



Administrator

Washington, DC 20201

OCT - 5 2007

Ms. S. Kimberly Belshe, Secretary
California Health and Human Services Agency
1600 Ninth Street
Sacramento, CA 95814

Dear Ms. Belshe:

We are pleased to inform you that your August 28, 2006, request to amend the California section 1115 Medicaid demonstration, entitled, Medi-Cal Hospital/Uninsured Care (Waiver 11-W-00193/9), under the authority of section 1115(a) of the Social Security Act (the Act), has been approved for the period October 5, 2007, through August 31, 2010.

The California section 1115(a) demonstration approved August 31, 2005, involved stabilizing the financing of the State's safety net hospitals and the implementation of other Medicaid reforms. The approved demonstration created a Safety Net Care Pool (SNCP), which was to have provided up to \$766 million in Federal funds annually for 5 years, totaling \$3.83 billion in Federal financial participation. The pool was to be used to assist providers with unreimbursed costs incurred serving uninsured patients.

Of the \$766 million, \$180 million was contingent upon the State meeting specified goals in each of the 5 years of the demonstration. The State did not meet the specified goals in years 1 and 2 of the Demonstration, and the \$180 million in potential Federal funding for the SNCP will not be available in each of those years.

The amended section 1115 demonstration authorizes the State to create a Coverage Initiative (CI) to expand health care coverage for eligible low-income, uninsured individuals utilizing an allotment of \$180 million in Federal funds per year for the period October 5, 2007, through August 31, 2010. The benefit package provided in the CI is only to be applied to those eligible individuals enrolled in the approved CI programs connected to this component of the SNCP.

The Department of Health and Human Services' approval of the amended demonstration, including the waivers and the costs not otherwise matchable authority that are described in the enclosed list, are conditioned on the State's acceptance of the Special Terms and Conditions (STCs). The STCs will be effective October 5, 2007, unless otherwise specified. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the Demonstration.

On May 25, 2007, the Centers for Medicare & Medicaid Services (CMS) placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to

Ensure the Integrity of Federal-State Financial Partnership), on display in the *Federal Register*. This rule, found at 72 Fed. Reg. 29748 (May 29, 2007), would modify Medicaid reimbursement. Because of this regulation, some or all of the payments outlined in the STCs may no longer be allowable expenditures for Federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007, instructed CMS to take no action to implement this final regulation for 1 year. CMS will abide by the time frames specified by the statute. However, the State is not relieved of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements.

Your project officer is Mr. Steven Rubio. He is available to answer any questions concerning your section 1115 demonstration. Mr. Rubio's contact information is as follows:

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Center for Medicaid and State Operations
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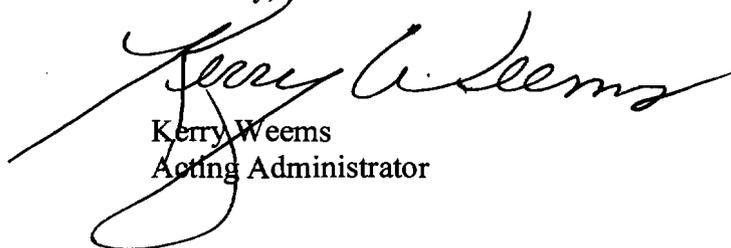
Official communications regarding program matters should be sent simultaneously to Mr. Rubio and to Ms. Linda Minamoto, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Minamoto's contact information is as follows:

Ms. Linda Minamoto
Associate Regional Administrator
75 Hawthorne Street
San Francisco, CA 94105

If you have questions regarding this approval, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

Again, congratulations on the approval of this amendment to your section 1115 demonstration. We look forward to the success of the Coverage Initiative.

Sincerely,



Kerry Weems
Acting Administrator

Enclosures

Page 3 – Ms. S. Kimberly Belshe

bcc: Linda Minamoto, Associate Regional Administrator, Region IX
Michelle Baldi, Health Insurance Specialist, Region IX
Jim Frizzera, Director, Financial Management Group, CMSO

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
Amended October 5, 2007**

NUMBER: 11-W-00193/9

TITLE: Medi-Cal Hospital/Uninsured Care Demonstration

AWARDEE: California Health and Human Services Agency

I. PREFACE

The following are the Special Terms and Conditions (STCs) for California's Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the California Health and Human Services Agency (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective September 1, 2005 unless otherwise specified. This Demonstration is approved through August 31, 2010.

The STCs have been arranged into the following subject areas: Program Description; General Program Requirements; General Reporting Requirements and General Financial Requirements.

Additionally ten attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION

The California Medi-Cal Hospital/Uninsured Care section 1115(a) demonstration is a comprehensive, multi-year plan involving stabilizing the financing of the State's safety net hospitals and the implementation of other Medicaid reforms. The State has negotiated a Safety Net Care Pool (SNCP) to assist in treating the large pool of uninsured who presently utilize public hospital emergency rooms for primary and preventive care services. The non-Federal funds for the SNCP (and the Coverage Initiative described below) will be primarily Certified Public Expenditures (CPEs).

Part of the annual SNCP funds are restricted for use in each of Demonstration Years 3, 4 and 5 that are targeted to fund a Healthcare Coverage Initiative (Coverage Initiative) that will expand coverage options for individuals currently uninsured. The State has designed the Coverage Initiative to utilize existing relationships between the uninsured and safety net health care systems, hospitals, and clinics and has been constructed to:

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, & Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these STCs are part, shall apply to the Demonstration.
3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy that occur after the approval date of this Demonstration, unless the provision being changed is explicitly waived under the STCs herein governing the Demonstration.

For the current period of this demonstration, the foregoing requirement shall apply to all applicable regulation and policy issued by CMS, with respect to the Deficit Reduction Act (DRA) signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in 1903(x).

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law, regulation, or policy statement impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the Demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. If mandated changes in the Federal law require State legislation, the changes shall take effect on the earlier of the day such State legislation becomes effective, or on the last day of any period such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State shall be required to submit Title XIX State plan amendments for reimbursement methodologies affecting Section 4.19-A of the Medicaid State plan.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, reimbursement, cost sharing, evaluation design, Federal financial participation (FFP), sources of non-Federal share funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state shall not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive except as otherwise specified in these STCs and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below
7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
 - a. An explanation of the public process used by the State to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current “with waiver” status on both a summary and detailed level through the current approval period of the Demonstration using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed amendment which isolates the impact of the amendment;
 - c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - d. If applicable, a description of how the evaluation design shall be modified to incorporate the amendment provisions.
8. **Continuation of the Demonstration.** The following provisions apply to the phase-out of the demonstration:
 - a. The State will submit a plan for phase-out of the demonstration to CMS at least 6 months prior to initiating phase-out activities and, if desired by the State, the State will submit an extension plan (or an application for renewal of the waiver) on a timely basis to prevent termination of the Coverage Initiative if the demonstration is extended or renewed by CMS. Nothing herein will be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval.
 - b. During the last 6 months of the demonstration, the enrollment of individuals in the Coverage Initiative who would not be eligible for Medicaid under the current State Plan will not be permitted unless the demonstration is extended by CMS.

9. **Demonstration Phase-Out.** The State will submit a plan for phase-out of the demonstration to CMS at least 6 months prior to initiating phase-out activities. Nothing herein will be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval.

10. **Suspension or Termination of Demonstration.** CMS may suspend or terminate the demonstration, in whole or in part, at anytime before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

Likewise, the State may suspend or terminate this Demonstration in whole or in part, at any time before the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. If the Demonstration is terminated, or if any relevant waivers are suspended by the State, CMS will be liable only for normal closeout costs.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply with the terms and conditions governing this Demonstration.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw any waiver or expenditure authority at any time it determines that continuing the waiver or expenditure authority would no longer be in the public interest or promote the objectives of title XIX. CMS shall promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, CMS and the State will agree on a phase-out plan and effective date. Upon the effective date, FFP is limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

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

14. **Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool.** The State has submitted and CMS has approved a funding and reimbursement protocol (Attachment F) to document the procedures and methodologies the State will use to determine those costs eligible for Federal matching through the Safety Net Care Pool through the Certified Public Expenditure (CPE) process. The reimbursement methodologies for hospitals participating in the Inpatient Hospital Component of this demonstration that are not described in Section 4.19-A of the Medicaid State Plan are described in Attachment F and

includes a description of any use of estimates or adjustment factors that will be used to modify actual cost findings.

15. **Coverage Initiative and Non-Hospital Provider Claiming Protocols.** Within 60 days after the effective date of these amended STCs, the State shall submit to CMS a separate funding and reimbursement protocol which explains the process the State will use to determine costs incurred by Coverage Initiative (CI) programs. This process must indicate how the CI programs will document CI costs; how interim payments will be made; and how reconciliations will be performed. In particular, the State must document how the CI CPE process will interact with the CPE process currently outlined in Attachment F, and used by the hospitals listed in Attachment C to document costs eligible for Federal matching. This process should only address the provision of medical services under the CI; the administrative cost claiming protocol is separately described in Attachment J.

This new funding and reimbursement protocol should also specify definitions, methodologies and cost-reporting formats for documenting expenditures made by the State and non-hospital based providers in order to claim Safety Net Care Pool (SNCP) Federal matching funds.

This new funding and reimbursement protocol must be approved by CMS before the State may claim FFP against the SNCP for all medical services provided under the CI as well as any non-hospital based provider costs.

16. **Maintenance of Effort (MOE).** The State must demonstrate that the annual amount of non-Federal funds expended for CI programs will be maintained or increased above the State Fiscal Year (SFY) 2006 level for the duration of the demonstration period, i.e., the State must demonstrate that total non-Federal expenditures for CI programs in years 3, 4 and 5 of the demonstration are equal to or exceed the total amount that would have been expended by either the State or local governments in SFY2006 in the absence of the demonstration. If the State cannot meet the MOE requirement, CMS will reduce Federal funding for CI expenditures by the amount of the deficiency.
17. **Federal Funds Participation (FFP).** No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the demonstration approval letter.
18. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State Notice Procedures set forth in 59 *Fed. Reg.* 49249 (1994) when any significant program changes to the Demonstration are proposed by the State.

IV. GENERAL REPORTING REQUIREMENTS

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

20. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in these STCs.
21. **Accounting Procedure.** The State has submitted and CMS has approved accounting procedures for the demonstration to ensure oversight and monitoring of demonstration claiming and expenditures. These procedures are included as Attachment H.
22. **Contractor Reviews.** The State will forward summaries of the financial and operational reviews that the State completes on applicants awarded contracts through the Coverage Initiative.
23. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, the Coverage Initiative, quality of care, access, the benefit package, cost-sharing, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.
24. **Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter (Attachment I). The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include, but are not limited to:
 - a. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package and other operational issues.
 - b. Action plans for addressing any policy and administrative issues identified.
 - c. Enrollment data including the number of persons in the uninsured population served under the demonstration, once the Coverage Initiative begins enrollment on September 1, 2007.
 - d. Budget neutrality monitoring tables.
 - e. Other items as requested.
25. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 60

days of receipt of comments from CMS, a final annual report shall be submitted for the demonstration year to CMS.

The annual report shall also contain the previous State fiscal year appropriation detail for those State programs referenced in paragraph 47 which are permissible expenditures under the Safety Net Care Pool.

26. **Final Report.** Within 120 days following the end of the demonstration, the State will submit a draft final report to CMS for comments. The State will take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

27. **Evaluation Design.** Within 90 days the effective date of these amended STCs, the State must submit to CMS for approval a draft evaluation design for the demonstration.

- a. At a minimum, the draft design shall discuss the outcome measures, including those in Attachment G, which will be used in evaluating the impact of each CI program during the period of approval, particularly among the target populations. The design shall also include the specific hypotheses being tested including an evaluation of the effectiveness of using SNCP funding for the CI programs. Further, it shall discuss the data sources and sampling methodology for assessing these outcomes, including the per capita cost of each CI program. Finally, the draft evaluation design shall include a detailed analysis plan that describes how the effects of the CI programs shall be isolated from other initiatives occurring in the State.
- b. CMS will provide comments on the draft evaluation design within 60 days of receipt, and the State will submit a final evaluation design within 60 days of receipt of CMS' comments.

