 years of age with the family incomes at or below 133% of the federal poverty level (FPL) will be subject to all Medicaid rules, except those explicitly waived through the STCs. What are the rules that have been waived through the STCs?	Please refer to the Expenditure Authority, Waiver Authority documents, and the PowerPoint presentation for the LIHP Informational Meetings, and other documents which will be posted on the LIHP webpage for the most current information regarding the Medicaid rules that are waived through the Demonstration.
Mental Health	28	Will the LIHP have to comply with mental health parity rules?	When the mental health parity regulations are released by CMS, the LIHP will have to comply unless the provisions are waived or identified as not applicable to the Demonstration.
Mental Health Benefits	29	How soon can counties with existing HCCI enrollees provide the new minimum mental health services to their new and existing MCE enrollees?	The new MCE minimum mental health services can be provided upon implementation of LIHP or counties with existing HCCI enrollees may begin transition to the new MCE minimum mental health services through a contract amendment to the previous HCCI contract.

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Topic	No.	Question	Answer
Mental Health Benefits	30	How soon can the LIHP provide mental health services in addition to the minimum mental health services under the BTR Demonstration project to the MCE population as required and to the HCCI population if allowed?	Additional MCE and HCCI mental health services can be provided upon CMS approval and implementation of the local LIHP.
MOE	31	Paragraph 44 of the STCs states: "If the State cannot meet the Maintenance of Effort (MOE) requirement, CMS will reduce Federal funding for LIHP expenditures by the amount of the deficiency." The MOE must be met at the local level. As written, the STC implies that if all but one county did not meet their MOE, the State would have failed to meet the MOE requirement. Therefore, CMS would reduce Federal funding. Is this a correct interpretation?	Each local LIHP is expected to meet the MOE requirement. The amount of each LIHP's MOE that is met is aggregated on an annual basis to calculate the statewide MOE requirement. With this aggregation, the statewide MOE is typically met even if one or more counties do not meet their MOE. Therefore, the federal funding would not be reduced.
MOE	32	Is the MOE for LIHP applicants without existing HCCI enrollees based on State Fiscal Year (SFY) 2009-10?	DHCS submitted a technical correction to the STCs to allow SFY 2009-10 as the base year for MOE determinations by counties without existing HCCI enrollees. DHCS will provide further clarification after CMS approves the technical correction.
Open Network	33	What does a county based delivery system with an open network mean?	An open network would reimburse any willing and qualified provider (based on Medicaid provider enrollment rules) who provided services to its enrollees in and outside the county.
Provider Choice	34	Is LIHP exempt from the Federal regulation of Section 1932(a)(3)(A) of the Social Security Act that requires enrollees be given a choice of at least two managed care organizations?	Yes, the Expenditure Authority states that all LIHP enrollees shall have a choice of at least two primary care providers, and may request a change of their primary care provider as described in federal regulations at 42 CFR 438.56(c).
Provider Network	35	If a LIHP uses providers that are nationwide would they be considered out-of-network providers?	No, the contract between the local LIHP and the nationwide provider would specify the locations available for their LIHP enrollees.
Provider Network	36	Can we provide our MCE and, if allowed, HCCI mental health benefits through our County Mental Health Services Program?	Yes, to the extent the minimum evidence-based benefits package for mental health care services is provided.
Provider Network	37	Can counties utilize a different provider network for MCE versus HCCI?	Yes.
Provider Network	38	What does carve out mean?	Carve out means that certain services are separated from the rest of the LIHP delivery system, and are provided by a different LIHP delivery system.
Provider Payments	39	What is the fee schedule to be used for the program?	The fee schedule for provider payments is determined by the local LIHP.
Provider Payments	40	What flexibility does the local LIHP have to set the payment rates for tertiary care facilities?	The local LIHP has the flexibility to set the payment rate for these facilities.