28. **Implementation of Evaluation Design.**

- a. The State shall implement the evaluation design and submit its progress in each of the quarterly and annual progress reports.
- b. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of §1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.
- c. The authority to operate each CI program will be renewed based on the evaluation of the CI program's success and cost-effectiveness in the interim evaluation report.
- d. If the authority for CI programs under the Safety Net Care Pool is not renewed, the State shall submit to CMS a draft of the evaluation report within 120 days after expiration of that portion of the Demonstration. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

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

V. GENERAL FINANCIAL REQUIREMENTS

Payments for Medicaid-Eligible Patients

30. **Selective Provider Contracting Program (SPCP).** The State will continue the SPCP (as described in Attachment E) as part of the 1115 demonstration, subject to Attachment F and other applicable STCs. This component of the demonstration is now referred to as the "Inpatient Hospital" component.
31. **Payments to Private Hospitals.** Only those private hospitals that contract with the State under the Inpatient Hospital component are paid in accordance with this Demonstration. Payments to these private hospitals will continue to be determined through negotiations with California Medical Assistance Commission (CMAC), and subject to the inpatient hospital upper payment limit for private hospitals.
- a. Reimbursement to private hospitals shall consist of per diem payments, and may also include supplemental payments previously made to those hospitals, including the payments made under the Graduate Medical Education (GME) program and the Emergency Services Supplemental Payment program (also known as the SB 1255 program) and shall not exceed, in the aggregate, the upper payment limit for private hospitals established under CMS regulations. Should CMS promulgate new regulations, the GME program must come into compliance in accordance with the effective date of the new regulations.
 - b. Replacement program payments (also known as the SB 855 program) will be satisfied through a new supplemental payment for Medicaid inpatient hospital services provided to Medicaid-eligible individuals not enrolled in managed care, and shall not exceed, in the aggregate, the upper payment limit for private hospitals established under CMS' regulations.
 - c. The non-Federal share of payments to private hospitals may be funded by transfers from units of local government, at their option, to the State. Any payments funded by intergovernmental transfers shall remain with the hospital and shall not be transferred back to any unit of government.
 - d. The State will inform CMS of the funding of all Medicaid payments to these hospitals through the quarterly payment report currently submitted to the Regional Office. This report has been modified to accommodate the identification of funding sources associated with each type of Medicaid payment received by each hospital.

- 32. Payments to Non-Designated Government-Operated Hospitals.** The hospitals not identified in Attachment C that participate in the Inpatient Hospital component will continue to be determined through negotiations with CMAC or by the State plan. Such contract hospitals may be eligible for supplemental payments and are subject to the applicable inpatient hospital upper payment limit for their provider type.
- a. The State will inform CMS of the funding of all Medicaid payments to these hospitals through the quarterly payment report currently submitted to the Regional Office. This report has been modified to accommodate the identification of funding sources associated with each type of Medicaid payment received by each hospital.
 - b. DSH payments will be paid in accordance with paragraph 39. If the State share of payments to government-operated hospitals is funded through CPEs, those CPEs will be calculated in accordance with the requirements and methodologies under Attachment F. Consequently, those hospitals will be added to Attachment C through the demonstration amendment process specified in Section II, paragraph 7 and their reimbursement will be dictated through the State Plan. Nothing in these STCs, or in the State Plan, shall preclude the State from appropriating State General Funds to the government-operated hospitals for the non-Federal share of certified expenditures.
- 33. Use of Provider Tax and Other Fees.** During the term of the demonstration, the State will not impose a provider tax, fee or assessment on inpatient hospitals, outpatient or physician services that will be used as the non-Federal portion of any Title XIX payment.
- 34. Reimbursement to Designated Government-Operated Hospitals.** Reimbursement to those hospitals identified in Attachment C will be based on allowable Medicaid inpatient hospital costs as identified on Medi-Cal 2552-96 cost reports. The methodology for computing such costs and the required procedures for claiming Federal matching funds is detailed in the Funding and Reimbursement Protocol included as Attachment F.
- 35. Certified Public Expenditures (CPEs).** Total computable expenditures certified as the basis for Federal claiming may be based upon all sources of funds available to government entities that directly operate health care providers. However, the sources of funds utilized shall not include impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act and prohibited by paragraph 33, or by other Federal funds. For this purpose, Federal funds do not include patient care revenue received as payment for services rendered under programs such as Coverage Initiative program, Medicare or Medicaid.
- 36. Payments to Hospitals.** Under this demonstration, payments to hospitals may include Medicaid inpatient and outpatient payments to hospitals identified in Attachment C that meet the eligibility requirements for participation in the Construction/Renovation Reimbursement Program, pursuant to California Welfare and Institutions Code section 14085.5. To the extent that the State continues to make these payments, such payments shall not be funded by CPEs and shall be considered Medicaid revenue that must be offset against uncompensated costs eligible for DSH payments. These supplemental payments are in addition to the

Medicaid rates described in Attachment F for inpatient Medicaid services, and the non-Federal share must be funded by State or local general funds.

37. **Federal Financial Participation (FFP).** The State shall not receive FFP for Medicaid and Safety Net Pool payments to government-operated hospitals designated in Attachment C in excess of costs as defined in paragraph 35 or recognized under paragraph 36. This does not preclude payments to these hospitals from DSH funds.

Disproportionate Share Hospital (DSH) Payments

38. **Use of DSH Allotment.** Effective July 1, 2005, the statewide DSH allotments under section 1923(f) of the Social Security Act (the Act) shall be used as follows:

- a. FFP shall be available for DSH payments made to government-operated hospitals funded by: (1) the State General Fund; or (2) CPEs of the government-operated hospitals identified in Attachment C (and other government-operated hospitals, as approved by CMS).
- b. DSH payments may be made up to the amount of uncompensated Medicaid and uninsured costs of hospital services furnished by the subject hospital, including costs associated with non-emergency services rendered to unqualified aliens. CPEs will be determined in accordance with paragraph 34.
- c. A defined DSH pool available for payments to private hospitals to the extent necessary under sections 1923(b) and (c) of the Social Security Act.

39. **Additional DSH Payments.** In addition to the FFP available for DSH payments authorized under paragraph 38, and to the extent authorized by Federal statute, payments not to exceed 175 percent of the uncompensated care costs for serving Medicaid and uninsured patients may be made to government-operated hospitals. The non-Federal share of payments above 100 percent of uncompensated care costs may be funded by intergovernmental transfers from the hospitals, or from units of government with which they are affiliated as defined in paragraph 36. Reporting requirements for these payments are specified in Attachment F.

- a. For demonstration years 1 and 2 only, for any hospital eligible to receive 175% DSH payments, Safety Net Care Pool (SNCP) payments made to the hospital in lieu of DSH payments will not be offset against the DSH eligible uncompensated care costs for purposes of determining the hospital-specific DSH limit. Such payments will be offset prior to making a DSH payment to ensure no duplication of payment.
- b. With respect to DSH payments made under this paragraph, the State and county or hospital district/authority (for non-State government-operated entities) will provide annual assurances that any transfer of funds from a government-operated hospital or related governmental unit or entity will be no greater than the non-Federal portion of the payment funded by the intergovernmental transfer.

- c. The State will provide assurances that government-operated hospitals will retain the full amount of the payment resulting from the use of intergovernmental transfers. No portion of the payments funded by Federal, county, or State funds made to government-operated hospitals will be returned to any unit of government.
- d. Retention of such funds by the government-operated hospitals for use in either the current or subsequent fiscal year is allowable. "Retention," when applicable, is established by demonstrating that the retained earnings account of the hospital, at the end of any year in which it received DSH payments funded by intergovernmental transfers, has increased over the prior year's balance by the amount of any DSH payments received in excess of 100 percent of uncompensated care costs (to the extent that the hospital had earnings during the year of up to the amount of such DSH payments). These retained hospital funds may be commingled with county funds for cash management purposes, provided that such funds are appropriately tracked, and only the depositing facility is authorized to expend them.

40. **University of California Hospitals.** The State may add the University of California Los Angeles Medical Center and University of California San Francisco Medical Center to those hospitals that are eligible to receive DSH payments, subject to the DSH payment limits established pursuant to section 1923(g) of the Act and paragraph 38. The State will not make DSH payments above 100% to these two hospitals. DSH payments to the other three University of California hospitals on Attachment C will continue subject to paragraphs 38 and 39.

41. **Redistribution of DSH funds.** The State may redistribute the Federal portion of DSH funds it receives which are based on hospitals' CPEs, provided that the recipient hospital does not return any portion of the funds received to any unit of government. No Federal matching funding is available for such redistribution. Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable. For purposes of applying the DSH payment limit of section 1923(g) of the Act, amounts claimed for Federal match by each hospital shall be counted as payments to the hospital whose CPE generated the FFP rather than the hospital receiving the distributed funds.

Safety Net Care Pool (SNCP)

42. **SNCP Established.** A Safety Net Care Pool will be established to ensure continued government support for the provision of health care services to uninsured populations.

43. **Use of SNCP Funds.** Safety Net Care Pool funds may be used for health care expenditures (medical care costs) that are incurred:

- a. By the State for medical care under the Medically Indigent Long Term Care program, Breast and Cervical Cancer Treatment Program, the California Children Services program, and the Genetically Handicapped Persons program; or

- b. 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; or
- c. By County grantees for direct service and administrative costs of a Coverage Initiative, as described in paragraph 50.

Expenditures from the Safety Net Care Pool are subject to the budget neutrality expenditure limit established in Attachment B.

44. Restricted Use of SNCP Funds. Federal funds in the amount of \$180 million in the Safety Net Care Pool in each demonstration year is limited as follows:

- a. In demonstration years 1 and 2, use of the \$180 million in each year is contingent on meeting specific milestones to implement a Medicaid Program Redesign, which will expand the number of counties in California covered by Medi-Cal Managed Care, and require the enrollment of Medi-Cal only seniors and persons with disabilities into Medi-Cal Managed Care; and
- b. In demonstration years 3, 4 and 5, use of the \$180 million in each year is contingent on implementation of a Healthcare Coverage Initiative, which will expand coverage options for individuals currently uninsured.
- c. Because the State did not meet the milestones to implement the Medicaid Program Redesign in either demonstration years 1 or 2, the restricted portions of the Safety Net Care Pool funds from those years are not available for use in subsequent demonstration years for the Healthcare Coverage Initiative.

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

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

In the event that the use of CPEs by the State and government-operated entities is insufficient to access all funds in the Safety Net Care Pool and fully utilize California's DSH allotment, the State must propose alternate legitimate funding mechanisms. However, CMS must

review and approve any such alternate funding prior to its use as the non-Federal share of a payment under Title XIX. Such proposed funding will not include funding linked to new provider taxes prohibited under paragraph 33.

47. Prohibited Uses of SNCP funds. The Safety Net Care Pool funds cannot be used for costs associated with the provision of non-emergency care to unqualified aliens.

- a. To implement this limitation, 17.79 percent of total provider expenditures or claims for services to uninsured individuals will be treated as expended for non-emergency care to unqualified aliens.
- b. Notwithstanding subparagraph (a), the State shall implement this requirement for the following State-funded programs that would be within the definition of medical assistance in this manner:
 - i. Expenditures for the Medically Indigent Long Term Care (MI/LTC) program will not be reduced by 17.79 percent because there are no unqualified aliens receiving services under this program.
 - ii. Expenditures for the Breast and Cervical Cancer Treatment Program (BCCTP) will be reduced by the costs related to providing services to those individuals with aid codes used to designate unqualified aliens; however, the 17.79 percent reduction will not be applied otherwise.
 - iii. Expenditures for the California Children Services (CCS) program and the Genetically Handicapped Persons Program (GHPP) will be reduced by 17.79 percent as specified in subparagraph (a).
- c. Notwithstanding the limitation outlined in subparagraph (a), this requirement shall not be applied to expenditures for the Coverage Initiative authorized under this section.
- d. Nothing in this paragraph is intended to restrict payments for the provision of care to unqualified aliens pursuant to sections 1903(v) and 1923 of the Act.
- e. Unexpended funds in the Safety Net Care Pool may not be used to make payments under the Inpatient Hospital component of the demonstration.

48. Allowable Costs under SNCP. Hospital costs paid from the Safety Net Care Pool will be determined in accordance with Attachment F and paragraph 47. For costs incurred by the State and non-hospital based providers, CMS and the State will develop and agree to definitions, methodologies, and cost-reporting formats under the new Coverage Initiative and Non-Hospital Claiming Protocol required under Section II, paragraph 15.

49. Redistribution of SNCP Funds. The State may redistribute Federal matching funds drawn against Safety Net Care Pool claims it receives which are based on providers' CPEs. However, providers receiving Federal funds in excess of their certified costs cannot return any portion of the payment received to any unit of government and cannot claim the CPEs for any other purpose. No Federal matching funding is available for such redistributions.

Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable and subject to paragraph 39(d).

HealthCare Coverage Initiative (Coverage Initiative)

50. Federal Financial Participation for the Coverage Initiative. A reserved amount of \$180 million in Federal funds is created within the Safety Net Care Pool in each of Demonstration Years 3, 4 and 5. This amount may only be used to fund a Coverage Initiative that will expand coverage options for individuals currently uninsured. The Coverage Initiative may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals, and clinics. Eligibility for the Coverage Initiative (CI) is specified in paragraph 53, and additional parameters of the CI are outlined in Attachment G.

The State may utilize additional portions of the Safety Net Care Pool funds for this purpose, but no portion of the \$180 million Federal funds sub-cap in each of the 3 years may be used for any demonstration expense other than the Coverage Initiative. The \$180 million share portion of Safety Net Care Pool funds for each of the last three demonstration years are considered annual allotments and any unspent dollars are not allowed to roll over for use in subsequent demonstration years, if these funds are not spent during the demonstration years. This does not preclude payment for activities performed or services rendered during one of these demonstration years after the end of that demonstration year from the annual allotment for that year.

51. Coverage Initiative Allocations. The Department of Health Care Services (DHCS) will determine Coverage Initiative allocations for a three-year period covering years three, four, and five of the Demonstration. The allocations will reimburse selected programs for health care coverage service costs incurred between September 1, 2007, and August 31, 2010 for the approved Coverage Initiative. The reimbursement of health care coverage service costs must be compliant with the Office of Management and Budget Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments."

52. Milestones. The State met the following milestones for the Coverage Initiative:

- a. January 31, 2006 — Submit a concept paper on the Coverage Initiative.
- b. September 1, 2006 — Submit a waiver amendment on structure, eligibility and benefits for the Coverage Initiative.

The State also agrees to begin enrollment in the Coverage Initiative by September 1, 2007.

53. Eligibility. Individuals are eligible for CI programs if they:

- a. Are between the ages of 19 and 64;
- b. Have incomes at or below 200 percent of the FPL; and

- c. Are not eligible for Medicaid or SCHIP.
- d. Those individuals with incomes 101 percent of the FPL and above who meet the requirements in subparagraphs (a) through (c) shall not have had health insurance in the three months prior to enrollment in the CI, unless the individual had employer-sponsored health insurance and one of the following events occurred in the three months prior to application for the CI:
 - i. Loss of job;
 - ii. A move to a zip code area or region that is not covered by the employer-sponsored health insurance;
 - iii. Loss of health insurance because the employer stopped providing health insurance for all employees;
 - iv. A divorce or legal separation from the individual whose employer provides health insurance;
 - v. The death of the individual who is the subscriber of the employer-sponsored insurance;
 - vi. Termination or cancellation of the individual's Consolidated Omnibus Budget Reconciliation Act (COBRA) policy.
- e. No asset test will be imposed upon Coverage Initiative enrollees.

54. **Enrollment in the Coverage Initiative.** Eligibility determinations for the Coverage Initiative will be made by individuals who are employed under merit system principles by local governments, including local health departments. These employees will refer any applicant who may be eligible for either Medicaid or SCHIP to the county social services office for an eligibility determination.

Enrollment in any Coverage Initiative may be limited at any time based on funds available.

55. **Coverage Initiative Benefits.** Benefits offered under the Coverage Initiative may not include any services or cost-sharing beyond those outlined in the table below. Any expansion of benefits or increase in cost-sharing will be subject to the amendment process outlined in Section II, paragraph 7. Not all cost-sharing maximums outlined below apply in all CI programs.

<u>Coverage Initiative Benefits</u>	<u>Maximum Cost Sharing</u> (co-payments or co-insurance)
Inpatient Hospital	
General acute hospital	Maximum of \$550/admission plus 35% of full charges; possible lien on property possessed or acquired in the future
Psychiatric hospital	Maximum of \$500/admission

<u>Coverage Initiative Benefits</u>	<u>Maximum Cost Sharing (co-payments or co-insurance)</u>
Inpatient drug and alcohol treatment	None
Acute rehabilitation hospital	0-100% FPL - \$50/admission 101-200% FPL - \$100/admission
Emergency room	\$100 per visit
Outpatient Hospital Services	
Physician	\$20/visit
Optometry	\$20/visit
Psychology	\$20/visit
Podiatry	\$20/visit
Physical therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Occupational therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Speech therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Audiology (includes hearing aids)	\$20/visit
Laboratory	\$5/visit equal to or less than 100% FPL
Radiology	\$25/diagnostic service; \$50/CT, ultrasound or ECG; \$150/MRI
Prosthetic and orthotic devices	50% of cost
Durable medical equipment	50% of cost
Prescribed and over-the-counter drugs	\$5/prescription under \$50; \$15/prescription between \$50 and \$200; 20% of cost for prescription over \$200, with maximum of \$100/prescription
Medical supplies (may include incontinence supplies)	\$10
Use of hospital facilities	0-100% FPL - \$5/visit 101-200% FPL - \$100/visit Co-pay \$100 for first 5 days, \$25 each additional day, Max of \$500 per admission, outpatient surgery co-pay sliding scale fee (0-25% of Medicare fee)

<u>Coverage Initiative Benefits</u>	<u>Maximum Cost Sharing (co-payments or co-insurance)</u>
Outpatient drug therapy services	\$100/treatment
Hemodialysis	0-100% FPL - \$15/visit 101-200% FPL - \$25/visit
Clinic Services (rural health, federally qualified health (FQHC), FQHC look-alike, community, county, specialty clinics and State Licensed Free Clinic).	
Physician	\$20/visit
Optometry	\$20/visit
Psychology	\$20/visit
Podiatry	\$20/visit
Physical therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Occupational therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Speech therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Audiology (includes hearing aids)	\$20/visit
Laboratory	\$5/visit
Radiology	\$25/diagnostic service; \$50/CT, ultrasound or ECG; \$150/MRI
Prosthetic and orthotic devices	50% of cost
Durable medical equipment	50% of cost
Prescribed and over-the-counter drugs	\$5/prescription under \$50; \$15/prescription between \$50 and \$200; 20% of cost for prescription over \$200, with maximum of \$100/prescription
Medical supplies (includes incontinence supplies)	\$10
Outpatient drug therapy services	\$100/treatment
Hemodialysis	\$25/visit 101% FPL and over
Laboratory	\$5/visit 101% FPL and over
Radiology (radiological services, portable imaging, and radioisotope services)	\$25/diagnostic service; \$50/CT, ultrasound or ECG
Nursing home care: Skilled nursing, Intermediate Care	None
Subacute care facilities (licensed and certified skilled	\$100/inpatient visit 101% FPL and

<u>Coverage Initiative Benefits</u>	<u>Maximum Cost Sharing (co-payments or co-insurance)</u>
nursing)	over
Physician Services	
Physician services	\$20/visit; \$50/visit for specialist
Dental services provided by a physician	\$20/visit; \$100 for oral surgery
Telemedicine	None
Smoking cessation	\$5/box of patches
Sign language interpretation	\$10/visit
Dental services (includes dentures)	\$20/visit for basic services, restorative and periodontics; \$100/oral surgery \$30/visit + 80% UCR for major restorative
Ophthalmology and optometry services, (includes eye glasses and optical fabricating laboratories)	0-100% FPL - \$10/visit 101-200% FPL - \$20/visit
Podiatry	\$20/visit
Home Health Services	
Registered nurse	\$5/visit 101% FPL and over
Licensed vocational nurse	\$5/visit 101% FPL and over
Licensed therapist (physical, occupational, and speech)	\$5/visit 101% FPL and over
Social worker	\$5/visit 101% FPL and over
Home health aide	\$5/visit 101% FPL and over
Psychology services	None
Infusion services	None
Medical supplies, equipment and appliances	None
Physical therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Occupational therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Speech therapy	0-100% FPL - \$15/visit 101-200% FPL - \$20/visit
Prosthetic appliances	50% of cost
Orthotic appliances	\$10

<u>Coverage Initiative Benefits</u>	<u>Maximum Cost Sharing (co-payments or co-insurance)</u>
Durable medical equipment	50% of cost
Non-physician practitioner services (midwives, family nurse practitioners, pediatric nurse practitioner, general nurse practitioner, physician assistants, and nurse anesthetist)	\$20/visit
Personal care services	None
Nonemergency medical transportation	None
Acupuncture	0-100% FPL - none 101-200% FPL - \$5/visit
Blood bank services	\$15
Outpatient hemodialysis and peritoneal dialysis	0-100% FPL-\$5/visit, 101-200% FPL-\$10/visit
Audiology (includes hearing aids)	\$10/visit
Indian Health Services**	0-100% FPL - \$5/visit 101-200% FPL - \$10/visit
Ambulatory surgical center services	Maximum of \$550/admission plus 35% of full charges; possible lien on property possessed or acquired in the future
Mental health services	\$20/visit
Medical supplies (includes incontinence supplies)	\$10

** not covered under PL 93:638

56. **Coverage Initiative Premiums.** Premiums charged to enrollees may not exceed the amounts outlined in the table below. Any increase in premiums charged to enrollees under the Coverage Initiative will be subject to the amendment process outlined in Section II, paragraph 7.

FPL	Monthly Premium
0 – 100%	\$0
101 – 200%	\$25

57. **Coverage Initiative Enrollment Fees.** An annual enrollment fee charged to enrollees may not exceed \$250 per individual or \$300 per family. Any increase in annual enrollment fees charged to enrollees under the Coverage Initiative will be subject to the amendment process outlined in Section II, paragraph 7.

58. **Prior Approval of Claiming Mechanism.** The State must obtain prior approval for the methodology used to capture administrative costs associated with the Coverage Initiative for each CI program. Additional requirements are specified in Attachment J.
59. **Medicare Part D.** No duplication of coverage of the Part D benefits will be provided under this demonstration.

Attachment A
General Financial Requirements Under Title XIX

1. **Quarterly Reports.** The State will provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Medi-CalHospital/Uninsured Care demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Attachment B (Monitoring Budget Neutrality).
2. **Reporting Expenditures under the Demonstration.** In order to track expenditures under this demonstration, California will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM).
 - a. All Demonstration expenditures claimed under the authority of Title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered). For monitoring purposes, costs settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.c. For any other costs settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on Lines 9 and 10.c., as instructed in the SMM. The term "expenditures subject to the budget neutrality cap," is defined in paragraph 3.
 - b. For each Demonstration year, five (5) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration Services. The specific waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets below:
 - i. Safety Net Care Pool – Hospital Services [SNCP-Hosp.];
 - ii. Safety Net Care Pool – Non-Hospital Services [SNCP – Non-Hosp.];
 - iii. Coverage Initiative [CI];
 - iv. Private and Non-Designated Government-Operated Hospital Payments [P/ND Govt. Hosp]; and
 - v. Designated Government-Operated Hospital Payments [D. Govt. Hosp]
3. **Expenditures Subject to the Budget Neutrality Cap.** For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Safety Net Care Pool expenditures, identified in paragraph 2(b)(i-iii). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.
4. **Expenditures Subject to Hospital Payment Limits.** For purposes of this paragraph, the term “expenditures subject to hospital payment limits” must include all expenditures made by

and payments to hospitals for Medicaid payments in providing services to patients under the Inpatient Hospital component of the demonstration, identified in paragraph 2(b)(iv-v) consistent with Attachment F. All expenditures that are subject to the hospital payment limits are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver as specified in Attachment B.

5. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration on Forms 64.10 Waiver and/or 64.10P Waiver. For each Demonstration year, two separate Forms CMS-64.10 Waiver and/or 64.10P Waiver must be completed to track, report, and identify administrative costs directly attributable to the Demonstration and those that are attributable to the Health Care Coverage Initiative for each CI program under the demonstration. The specific waiver names to be used to identify these separate Forms CMS-64.10 Waiver and/or 64.910 Waiver appear in brackets below:
 - a. Administrative Costs - General [Non-CI Admin.];
 - b. Administrative Costs – Coverage Initiative [CI Admin.];
6. **Administrative Costs Associated with Coverage Initiative.** For these costs, the State must distinguish between direct services provided under the Coverage Initiative and administrative activities to ensure there is no duplicate claiming for each CI program.
7. **Claiming Period.** All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. All claims for services during the demonstration period must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
8. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. California must estimate matchable Medicaid expenditures (total computable and Federal share) subject to the budget neutrality cap and separately report these expenditures by quarter for each Federal fiscal year on Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the appropriate Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
9. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding and in accordance with Section IV, paragraphs 35 and 50, CMS will provide FFP at the applicable Federal reimbursement rate as outlined below, subject to the limits described in Attachment B:

- a. Administrative costs, including those associated with the administration of the Medi-Cal Hospital/Uninsured Care demonstration.
 - b. Net medical assistance payments/expenditures and prior period adjustments paid in accordance with the approved State Plan.
 - c. Net Safety Net Care Pool expenditures during the operation of this demonstration.
10. **Sources of Non-Federal Share.** The State certifies that State and local monies are used as matching funds for the demonstration. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding must be compliant with section 1903(w) of the Act and any applicable regulations. Further, these sources and distribution of monies involving Federal match are subject to CMS approval in accordance with Section IV, paragraphs 33 and 39. Upon review of the sources of the non-Federal share of funding and distribution methodologies, any sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
11. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.
12. **Cost-Claiming.** All costs will be claimed in accordance with OMB Circular A-87 as defined within Attachment F, and any other cost claiming methodologies or protocols approved by CMS under this Demonstration .

Attachment B

Monitoring Financial Performance of the Demonstration

Budget Neutrality Monitoring.

1. **Limit on Title XIX Funding.** California will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The limit is determined using an aggregate cap method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
2. **Calculation of the Annual Budget Neutrality Expenditure Cap.** For each year of the demonstration, a cap will be set for the Safety Net Care Pool in the amount of \$1.532 billion total computable. Of that amount a sub-cap to be used for a Coverage Initiative in demonstration years 3, 4 and 5, of \$360 million total computable is restricted by the provisions of Section V, paragraphs 50 through 59. Unexpended funds from the restricted amount may not be used for purposes other than these provisions for the Coverage Initiative and may not be carried over to other years. For the balance of the Safety Net Care Pool amount each year, any unexpended portion may be expended for Safety Net Care Pool purposes in subsequent demonstration years subject to the restrictions outlined in Section V, paragraph 50 regarding the Coverage Initiative.
3. **Calculation of the Cumulative Budget Neutrality Expenditure Cap.** The annual budget neutrality expenditure caps for each of the five years of the demonstration approval period as specified in paragraph 2 above are added together to create a cumulative cap of \$7.66 billion total computable for the entire demonstration period. The Federal share of the cumulative budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures under the demonstration.
4. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
5. **Enforcement of Budget Neutrality.** The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis, subject to Attachment B and an annual calculation of hospital upper payment limits. The limit calculated above will apply to actual expenditures for demonstration, as reported by the State under Attachment A. If at the end of

the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS.

There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Hospital Payment Monitoring

1. **Inpatient Hospital Component Payments.** The payments to hospitals for Medicaid expenditures in the Inpatient Hospital Component are subject to the following:
 - a. The maximum payments to private hospitals shall be the private hospital Federal upper payment limit (UPL).
 - b. The maximum payments to government-operated hospitals shall be the applicable governmental Federal UPL and the limits specified in Section IV, paragraphs 32, 34 and 35.

Attachment C

Government-operated Hospitals to be Reimbursed on a Certified Public Expenditure Basis

State Government-operated University of California (UC) Hospitals

1. UC Davis Medical Center
2. UC Irvine Medical Center
3. UC San Diego Medical Center
4. UC San Francisco Medical Center
5. UC Los Angeles Medical Center
6. Santa Monica UCLA Medical Center (aka – Santa Monica UCLA Medical Center & Orthopedic Hospital)

Non-State Government-operated

Los Angeles County (LA Co.) Hospitals

1. LA Co. Harbor/UCLA Medical Center
2. LA Co. Martin Luther King Jr./Drew Medical Center (for the period July 1, 2005-August 15, 2007 only)
3. LA Co. Olive View Medical Center
4. LA Co. Rancho Los Amigos National Rehabilitation Center
5. LA Co. University of Southern California Medical Center

Other Government-Operated Hospitals

1. Alameda County Medical Center
2. Arrowhead Regional Medical Center
3. Contra Costa Regional Medical Center
4. Kern Medical Center
5. Natividad Medical Center
6. Riverside County Regional Medical Center
7. San Francisco General Hospital
8. San Joaquin General Hospital
9. San Mateo County General Hospital
10. Santa Clara Valley Medical Center
11. Tuolumne General Hospital (for the period July 1, 2005-June 30, 2007 only)
12. Ventura County Medical Center

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

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

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

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

Attachment E

Inpatient Hospital Component

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

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

Further, the State is authorized to make final payments in connection with any amounts due to hospitals participating under the SPCP waiver which terminated on August 31, 2005, as provided under the terms of that waiver and current contracts with such providers for dates of service through August 31, 2005. Except as specified in paragraph 32, all remaining supplemental payments shall only go to private hospitals. The non-Federal share of such payments will be funded with State or local appropriations. These funds shall remain with the hospital and shall not be transferred back to any unit of governmental.

Finally, the State is authorized to make final payments in connection with any amounts due to hospitals under the State's disproportionate share hospital (DSH) program for State Fiscal Years 2003-04 and 2004-05. Such payments will not be treated as payments under this demonstration for purposes of budget neutrality. With respect to such payments, the State cannot use the current method of funding the non-Federal share of such payments in which providers do not retain 100% of the total computable claimed Medicaid expenditure for dates of service beyond June 30, 2005.

Attachment F

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool

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

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

Worksheet A

The hospital's trial balance of total expenditures, by cost center. The primary groupings of cost centers are:

- (i) overhead;
- (ii) routine;
- (iii) ancillary;
- (iv) outpatient;
- (v) other reimbursable; and,
- (vi) non-reimbursable.

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

Worksheet B

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

Worksheet C

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

Worksheet D

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

- (i) Under the apportionment process for each routine service cost center, a per diem is computed by dividing the cost center's reimbursable cost by the cost center's total patient days. The resulting per diem is multiplied by the number of program days to arrive at program cost.

Attachment F

Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool

(ii) Under the apportionment process for each ancillary/outpatient /other non-routine reimbursable cost center, the cost-to-charge ratio from Worksheet C for each cost center is multiplied by the program charge for that cost center to arrive at program cost.

Worksheet E

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

NOTES:

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

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

The term “finalized Medi-Cal 2552-96 cost report” refers to the cost report that is settled by the California Department of Health Services (DHS), Audits and Investigations (A&I) with the issuance of a Report On The Cost Report Review (Audit Report).

The term “filed Medi-Cal 2552-96 cost report” refers to the cost report that is submitted by the hospital to A&I and is due 5 months after the end of the cost reporting period.

Nothing in this document shall be construed to eliminate or otherwise limit a hospital’s right to pursue all administrative and judicial review available under the Medicaid program. Any revision to the finalized Audit Report as a result of appeals, reopening, or reconsideration shall be incorporated into the final determination.

(iii) Los Angeles County hospitals (to the extent that they, as all-inclusive-charge-structure hospitals, have been approved by Medicare to use alternative statistics such as relative value units in the cost report apportionment process) may also use alternative statistics as a substitute for charges in the apportionment processes described in this document. These alternative statistics must be consistent with alternative statistics approved for Medicare cost reporting purposes and must be supported by auditable hospital documentation.

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

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

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Interim Medicaid Inpatient Hospital Payment Rate

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

1. The process of determining the allowable Medicaid inpatient hospital costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal_2552-96 cost report for purposes of Medicaid reimbursement.
2. To determine the interim Medicaid payment rate, the State should use the most recently filed Medi-Cal 2552-96 cost report, follow the Medi-Cal 2552-96 cost report apportionment process as prescribed in the Worksheet D series to arrive at the total Medicaid non-psychiatric inpatient hospital cost.

On the Medi-Cal 2552-96 cost report, interns and residents costs should not be removed from total allowable costs on Worksheet B, Part I, column 26, since Medi-Cal does not separately reimburse for Graduate Medical Education costs via a per-resident amount methodology. If the costs have been removed, the State should add allowable interns and residents costs back to each affected cost center prior to the computation of cost-to-charge ratios on Worksheet C. This can be accomplished by using Worksheet B, Part I, column 25 (instead of column 27) for the Worksheet C computation of cost-to-charge ratios. The State is to only add back allowable interns and residents costs that are consistent with Medicare cost principles. If the hospital is a cost election hospital under the Medicare program, the costs of teaching physicians that are allowable as GME under Medicare cost principles shall be treated as hospital interns and residents costs consistent with non-cost election hospitals.

For hospitals that remove Medicaid inpatient dental services (through a non-reimbursable cost center or as an A-8 adjustment), the State will make necessary adjustments to Worksheet A trial balance cost (and, as part of the cost report flow, any other applicable Medi-Cal 2552-96 worksheets) to account for the Medicaid inpatient dental services identified in Attachment D to the Special Terms and Conditions. This is limited to allowable hospital inpatient costs and should not include any professional cost component.

Additionally, the State will perform those tests necessary to determine the reasonableness of the Medicaid program data (i.e., Medicaid days and Medicaid charges) from the reported Medi-Cal 2552-96 cost report's Worksheet D series. This will include reviewing the Medicaid program data generated from its MMIS/claims system for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report. However, because the MMIS/claims system data would generally not include all paid claims until 18 months after the Fiscal Year Ending (FYE) of the cost report, the State will take steps to verify the filed Medicaid program data, including the use of submitted Medicaid claims. Only Medicaid

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program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

Medicaid payments that are made independent of the Medicaid inpatient hospital non-psychiatric per diem for Medicaid inpatient hospital services of which the costs are already included in the Medicaid inpatient hospital non-psychiatric cost computation described above, must be offset against the computed Medicaid non-psychiatric inpatient hospital cost before a per diem is computed in Step number 3 below.

3. The computed Medicaid non-psychiatric inpatient hospital cost computed in Step number 2 above should be divided by the number of Medicaid non-psychiatric inpatient hospital days as determined in Step number 2 above for that period which corresponds to the most recently filed Medi-Cal 2552-96 cost report.
4. The Medicaid per day amount computed in Step number 3 above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The Medicaid per day amount may be further adjusted to reflect increases and decreases in costs incurred resulting from changes in operations or circumstances as follows:
 - (i) Inpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
 - (ii) Inpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

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

5. An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

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

The State will adjust the cost used in the Worksheet C computation by adding back allowable interns and residents costs to the appropriate cost centers as explained in Step number 2 in the Interim Medicaid Inpatient Hospital Payment Rate section of this document. The State will also

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adjust the cost for inpatient dental as explained in Step 2 for those hospitals that used such adjustment to create the interim Medicaid payment rate.

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

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

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

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

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

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

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generated from its MMIS/claims system for the respective cost reporting period. Only Medicaid program data related to medical services that are eligible under the Medicaid inpatient hospital cost computation should be used in the apportionment process.

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

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

To determine a governmentally-operated hospital's allowable Safety Net Care Pool (SNCP) costs and the associated SNCP reimbursements and to determine a hospital's allowable uncompensated care costs eligible for disproportionate share hospital (DSH) reimbursement when such costs are funded by a State through the certified public expenditure (CPE) process, the following steps must be taken to ensure Federal financial participation:

Safety Net Care Pool (SNCP) Payments to Hospitals

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

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

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

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

In the cost report apportionment process in Worksheet D series, auditable uninsured program data (days and charges) will be used to determine uninsured hospital cost. This data will be submitted to the State by the hospitals based on data from the hospital's records. Only

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program data for medical services eligible for SNCP should be included in the apportionment process in the Worksheet D series. Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

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

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

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

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

3. The net SNCP cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net SNCP costs may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:
 - (i) Inpatient and outpatient hospital costs not reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
 - (ii) Inpatient and outpatient hospital costs incurred and reflected on the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

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

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4. The total SNCP certifiable expenditures as computed above should be reduced by 17.79% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.
5. The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:
 - (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
 - (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
 - (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments
 - (iv) Total inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
 - (v) Total non-hospital costs funded by SNCP payments.

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

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

Interim Reconciliation of Interim SNCP Payments to Hospitals

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

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

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

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

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

The total SNCP certifiable expenditures as computed above should be reduced by 17.79% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

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

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

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

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

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Final Reconciliation of Interim SNCP Payments to Hospitals

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

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

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

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

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

The total SNCP certifiable expenditures as computed above should be reduced by 17.79% to account for non-emergency care furnished to unqualified aliens. The costs of non-emergency care furnished to unqualified aliens are eligible for federal matching funds under the DSH program only. Those costs that are limited to SNCP funding in Attachment D are not eligible for federal matching funds under the DSH program.