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Topic	No.	Question	Answer
Provider Payments	41	Are local LIHPs required to pay for emergency services and post-stabilization services provided by out-of-network providers at 30 percent of the Roger's rate for inpatient services and 30 percent of the Medi-Cal FFS rates for physician services?	Local LIHPs are required to pay at least 30 percent of these rates but may pay an amount higher than the 30 percent rate.
Provider Payments	42	How will counties know the "applicable regulatory fee-for-service rate under the State plan"? How will counties know the "regional un-weighted average of per diem rates paid to SPCP-contracted hospitals"?	The information is in All Plan Letters (APLs) from the Medi-Cal Managed Care Division and is available at <a href="http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDAPLPLSubjectListing.aspx">http://www.dhcs.ca.gov/formsandpubs/Pages/MMCDAPLPLSubjectListing.aspx</a> . The two applicable APLs are also posted under "Resources" on the LIHP webpage.
Provider Payments	43	Can the local LIHP negotiate a lower rate than PPS rates for FQHCs?	No.
Provider Payments	44	Is there a minimum rate requirement for a contractor that is not an FQHC?	No.
Retroactive Claiming	45	If a county without existing HCCI enrollees implements the LIHP June 1, 2011, and it decides to do an IGT, can the county ask for retroactive reimbursement to March 1st?	No.
Retroactive Claiming	46	If an existing HCCI county allowed retroactive eligibility, would it have to cover out-of-network emergency services?	Yes, but only for MCE enrollees according to STC 63 f.
SPD Training	47	The Sensitivity Training outlined in the STCs indicates that the State shall submit the training to CMS by November 1, 2010. And that all appropriate plan and State staff shall be trained using the Seniors and People with Disabilities (SPD) Sensitivity Training Curriculum by March 2011.	This provision applies to the SPD population and not to the LIHP population.
Transition	48	When can counties with existing HCCI enrollees begin transitioning to requirements of the new STCs under the BTR Demonstration?	Counties with existing HCCI enrollees can begin transitioning to the new requirements after November 1, 2010 and must comply with all the new requirements upon implementation of the LIHP and no later than June 30, 2011. For additional information on transition refer to questions 2, 8, and 32.
Waiting List	49	Is a waiting list required?	No.



DAVID MAXWELL-JOLLY  
Director

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



ARNOLD SCHWARZENEGGER  
Governor

**ATTACHMENT 1**

DATE: July 6, 2010

MMCD All Plan Letter 10-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: 2010-11 RATES FOR EMERGENCY INPATIENT SERVICES PROVIDED  
BY OUT-OF-NETWORK ACUTE CARE HOSPITALS

This All Plan Letter (APL) provides Medi-Cal managed care health plans with rates for emergency inpatient services provided to Plan enrollees during the 2010-11 rate period by acute care hospitals that are not part of the health plan's provider network. This APL replaces the rates published in APL 09-012.

For purposes of this letter, the term "out-of-network" means an acute care hospital — including hospitals that contract with the Department of Health Care Services (DHCS) under the Selective Provider Contracting Program (SPCP)—that does not have in effect a contract with a Medi-Cal managed care health plan for inpatient services. In this APL, out-of-network is used instead of "non-contracted" to avoid confusion with the term's use for non-SPCP hospitals.

The rates published below result from the unweighted average of per-diem rates paid to SPCP-contracted hospitals within each of the three regions identified by the California Medical Assistance Commission (CMAC). These rates have been trended forward based on annual increases in the regional average SPCP contract rates, as published in the CMAC Annual Report to the State Legislature. SPCP rates for individual hospitals are confidential for four years; health plans and their subcontractors are prohibited from compelling hospitals to disclose their SPCP rates.

Separate rates are calculated for tertiary and non-tertiary hospitals. A "tertiary" hospital is a Children's Hospital or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority. A list of tertiary and non-tertiary hospitals is included in the CMAC Annual Report to the State Legislature, available at <http://www.cmac.ca.gov/annual.asp>.