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

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

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

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

Disproportionate Share Hospital (DSH) Payments

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

1. The process of determining the allowable DSH costs eligible for Federal financial participation (FFP) begins with the use of each governmentally-operated hospital's most recently filed Medi-Cal 2552-96 cost report for purposes of Medicaid reimbursement.
2. The total Medicaid managed care and Medicaid psychiatric inpatient and outpatient hospital shortfall and the uninsured hospital inpatient and outpatient costs should be computed by using the most recently filed Medi-Cal 2552-96 cost report.¹

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

In the cost report apportionment process in the Worksheet D series, auditable Medicaid managed care, Medicaid psychiatric, and uninsured program data (days and charges) will be used to compute the hospital's eligible DSH cost. This data will be submitted to the State. Only hospital inpatient and outpatient program data for medical services eligible for DSH should be included in the apportionment process in Worksheet D series. The program data should be from the period which corresponds to the most recently filed Medi-Cal cost report.

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

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Though not part of the standard Medi-Cal 2552, this information provided to the State is subject to the same audit standards and procedures as the data included in the Medi-Cal 2552 cost report.

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

3. All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital services (i.e. the DSH eligible costs claimed for SNCP payments) and any self-pay payments made by or on behalf of uninsured patients for such services, must be offset against the computed cost from Step number 2 above to arrive at the eligible DSH expenditure. Payments, funding and subsidies made by a state or a unit of local government shall not be offset (e.g., state-only, local-only or state-local health programs). Using CPEs as a funding source, federal matching funds for DSH payments may be claimed up to the hospital's eligible uncompensated costs as determined in this process. Notwithstanding all of the foregoing, for purposes of calculating a hospital's 175% DSH limit only, SNCP payments claimed for the hospital's DSH eligible costs will not be counted as revenue offsets during Demonstration years one and two.
4. The net DSH cost computed above can be trended to current year based on Market Basket update factor(s) or other hospital-related indices as approved by CMS. The net DSH costs may be further adjusted to reflect increases or decreases in costs incurred resulting from changes in operations or circumstances as follows:
 - (i) Inpatient and outpatient hospital costs not reflected in the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would be incurred and reflected on the Medi-Cal 2552-96 cost report for the spending year.
 - (ii) Inpatient and outpatient hospital costs incurred and reflected in the filed Medi-Cal 2552-96 cost report from which the interim payments are developed, but which would not be incurred or reflected on the Medi-Cal 2552-96 cost report for the spending year.

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

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

5. The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 82.21% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is

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also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

- (i) Total inpatient and outpatient hospital costs eligible only for SNCP funded by SNCP payments;
 - (ii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by SNCP payments;
 - (iii) Total inpatient and outpatient hospital costs eligible for both DSH and SNCP funded by DSH payments;
 - (iv) inpatient and outpatient hospital costs eligible only for DSH funded by DSH payments;
 - (v) Total non-hospital costs funded by SNCP payments.
6. Interim DSH payments can be made based on the eligible DSH expenditure computed above. The interim payments can be on a quarterly or other periodic basis, but such payments must account for all revenue offsets. There will be no duplication of claiming with respect to costs as SNCP certifiable expenditures and DSH certifiable expenditures.

Interim Reconciliation of Interim DSH Payments

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

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

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

All applicable Medicaid inpatient and outpatient hospital revenues, all SNCP payments claimed with respect to the hospital's expenditures for the provision of inpatient and outpatient hospital

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

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 82.21% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

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

An audit factor may be applied to the filed Medi-Cal 2552-96 cost report to adjust computed cost by the average percentage change from total reported costs to final costs for the three most recent Medi-Cal 2552-96 cost reporting periods for which final determinations have been made. Such percentage must be identified to CMS.

Final Reconciliation of Interim DSH Payments

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

As discussed in the Interim Medicaid Inpatient Hospital Payment Rate section of this document, the State will adjust the cost used in the Worksheet C computation by adding back allowable interns and resident's costs to the appropriate cost centers. The State will also adjust the cost for inpatient dental as explained in Step 2 of the Interim Medicaid Inpatient Hospital Payment Rate

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section for those hospitals that used such adjustment to create the interim Medicaid payment rate and as identified in Attachment D to the Terms and Conditions.

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

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

The State will identify that portion of the certifiable DSH expenditures computed above that is also eligible as SNCP costs (a maximum of 82.21% of the hospital uninsured costs). The State will identify that portion of the SNCP certifiable expenditures computed above that is also eligible as Disproportionate Share Hospital costs. Annually, the State will separately identify to CMS:

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

NOTES:

- (i) All disproportionate share hospital (DSH) payments, funded through certified public expenditures or otherwise, are subject to the State of California's aggregate DSH allotment.

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Funding and Reimbursement Protocol for Claiming Against the Safety Net Care Pool

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

Attachment G

Coverage Initiative

This attachment provides the parameters for the Coverage Initiative authorized under Section IV, paragraph 50 of these STCs. Under the Coverage Initiative, California will expand health care coverage for eligible uninsured individuals utilizing the annual \$180 million in Federal funds under the Safety Net Care Pool which are available in years 3, 4 and 5 of the Demonstration.

Background

Senate Bill (SB) 1448 (Stats. 2006, ch. 76) enacted by the State provides the statutory framework for the development and implementation of the Coverage Initiative by adding Part 3.5 (commencing with section 15900) to Division 9 of the Welfare and Institutions Code. Implementation of the Coverage Initiative is subject to the availability of an annual federal allocation of \$180 million as referenced above. The provisions of SB 1448 are incorporated by reference into this document.

Funding Purpose

The SNCP funding available under the Coverage Initiative may only be used to expand health care coverage to eligible persons in accordance with the requirements of SB 1448 and these STCs. SB 1448 requires that expansion of health care coverage for eligible low-income, uninsured individuals cannot diminish access to health care available for other low-income, uninsured individuals, including access through disproportionate share hospitals, county clinics, or community clinics. Health care coverage programs funded under the Coverage Initiative are not considered “entitlement” programs.

Coverage Initiative Funding Amount

No more than \$180 million in Federal funds will be available for each of the three consecutive program years to develop and implement health care coverage programs for eligible persons.

Funding is available for health care services only. Allocations cannot be used for administrative costs. However, funding is available for administrative activities associated with the Coverage Initiative as outlined in Attachment J of the STCs. Federal funds will be available for start-up, implementation and closeout costs associated with Coverage Initiative activities for costs incurred on or after March 29, 2007 through August 31, 2010 at the Federal Financial Participation rate of 50 percent. These costs should be consistent with Attachment J and will be specified in the new Coverage Initiative and Non-Hospital Claiming Protocol to be developed jointly by CMS and the California Department of Health Care Services (DHCS).

Coverage Initiative Programs

The recipients of the available Federal funds under the CI may only be a governmental entity that is a county, a city and county, a consortium of counties serving a region consisting of more than one county, or a health authority. The following entities have been contracted by DCHS to provide services under the Coverage Initiative:

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Coverage Initiative

1. **Alameda County:** The Alameda County Excellence (ACE) program will provide an enhanced health benefits plan to all eligible and enrolled residents of Alameda County with incomes at or below 200 percent of the federal poverty level (FPL). This plan emphasizes chronic disease management through preventive primary care at a designated medical home. The target population is the high-cost, chronically ill. The goal of ACE is to coordinate access and delivery of services, and to focus the design of care to reflect the needs of chronically ill enrollees and those with sufficient risk-factors that may lead to an additional chronic condition.
2. **Contra Costa County:** The Contra Costa Health Care Coverage Initiative (HCI) program focuses on inpatient, ancillary, radiology, laboratory, outpatient, emergency, and specialty care. Its comprehensive benefit package is structured to mirror the Medi-Cal program with a prevention component. Its target population consists of low-income residents with incomes at or below 200 percent of the FPL. This program will provide an opportunity to decrease the cost of expensive emergency care and increase the utilization of primary care and early intervention.
3. **Kern County:** The Kern County Camino de Salud Network will implement a comprehensive health coverage program for the uninsured and indigent population in Kern County, who are currently using Kern Medical Center's (KMC) Emergency Department as their provider of last resort and have incomes below 200 percent of the FPL. Through this program, the uninsured will have access to a package of health services including primary and preventive care, specialized outpatient services, and ancillary and diagnostic services targeted to detect, treat and monitor health problems in order to reduce the burden of disease and improve health.
4. **Los Angeles:** The Los Angeles County Department of Health Services (LACDHS) will implement a program called Healthy Way LA. It will expand health care coverage to uninsured adult residents of the county with incomes below 133 1/3 percent of the FPL, chronic conditions such as diabetes and hypertension, as well as patients nearing Medicare-eligible age and those who have been using LACDHS services in a chronic but uncoordinated manner. Enrollees will have a medical home and expanded access to primary, preventive and specialty services.
5. **Orange County:** The Orange County Medical Services Initiative (MSI) program will arrange for primary and preventive services for existing enrollees and for primary and preventive services, diagnostic and ancillary services, and hospital care services for an increased number of the county's adult indigent residents, all with incomes at or below 200 percent of the FPL. These services will be provided through safety net community clinics, disproportionate share and other hospitals, and other health care providers.
6. **San Diego County:** Safety Net Access Program (SNAP), San Diego County's Coverage Initiative program, developed by the County's Health and Human Services Agency, is a public private partnership built upon the local health care safety net system. It will enroll

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Coverage Initiative

eligible uninsured with incomes at or below 200 percent of the FPL and underserved San Diego residents in a chronic disease management program targeting the high cost medical conditions of diabetes and hypertension and those who may have accessed care in a hospital emergency department.

7. **San Francisco City and County:** The Health Access Program (HAP) is the City and County of San Francisco's CI program which will provide services to indigent and uninsured residents with incomes at or below 200 percent of the FPL. HAP benefits will provide many of the Medi-Cal program benefits to enrollees. In addition, under HAP, participants will have a medical home, health promotion and education, and utilization management and quality improvement systems. These new service expansions will be accomplished via client participation in a local health plan, the San Francisco Health Plan.
8. **San Mateo County:** The WELL-Plus Initiative will target adults with incomes at or below 200 percent of the FPL. WELL-Plus will include health care services in outpatient and inpatient settings; preventive and early intervention services; ancillary and specialty care. Managed care principles will ensure a medical home for enrollees, reduce episodic and fragmented care, and emphasize preventative and primary care.
9. **Santa Clara County:** The Valley Care Program will provide comprehensive primary and preventive health care from their choice of primary care providers selected from a network of public and private clinics and practitioners to enrollees with incomes at or below 200 percent of the FPL. While the program will cover all county residents that meet the DRA and FPL criteria, the program targets self-employed or low-wage workers and builds on the shared responsibility model, which distributes the health coverage cost between employer, employee, and the community.
10. **Ventura County:** The Ventura County Health Care Agency (HCA) will expand health coverage for uninsured residents with incomes at or below 200 percent of the FPL by offering a comprehensive system of care called the Access Coverage Enrollment (ACE) Program. This program will emphasize communication across the health care continuum, incentives for provider and enrollee engagement in preventive health services, and effective use of community-based health care partners to ensure geographically favorable access to medical care. The focus of the benefit package is on preventive care and health maintenance of chronic conditions. A unique component with the ACE Program is the Small Employer-Based Enrollment Program designed to reach agricultural workers.

Funding Requirements

Allocation/Reallocation Process and Requirements

The State will be responsible for the allocation of SNCP funds to be claimed under the Coverage Initiative to CI programs. These programs must make expenditures for health care coverage according to a schedule that will be determined by CDHS.

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Coverage Initiative

If a CI program is not meeting the State's expenditure schedule in a program year, the State may suspend or terminate the contract with the selected applicant after notifying CMS in writing of the change.

Allocations

There must be at least five separate CI programs in operation around the State, and no single CI program will receive an initial allocation greater than 30 percent of the total Federal funds available allowed under the Coverage Initiative. However, the State may reduce the allocation to a CI Program if it fails to meet its expenditure schedule, and reallocate the remaining Federal Funds to other health care coverage programs.

Use of Funds

SNCP funds allocated to CI programs must supplement, and not supplant, any county, city and county, health authority, State, or Federal funds that would otherwise be spent on health care services in that county, city and county, consortium of counties serving a region, or health authority. Funding, such as a grant, that is currently received from a particular source that is specifically targeted for a specified purpose or program cannot be used as the non-Federal share of funds for programs under the Coverage Initiative. However, those programs could be expanded by additional expenditures of non-Federal funds.

This expansion of services could be accomplished by for example, offering additional services, or modifying current standards of eligibility, or providing health care coverage to the target population. The base year data to identify the number of eligible persons will be Fiscal Year 2006-2007, subject to final reconciliation in the program year.

Federal funds that are available in a particular program year can only be paid for services provided in that particular program year. To the extent that these funds are not claimed for services provided in a given program year, they cannot be paid for expenses incurred for services provided in a later program year. This does not preclude the State from using demonstration Years 3, 4, or 5 funds to pay for activities performed or services rendered during demonstration Years 3, 4, or 5 after the end of the respective demonstration year.

The total-funds expenditure certified by the selected applicants must be from an appropriate source of local funds. The source of funds utilized must not include other Federal funds (Federal funds received as revenue for providing patient care services are exempted from the limitation on the use of federal funds) or impermissible provider taxes or donations, as defined under section 1903(w) of the Social Security Act, and applicable federal regulations.

The State will submit for CMS approval a funding and reimbursement protocol which explains the process the State will use to determine costs incurred by Coverage Initiative (CI) programs. This process must indicate how the CI programs will document CI costs; how interim payments will be made; and how reconciliations will be performed. In particular, the State must document

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Coverage Initiative

how the CI CPE process will interact with the CPE process currently outlined in Attachment F, and used by the hospitals listed in Attachment C to document costs eligible for Federal matching. This process should only address the provision of medical services under the CI; the administrative cost claiming protocol is separately described in Attachment J.

This new funding and reimbursement protocol should also specify definitions, methodologies and cost-reporting formats for documenting expenditures made by the State and non-hospital based providers in order to claim Safety Net Care Pool (SNCP) Federal matching funds.

This protocol must be approved by CMS before the State may claim FFP against the SNCP for all medical services provided under the CI as well as any non-hospital based provider costs.

Citizenship/Identity Documentation Requirements

The CI programs must comply with requirements of section 6036 of the Deficit Reduction Act of 2005 entitled, "Improved Enforcement of Documentation Requirements," (Pub.L. 109-171) for enrollment of eligible low-income, uninsured persons covered under the Coverage Initiative. The CI programs will be required to obtain satisfactory documentary evidence of U.S. citizenship and identity for eligible low-income, uninsured persons who declare their U.S. citizenship before enrolling them into health care coverage programs

Program Evaluation

The State is required to evaluate the health care coverage programs funded under the Coverage Initiative, and to submit an evaluation report to CMS including:

1. Program Income and Expenditures by Coverage Initiative program
2. How the Coverage Initiative program expanded the number of Californians who have health care coverage.
3. How the Coverage Initiative program strengthened and/or built upon the local health care safety net system, including disproportionate share hospitals, and county and community clinics.
4. How the Coverage Initiative program improved access to high quality health care and health outcomes for individuals.
5. How the Coverage Initiative program created efficiencies in the delivery of health care services that could lead to savings in health care costs.
6. How the Coverage Initiative program provided grounds for long-term sustainability of the programs funded under the Coverage Initiative beyond August 31, 2010, when the annual federal allocation for the Coverage Initiative ends.

Attachment H

Department of Health Care Services Accounting Procedures

I. State-Only Programs

Introduction

The Department of Health Care Services' (DHCS's) claims federal funds from the Safety Net Care Pool (SNCP), established under the Medi-Cal Hospital/Uninsured Care Demonstration (No.11-W-001993/9), by claiming the costs of programs funded only with State General Funds. Under these programs, known as State-Only programs, California provides services to individuals who are not otherwise eligible to receive healthcare services under the Medi-Cal program. These programs include the following:

- Breast and Cervical Cancer Treatment Program (BCCTP)
- Medically Indigent Adults/Long Term Care (MIA/LTC) Program
- California Children's Services (CCS) Program
- Genetically Handicapped Persons Program (GHPP)

SNFD Responsibility

To ensure compliance with federal requirements related to certified public expenditures and the reporting of those expenditures, SNFD's Hospital Contracts Supplemental Payments Unit coordinates with:

- SNFD's Hospital Finance Team
- DHCS's Fiscal Forecasting and Data Management Branch
- Electronic Data Systems (EDS), California's fiscal intermediary
- Individual DHCS State-Only Programs
- DHCS's Medi-Cal Accounting Office (Accounting)

Claim Calculation

SNFD staff obtains reports on monthly expenditures for each of the State-Only programs from EDS and then determines the appropriate amounts for claiming against the SNCP. Because the costs of providing non-emergency services to undocumented immigrants cannot be claimed against the SNCP, DHCS must calculate the claim for each State-Only program as follows:

- BCCTP – Costs for services provided to undocumented immigrants are removed from the total program costs, but no further reduction is applied before the claim is made.

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Department of Health Care Services Accounting Procedures

- MIA/LTC – Costs are not reduced and no reduction factor is applied to the claim because no undocumented immigrants receive services under this program.
- CCS – A 17.79 percent reduction factor is applied to program costs before costs are claimed because DHCS does not know whether undocumented immigrants receive services under this program.
- GHPP – A 17.79 percent reduction factor is applied to program costs before costs are claimed because DHCS does not know whether undocumented immigrants receive services under this program.

Review Process

SNFD's Associate Accounting Analyst prepares spreadsheets of expenditure data to provide running totals.

Internal staff provides peer review for verification.

SNFD works with Accounting to monitor and balance funds for these programs.

Payment Submission

SNFD submits requests for federal financial participation to Accounting. Copies of the EDS reports are attached to requests.

II. Certified Public Expenditures (CPEs)

Introduction

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

Cost Submission

At least annually, designated public hospitals send to the Safety Net Financing Division (SNFD) an estimate of their CPEs for the project (current) year, accompanied by an attestation of the costs. The CPEs are derived from the Medi-Cal 2552-96 cost report and other worksheets developed by DHCS to assist the hospitals in estimating their expenditures. These CPEs are used to establish an estimated, interim per diem rate to reimburse designated public hospitals for the costs of providing acute inpatient care to Medi-Cal beneficiaries, and as the non-federal share of Disproportionate Share Hospital (DSH) payments, and payments from the Safety Net Care Pool (SNCP) established by the Medi-Cal Hospital/Uninsured Care Demonstration.

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Review Process

SNFD compares current year costs to costs for the immediately preceding year for consistency, and performs other tests for reasonableness and validation. If discrepancies or outliers are identified, SNFD staff work directly with staff of the designated public hospitals to resolve issues and correct data.

Submit Interim Payment Request

Interim per Diem Rate – SNFD staff determines the estimated, interim per diem rate for the designated public hospitals and instructs the Department of Health Care Services' (DHCS's) Payment Systems Division's to load the rates on the Provider Master File. When the designated public hospitals submit claims to Electronic Data Systems (EDS), those claims are processed at the interim rate and submitted to the State Controller's Office (SCO for distribution.

Payments from the SNCP – SNFD staff generates a memorandum addressed to DHCS's Medical Care Services Accounting Office (Accounting). That memorandum instructs Accounting to process payments for federal funds from the SNCP to the designated hospitals. Accounting subsequently submits the payment request to the State Controllers Office where payments are distributed

Payments from the DSH Allotment – Please see the Accounting Process document entitled Disproportionate Share Hospital (DSH) Program, Designated Public Hospitals.

Interim Reconciliation

Designated public hospitals file cost reports for the project year five months after the end of the fiscal year. SNFD compares the cost data used to establish the estimated, interim per diem rate with the cost data on the filed cost report. If the cost data indicates the designated public hospitals' estimated interim per diem rate resulted in either an overpayment or underpayment, EDS reprocesses the claims and adjustments are made in the form of additional payments or receivables, as appropriate. SNFD submits adjusted payment data to Accounting.

The same process is used for the interim reconciliation of the interim payments from the SNCP and from the DSH allotment.

Final Reconciliation

Audited Medi-Cal 2552-96 cost reports for the project year, issued by DHCS's Audits and Investigations (A&I) Division, are used to determine the final per diem rate for each hospital. If the cost data indicates the designated public hospitals received an overpayment or underpayment, EDS reprocesses the claims and adjustments are made in the form of additional payments or receivables, as appropriate.

The same process is employed for the final reconciliation of the final payments from the SNCP and from the DSH allotment.

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Department of Health Care Services Accounting Procedures

SNFD submits adjusted payment data to Accounting.

Closure of FY Payment

Payments or receivables for a specific fiscal year (FY) are considered closed unless a hospital appeals A&I's audited cost report. The account will then remain open until the appeal is resolved.

III. Intergovernmental Transfers (IGTs)

Introduction

Intergovernmental transfers (IGTs) are transfers of public funds between governmental entities, such as from a county to the State. Local tax dollars is one source of the funding used for the transfer.

Pre-Transfer

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

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

Transfer

The amount of the IGTs used as the non-federal share of DSH payments will be determined by the data submitted to DHCS by the designated public hospitals. Staff of the DSH payment Unit will coordinate the amount and timing of transfers from the designated public hospitals to the STO.

CMAC staff coordinates with DHCS's Medical Operations Division (SNFD) staff on the amount and timing of IGTs to the STO under the provisions of section 14166.12 of the W&I Code.

Post-Transfer

For all IGTs, the county, or governmental entity, notifies DHCS after the transfer is complete. The transfer is verified and documented, and DHCS deposits the transferred amount into a special fund.

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Department of Health Care Services Accounting Procedures

Prepare Payment

For DSH payments see the Accounting Process entitled Disproportionate Share Hospital (DSH) Designated Public Hospitals.

For payments under the provisions of 14166.12 of the W&I Code, DHCS's SNFD staff prepares a payment package for each hospital that has been designated by the County or CMAC to receive the IGT funded payment. The packages are signed by the SNFD Division Chief. Each package includes:

- A memo addressed to DHCS Medical Care Services Accounting (Accounting) Branch Chief requesting authorization for payment.
- A Medicaid Certification Form with the signature of the Hospital Contracts Supplemental Payments (HCSP) Unit Chief, and the Hospital/Uninsured Care Demonstration Project Chief, to ensure appropriate use of Medicaid funds.
- A Copy of the support documents for SNFD Division Chief's signature.

Note: Package is reviewed by a peer for verification prior to routing for signatures.

Submit Payment Request

For DSH payments, see the Accounting Process entitled Disproportionate Share Hospital (DSH) Designated Public Hospitals

For payments under the provisions of 14166.12 of the W&I Code, after internal signatures are obtained, SNFD staff:

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

The payment packages are then submitted to Accounting.

DHCS Medical Care Services Accounting Office

For DSH payments, see the Accounting Process entitled Disproportionate Share Hospital (DSH) Designated Public Hospitals

For payments under the provisions of 14166.12 of the W&I Code, Accounting reviews the payment package, processes the payment request, and submits it to the State Controller's Office (SCO).

After payment is made, SCO will send a Remittance Advice to the HCSP Unit for verification of payment.

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Verification

For all IGT funded payments, quarterly review of all program expenditures ensures no yearly over spending. The Medi-Cal budget estimate is used to monitor expenditures to prevent overages. CMAC, Accounting, and DHCS Fiscal Forecasting compare expenditures with SNFD to verify amounts of payments.

IV. Non-designated Public Hospital Supplemental Payments

Introduction

The California Medical Assistance Commission (CMAC) negotiates contracts or contract amendments with hospitals participating in the Selective Provider Contracting Program (SPCP) to provide acute inpatient hospital care to Medi-Cal patients. In addition to a per diem rate of reimbursement, CMAC negotiates supplemental payments to these hospitals. Formerly, the non-federal share of these supplemental payments was made with intergovernmental transfers from counties, or other governmental entities, to the State. The programs that authorized these payments included:

- Emergency Services and Supplemental Payments (ESSP) Program;
- Medi-Cal Education Supplemental Payment and Medi-Cal Large Teaching Emphasis Hospital and Children's Hospital Medical Education Supplemental Payment Programs; and
- Small and Rural Hospital Supplemental Payment Program are eligible for the supplemental payments.

Under the provisions of SB 1100 (Chapter 560, Statutes of 2005), non-designated public hospitals will receive supplemental payments, but those payments will be funded with State General Funds and federal funds.