Rogers Amendment rates for the 2010-11 rate period are as follows.

<b>Rogers Amendment Welfare and Institutions Code 14091.3 CMAC Regional Average Rates for Out-of-Network Acute Care Hospital Emergency Inpatient Services Rate Period: 7/1/10 to 6/30/11</b>		
	Average	
	Non Tertiary	Tertiary
Other	\$1,551	\$2,062
San Francisco / Bay Area	\$1,908	\$2,943
Southern California	\$1,391	\$2,168

Other = All California counties other than those listed below.

San Francisco / Bay Area = Counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma

Southern California = Counties of Los Angeles, Orange, Riverside, San Bernardino, and Ventura

If you have any questions regarding this APL, please contact David Merritt, Health Program Specialist I, at (916) 552-9687 or [david.merritt@dhcs.ca.gov](mailto:david.merritt@dhcs.ca.gov).

Sincerely,



Tanya Homman, Chief  
Medi-Cal Managed Care Division



DAVID MAXWELL-JOLLY  
Director

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



ARNOLD SCHWARZENEGGER  
Governor

**ATTACHMENT 2**

DATE: July 6, 2010

MMCD All Plan Letter 10-008

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: 2010-11 RATES FOR POST-STABILIZATION INPATIENT SERVICES  
PROVIDED BY OUT-OF-NETWORK ACUTE CARE HOSPITALS

This All Plan Letter (APL) provides Medi-Cal managed care health plans with rates for post-stabilization inpatient services provided to Plan enrollees during the 2010-11 rate period by acute care hospitals that are not part of the health plan's provider network. This APL replaces the rates published in APL 09-013.

For purposes of this letter, "post-stabilization" refers to inpatient service day(s) following the inpatient service day on which a physician determines that the patient is stable enough to be safely transferred to a Plan hospital. The term "out-of-network" means an acute care hospital—including hospitals that contract with the Department of Health Care Services (DHCS) under the Selective Provider Contracting Program (SPCP)—that does not have in effect a contract with a Medi-Cal managed care health plan for inpatient services. In this APL, out-of-network is used instead of "non-contracted" to avoid confusion with the term's use for non-SPCP hospitals.

The rates published below result from the unweighted average of per-diem rates paid to SPCP-contracted hospitals within each of the three regions identified by the California Medical Assistance Commission (CMAC). These rates have been trended forward based on annual increases in the regional average SPCP contract rates, as published in the CMAC Annual Report to the State Legislature, and reduced by five percent. SPCP rates for individual hospitals are confidential for four years; health plans and their subcontractors are prohibited from compelling hospitals to disclose their SPCP rates.

Separate rates are calculated for tertiary and non-tertiary hospitals. A "tertiary" hospital is a children's hospital or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority. A list of tertiary and non-tertiary hospitals is included in the CMAC Annual Report to the State Legislature, available at <http://www.cmac.ca.gov/annual.asp>.

Rogers Amendment rates for the 2010-11 rate period are as follows.

<b>Rogers Amendment Welfare and Institutions Code 14091.3 CMAC Regional Average Rates for Out-of-Network Acute Care Hospital Post-Stabilization Inpatient Services Rate Period: 7/1/10 to 6/30/11</b>		
	Average	
	Non Tertiary	Tertiary
Other	\$1,474	\$1,959
San Francisco / Bay Area	\$1,813	\$2,796
Southern California	\$1,321	\$2,060

Other = All California counties other than those listed below.

San Francisco / Bay Area = Counties of Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma

Southern California = Counties of Los Angeles, Orange, Riverside, San Bernardino, and Ventura

If you have any questions regarding this APL, please contact David Merritt, Health Program Specialist I, at (916) 552-9687 or [david.merritt@dhcs.ca.gov](mailto:david.merritt@dhcs.ca.gov).

Sincerely,



Tanya Homman, Chief  
Medi-Cal Managed Care Division