Payment Submittal

Approximately two times per year, CMAC submits to the Department of Health Care Services' (DHCS's) Hospital Contracts Supplemental Payments (HCSP) Unit, the contracts/amendments (including a master list of all contracts) for supplemental payments from the Non-designated Public Hospital Supplemental Fund. Each contract/amendment indicates the amount and date to be paid.

Prepare Payment

The HCSP Unit prepares a payment package for each hospital for the HCSP Unit Chief's signature. Each package includes:

- A memo addressed to DHCS's Medical Care Services' Accounting (Accounting) Branch Chief requesting authorization for payment.

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- A Medicaid Certification Form for HCSP Unit Chief's signature to ensure appropriate use of Medicaid funds.
- A copy of the support documents for Medical Care Services Deputy Director's signature.

The package is reviewed by a peer for verification prior to routing to management for signatures.

Submit Payment Request

After internal signatures are obtained, HCSP Unit staff will:

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

The payment packages are submitted to Accounting.

MCS Accounting Office

Accounting processes the payment request and submits it to State Controller's Office (SCO). After the payment is made, SCO will send a Remittance Advice to the HCSP Unit for verification of payment.

Verification

Quarterly review of all program expenditures ensures no yearly over spending. The Medi-Cal budget estimate is used to monitor expenditures to prevent overages.

CMAC, Accounting, and DHCS Fiscal Forecasting compare expenditures with SNFD to verify amounts of payments.

V. Private Hospital Supplemental Payments

Introduction

The California Medical Assistance Commission (CMAC) negotiates contracts or contract amendments with hospitals participating in the Selective Provider Contracting Program (SPCP) to provide acute inpatient hospital care to Medi-Cal patients. In addition to a per diem rate of reimbursement, CMAC negotiates supplemental payments to these hospitals. Formerly, the non-federal share of these supplemental payments was made with intergovernmental transfers from counties, or other governmental entities, to the State. The programs that authorized these payments included:

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Department of Health Care Services Accounting Procedures

- Emergency Services and Supplemental Payments (ESSP) Program,
- Medi-Cal Education Supplemental Payment and Medi-Cal Large Teaching Emphasis Hospital and Children's Hospital Medical Education Supplemental Payment Programs, and
- Small and Rural Hospital Supplemental Payment Program are eligible for the supplemental payments.

Under the provisions of SB 1100 (Chapter 560, Statutes of 2005), private hospitals will receive supplemental payments, but those payments will be funded with State General Funds and federal funds.

Payment Submittal

Approximately two times per year, CMAC submits to the Department of Health Care Services' (DHCS's) Hospital Contracts Supplemental Payments (HCSP) Unit, the contracts/amendments (including a master list of all contracts) for supplemental payments from the Private Hospital Supplemental Payment Fund. Each contract/amendment indicates the amount and date to be paid.

Prepare Payment

The HCSP Unit prepares a payment package for each hospital for the HCSP Unit Chief's signature. Each package includes:

- A memo addressed to DHCS's Medical Care Services' Accounting (Accounting) Branch Chief requesting authorization for payment.
- A Medicaid Certification Form for HCSP Unit Chief's signature to ensure appropriate use of Medicaid funds.
- A copy of the support documents for Medical Care Services Deputy Director's signature.

The package is reviewed by a peer for verification prior to routing to management for signatures.

Submit Payment Request

After internal signatures are obtained, HCSP Unit staff will:

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

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The payment packages are submitted to Accounting.

MCS Accounting Office

Accounting processes the payment request and submits it to State Controller's Office (SCO). After the payment is made, SCO will send a Remittance Advice to the HCSP Unit for verification of payment.

Verification

Quarterly review of all program expenditures ensures no yearly over spending. The Medi-Cal budget estimate is used to monitor expenditures to prevent overages.

CMAC, Accounting, and DHCS Fiscal Forecasting compare expenditures with SNFD to verify amounts of payments.

VI. Distressed Hospital Supplemental Payments

Introduction

The California Medical Assistance Commission (CMAC) negotiates contracts or contract amendments with participating Selective Provider Contracting Program (SPCP) hospitals that meet criteria for distressed hospital payments. These hospitals must serve a substantial volume of Medi-Cal patients, be a critical component of the Medi-Cal program's health care delivery system, and be facing a significant financial hardship that may impair ability to continue their range of services for the Medi-Cal program.

Payment Submittal

Approximately two times per year, CMAC submits the contracts/amendments (including a master list of all contracts) for payments from the Distressed Hospital Fund to the Department of Health Care Services' (DHCS's), Hospital Contracts Supplemental Payments (HCSP) Unit for payment processing. Each contract/amendment indicates the amount and date to be paid.

Prepare Payment

The HCSP Unit prepares a payment package for each hospital for the HCSP Unit Chief's signature. Each package includes:

- A memo addressed to DHCS Medical Care Services Accounting (Accounting) Branch Chief requesting authorization for payment.
- A Medicaid Certification Form for HCSP's Unit Chief signature to ensure appropriate use of Medicaid funds.
- A copy of the support documents for Medical Care Services Deputy Director's signature.

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Department of Health Care Services Accounting Procedures

The package is reviewed by a peer for verification prior to routing to management for signatures.

Submit Payment Request

After internal signatures are obtained, HCSP Unit will:

- Make a photocopy of payment package for program files.
- Record data on spreadsheet (includes amount, date paid, and annual totals).

The payment packages are submitted to Accounting.

Medical Care Services Accounting Office

Accounting processes the payment request, and submits it to the State Controller's Office (SCO). After the payment is made, SCO will send a Remittance Advice to the HCSP Unit for verification of payment.

Verification

Quarterly review of all program expenditures ensures no yearly over spending. The Medi-Cal budget estimate is used to monitor expenditures to prevent overages.

CMAC, Accounting, and Fiscal Forecasting compare expenditures with the Medi-Cal Operations Division (SNFD) to verify amounts of payments.

VII. Disproportionate Share Hospital (DSH) Program

A. Designated Public Hospitals

Introduction

The Department of Health Care Services (DHCS) disburses about \$1 billion of the federal DSH allotment to eligible designated public hospitals annually. Hospitals that satisfy federal criteria specified in the Social Security Act, as determined by the California Medicaid State Plan (State Plan), are eligible to receive DSH program funding. The State Plan defines designated public hospitals, specifies the funding level, and describes the distribution methodology.

There are two methodologies for funding the non-federal share of DSH payments to designated public hospitals: certified public expenditures, and intergovernmental transfers. Designated public hospitals use certified public expenditures to claim DSH funding for up to 100 percent of their uncompensated care costs, and use intergovernmental transfers to claim DSH funding for up to 175 percent of their uncompensated care costs, as permitted by the Omnibus Budget Reconciliation Act of 1993.

Attachment H

Department of Health Care Services Accounting Procedures

Check Write Memorandum

The DSH Payment Unit generates a check write memorandum addressed to Electronic Data Systems (EDS), California's fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source.

The check write memorandum includes a payment authorization notice (PAN) and a memorandum to DHCS's Medi-Cal Accounting Office (Accounting). The DSH Payment Unit uses a unique PAN sequence number to identify each payment transaction. For payments using intergovernmental transfers as the non-federal share of the payment, the PAN provides Accounting with authorization to use the federal DSH allotment and intergovernmental transfer funds from the Medicaid Inpatient Adjustment Fund. The memorandum to Accounting provides instructions regarding the various funds through which the money must flow to draw federal funds.

Signature Authorization

Any individual in the DSH Payment Unit can author the EDS check write memorandum. The DSH Program signature authorization document includes the DSH Payment Unit Chief, the DSH Financing & Non-Contract Hospital Recoupment Section Chief, the Field Operations Support Branch Chief, and the Medi-Cal Operations Division Chief.

Payment Process

The payment process for designated public hospitals includes three phases.

Phase One:

Interim payments are disbursed to hospitals during and immediately after the program year. The interim payment phase includes four quarterly payments based on prior year DSH funding levels.

Phase Two:

Interim reconciliation occurs based on hospital cost reports filed seven months after the end of the state fiscal year. The reconciliation phase determines final hospital payment amounts based on actual hospital uncompensated costs. Appropriate adjustments are made to either distribute an interim reconciliation installment or recover an overpayment amount.

Phase Three:

The final reconciliation is based on audited hospital cost reports. Appropriate adjustments are made to either distribute the final installment or recover an overpayment amount.

Payment Request Submission

EDS prepares the check write computer file for submission to the State Controller's Office (SCO).

Attachment H

Department of Health Care Services Accounting Procedures

The Role of Other Offices

SCO generates and releases the warrants. The Medi-Cal Provider Branch maintains all records of provider eligibility, identification and contacts used by the DSH Payment Unit, EDS and the SCO to process the payment.

Quality Assurance

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

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

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

B. Non-Designated Public Hospitals

Introduction

The Department of Health Care Services (DHCS) disburses in the order of \$9.2 million of Disproportionate Share Hospital (DSH) Program funding to eligible non-designated public hospitals annually. Hospitals that satisfy federal criteria specified in the Social Security Act, and in the California Medicaid State Plan (State Plan), are eligible to receive DSH program funding. The State Plan defines non-designated hospitals, specifies the funding level, and describes the funding distribution methodology.

Check Write Memorandum

The DSH Payment Unit generates a check write memorandum addressed to Electronic Data Systems (EDS), the Medi-Cal fiscal intermediary. The check write memorandum specifies the funding period, the payment amount, and the funding source (50% General Fund and 50% Federal DSH allotment).

The check write memorandum includes a payment authorization notice (PAN) and a memorandum to DHCS's Medical Care Services Accounting office (Accounting). The DSH Payment Unit uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting authorization to use the General Fund and Federal DSH allotment. The memorandum to Accounting provides instructions regarding the accounting funds through which the money must flow through to draw federal funds.

Attachment H

Department of Health Care Services Accounting Procedures

Signature Authorization

The EDS check write memorandum can be authored by any DSH staff employee. The DSH Program signature authorization document includes the DSH Payment Unit Chief, the DSH Financing & Non-Contract Hospital Recoupment Section Chief, the Field Operations Support Branch Chief, and the Medi-Cal Operations Division Chief.

Payment Process

The payment process for non-designated public hospitals includes two phases.

Phase One:

During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. The interim payment phase includes three distinct cycles, as identified below:

- The first cycle, estimated payments consists of five monthly installments that are based on hospitals' DSH program funding during the previous program year.
- The second cycle, tentative payments consists of four monthly payments based on the DHCS's DSH payment procedures used in the 2004-05 DSH program year.
- The third cycle, adjusted payments consist of three additional installments after recalculating the payment amounts using appropriate corrections of hospital data.

Phase Two:

The second phase is a reconciliation based on hospital cost reports filed seven months after the end of the state fiscal year. The reconciliation phase determines final hospital payment amounts based on hospital uncompensated care costs. Appropriate adjustments are made to either distribute the final installment or recover any overpayment amounts.

Submit Payment Request

EDS prepares the check write computer file for submission to the State Controller's Office (SCO).

The Role of Other Offices

SCO generates and releases the warrants. The Medi-Cal Provider Branch maintains all records of provider eligibility, identification and contacts used by the DSH Payment Unit, EDS and the SCO to process the payment.

Quality Assurance

Annually, the DSH Eligibility Unit submits a DSH Program audit report to the Centers for Medicare & Medicaid Services as required by the Social Security Act. The DSH Payment Unit performs a final reconciliation of total DSH hospital-specific payments to ensure that funding, provided during and immediately after the project year, does not exceed appropriate

Attachment H

Department of Health Care Services Accounting Procedures

funding levels established by actual hospital uncompensated costs as required by the State Plan.

DSH program payment computations include automated verification that the federal DSH allotment, DSH State General Fund allocations, and intergovernmental transfers that make up the total DSH program funding level are not exceeded.

The DSH Payment Unit's protocols and procedures include quality audits to ensure that correct data is used appropriately and that the correct amounts are disbursed to the appropriate hospitals.

C. Private Hospitals

Introduction

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

Check Write Memorandum

The DSH Payment Unit generates a check write memorandum addressed to Electronic Data Systems (EDS), the Medi-Cal fiscal intermediary. The check write memorandum specifies the funding period, the payment amount and the funding source (50% General Fund and 50% Federal Medicaid funding).

The check write memorandum includes a payment authorization notice (PAN) and a memorandum to DHCS's Medical Care Services Accounting Office (Accounting). The DSH Payment Unit uses a unique PAN sequence number to identify each payment transaction. The PAN provides Accounting authorization to use the State General Fund and Federal Medicaid funds. The memorandum to Accounting provides instructions regarding the various funds through which the money must flow through to draw federal funds.

Signature Authorization

The EDS check write memorandum can be authored by any individual in the DSH unit. The DSH Program signature authorization document includes the DSH Payment Unit Chief, the DSH Financing & Non-Contract Hospital Recoupment Section Chief, the Field Operations Support Branch Chief, and the Medi-Cal Operations Division Chief.

Attachment H

Department of Health Care Services Accounting Procedures

Payment Process

The payment process for private hospitals includes two phases.

Phase One:

During the first phase, interim payments are disbursed to hospitals during and immediately after the program year. The interim payment phase includes three distinct cycles as identified below:

- The first cycle, estimated payments consist of 5 monthly installments that are based on hospitals DSH program funding during the previous program year.
- The second cycle, tentative payments consist of 4 monthly payments based on the DSH payment procedures used in the DSH program year.
- The third cycle, adjusted payments consist of 3 additional installments after recalculating the payment amounts using appropriate corrections of hospital data.

Phase Two:

The second phase is a reconciliation of final hospital payment amounts calculated using the most accurate data as specified in the Welfare & Institutions Code section 14166.12 and stabilization funding. Appropriate adjustments are made to either distribute the final installment or recover an overpayment amounts.

Submit Payment Request

EDS prepares the check write computer file for submission to the State Controller's Office (SCO).

The Role of Other Offices

SCO generates and releases the warrants. The Medi-Cal Provider Branch maintains all records of provider eligibility, identification and contacts used by the DSH Payment Unit, EDS and the SCO to process the payment.

Quality Assurance

Annually, the DSH Eligibility Unit submits a DSH program audit report to the Centers for Medicare & Medicaid Services as required by the Social Security Act. The DSH Payment Unit performs a final reconciliation of total DSH hospital-specific payments to ensure that funding, provided during and immediately after the project year, does not exceed appropriate funding levels established by actual hospital uncompensated costs as required by the State Plan.

DSH Program payment computations include automated verification that DSH replacement payments funded by State General Funds are correct and that the appropriate federal funding amounts are drawn down.

Attachment H

Department of Health Care Services Accounting Procedures

The DSH Payment Unit's protocols and procedures include quality audits to ensure that correct data is used appropriately and that the correct amounts are disbursed to the appropriate hospitals.

VIII. Construction/Renovation Reimbursement Program (SB 1732)

Introduction

In 1989, Senate Bill (SB) 1732 was enacted to establish the Construction/Renovation Reimbursement Program (also known as the SB 1732 program) (Welfare and Institutions Code 14085.5). Under this program, reimbursement is provided to 23 eligible hospitals for the debt service costs incurred on revenue bonds used to finance eligible hospital construction project(s).

Invoice Submittal

Invoices are submitted by participating hospitals to the Department of Health Care Services' (DHCS's) Hospital Contracts Supplemental Payments Unit (HCSPU) no more than twice each year. The invoices consist of the following:

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

Review/Record Process

HCSPU's staff verify inclusion and accuracy of all required documents in the invoice package.

Prepare Payment

HCSPU's staff calculates reimbursement amounts on a spreadsheet by:

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

Reimbursement payment package is prepared, reviewed and approved by the Inpatient Contract & Monitoring Section Chief.

Attachment H

Department of Health Care Services Accounting Procedures

Submit Payment Request

- Payment request submitted to Electronic Data Systems (EDS).
- Notification letter mailed to hospital.
- Copy of notification letter submitted to the California Medical Assistance Commission.

Payment Dispersed

- EDS forwards payment request to the State Controller's Office (SCO).
- EDS sends copy of payment request to HCSPU.
- SCO mails the payment to the hospital.

Expenditure Verification

EDS records payment amounts in their database, accessible by HCSPU and DHCS's Fiscal Forecasting Branch.

HCSPU verifies amounts from internal documentation with EDS's data.

IX. Selective Provider Contracting Program – Per Diem Payments

Introduction

The Selective Provider Contracting Program (SPCP) was established in 1982 and operated under a two-year section 1915(b) waiver until August 31, 2005. On September 1, 2005, the federal Centers for Medicare & Medicaid Services approved the continuation of a restructured SPCP under California's new five-year section 1115 Medi-Cal Hospital/Uninsured Care Demonstration. The SPCP allows the Department of Health Care Services (DHCS) to selectively contract with acute care hospitals to provide inpatient hospital care to Medi-Cal beneficiaries. Under the SPCP, the California Medical Assistance Commission (CMAC) negotiates contract terms and conditions and per diem rates with participating hospitals on behalf of DHCS. This program has resulted in millions of dollars of savings each year to both the State and Federal Government.

Contract process

CMAC submits proposed contract(s)/amendment(s) to DHCS's Hospital Contracts Administration Unit (HCAU) for review. After review, final proposed contracts/amendments are presented at a CMAC meeting for approval by the Commissioners. The approved contracts/amendments are signed by authorized hospital representatives and submitted by CMAC to HCAU for processing. The HCAU analyst prepares contract/amendment packages for processing and obtains the signature of DHCS's delegated Contract Officer (Medi-Cal Operations Division Chief) to fully execute the contracts/amendments.

Attachment H

Department of Health Care Services Accounting Procedures

Notification process

HCAU notifies DHCS's Payment Systems Division, Provider Enrollment Branch, of new per diem rates and/or new Current Procedural Terminology codes, revenue codes, and Health Care Procedure Coding System codes, to update the Provider Master File with the hospitals-specific information. This file is used by the DHCS's fiscal intermediary, Electronic Data Systems, to process and pay claims submitted by all Medi-Cal providers, including those participating in the SPCP.

Distribution process

HCAU distributes fully executed contracts/amendments to the following:

- Contracted hospital
- CMAC Executive Director
- Medi-Cal Field Office
- DHCS Audits and Investigations

Attachment I

Quarterly Report Guidelines

In accordance with Section III, paragraph 24, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 30 days after the end of each quarter.

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

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – State of California (Medi-Cal Hospital / Uninsured Care Demonstration 11-W-00193/9)

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

Example:

Demonstration Year: 2 (9/1/06 - 11/30/06)

Introduction:

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

Enrollment Information:

Please complete the following table that outlines current enrollment in each CI program under the demonstration. The State should indicate “N/A” where appropriate.

Note: Enrollment counts should be person counts, not participant months.

CI Programs	Current Enrollees (to date)

Attachment I

Quarterly Report Guidelines

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Developments/Issues:

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

Consumer Issues:

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

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

Enclosures/Attachments:

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

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The State may also add additional program headings as applicable.

Date Submitted to CMS:

Attachment J

Administrative Cost Claiming Protocol

Preface

In addition to all other amounts otherwise payable by CMS to the California Department of Health Care Services (CDHS) under the Demonstration, CMS will provide Federal financial participation (FFP) to CDHS at the regular 50 percent match rate for administrative costs including, start up, implementation and close out costs associated with the approved Coverage Initiative (referred to as the Administrative Cost Claiming Protocol) incurred on or after March 29, 2007 through August 31, 2010, subject to the limitations outlined below.

I. General Conditions

Under the Coverage Initiative Administrative Cost Claiming Protocol, the State must:

1. Obtain prior approval for the methodology used to capture administrative costs associated with the Coverage Initiative for each CI program.

OMB Circular A-87 contains the requirements regarding documentation for compensation of salary and wages and acceptable mechanisms for allocating such costs. ASMB C-10, the U.S. Department of Health and Human Services' implementation guide for OMB Circular A-87, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting.

2. Describe how it will offset other revenue sources for administrative expenditures associated with the Coverage Initiative.
3. Detail the oversight and monitoring protocol to oversee administrative claiming for the Coverage Initiative program. In addition, the State will:
 - 1) monitor the implementation process for each CI program including, but not limited to, review of training materials, observation of training, interviews with time study participants and review and verification of the claims submitted; and
 - 2) monitor the implementation of this time study to assure proper use of the time study codes by each CI program and proper application of the methodology. The State agrees to provide summary reports to the CMS Regional Office detailing the results and issues/concerns identified in the monitoring process on a quarterly basis.
4. Obtain prior approval for any new categories of administrative expenditures to be claimed under the Coverage Initiative.

Attachment J

Administrative Cost Claiming Protocol

5. Agree that any regulations or national guidelines issued by CMS, relating to the use of time study codes, methodologies for conducting time studies or other elements of claims for administrative activities will be incorporated into the Coverage Initiative based on the effective date of the applicable policy change.
6. Agree to permit CMS to review any forms and/or documents that are subsequently developed for use by this program, prior to modification or execution. These would include, but are not limited to, the time study training materials and the time study forms in use by the selected applicants.
7. Agree to submit all changes to the administrative claiming to CMS for review and approval prior to implementation.

II. Allowable Administrative Costs

The State has indicated that Coverage Initiative administrative costs will include the following:

1. Health care coverage program outreach that provides information about services; and encourages eligible low-income persons to apply.
2. Development of screening and enrollment processes and systems to identify and facilitate the enrollment of eligible low-income persons for receipt of services.
3. Health care coverage program planning to develop strategies to deliver, monitor and oversee program services.
4. Enrollment of eligible low-income, uninsured persons into health care coverage programs.
5. Development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses.
6. Data collection and analyses of reports, studies, or surveys required by DHCS or CMS.
7. Developing, monitoring and administering contracts or other arrangements with private and or other public entities for delivery of services.
8. Operations of the Coverage Initiative administrative functions, e.g. accounting, data management, staff supervision and personnel management, etc.
9. Care/case management of eligible low-income persons receiving health care coverage program services.

Of the nine above-stated administrative activities, CMS has determined the following activities may be claimed directly, with the associated costs captured through a time study methodology:

1. Program outreach;
2. Development of screening and enrollment processes and systems;
3. Programming development and planning costs;
4. Enrollment of individuals into the CI; and
9. Care and case management.

Attachment J

Administrative Cost Claiming Protocol

CMS has determined that the remaining Coverage Initiative administrative costs are typically considered overhead costs that are more appropriately captured and paid for through the use of a cognizant agency approved indirect cost rate:

5. Development and maintenance of data collection and quality monitoring systems that facilitate reporting and analyses.
6. Data collection and analyses of reports, studies, or surveys required by CDHS or CMS.
7. Developing, monitoring and administering contracts or other arrangements with private and or other public entities for delivery of services.
8. Operations of the Coverage Initiative administrative functions, e.g. accounting, data management, staff supervision and personnel management, etc.

OMB Circular A-87, Attachment A, Section F, states in part, that indirect costs are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. Amounts not recoverable as indirect costs or administrative costs under one Federal award may not be shifted to another Federal award, unless specifically authorized by Federal legislation or regulation.

DHCS must utilize the cognizant agency approved indirect cost rate to identify allowable administrative cost categories, including the four activities listed above. Additional costs outside of the indirect cost rate will not be recognized by CMS and are not eligible for FFP.

For the remaining five categories of administrative activities, additional information from DHCS is required. The State must develop and submit an Implementation Plan that includes formal mechanism (ie, a time study) to accurately capture and allocate costs in these areas. CMS will review time studies for each selected applicant or the entire program as a whole and provide approval before FFP is permitted.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY
Amended October 5, 2007**

NUMBER: 11-W-00193/9

TITLE: California Medi-Cal Hospital/Uninsured Care Section 1115
Demonstration

AWARDEE: California Department of Human Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration beginning September 1, 2005, through August 31, 2010.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers shall enable California to implement the California Medi-Cal Hospital/Uninsured Care Section 1115 Demonstration.

- 1. Overall State Plan Requirements** **Section 1902(a)**

To the extent that the State would be required to describe in its State plan the payment amount or methodology for the basic payment being made for hospitals participating in the Inpatient Hospital Component (formerly the Selective Provider Contracting Program).
- 2. Single State Agency** **Section 1902(a)(5)**

To the extent necessary to enable the California Medical Assistance Commission to conduct contract negotiations with hospitals participating in the Inpatient Hospital Component.
- 3. Institutional Payment Rate-Setting Process** **Section 1902(a)(13)(A)(i) through (iii)**

To the extent that the State would be required to set rates for hospitals using a public process.
- 4. Freedom of Choice** **Section 1902(a)(23)**

To the extent necessary to require enrollees to utilize facilities which have contracted with Medi-Cal under the Inpatient Hospital Component (formerly the Selective Provider Contracting Program).

Demonstration Approval Period: September 1, 2005 - August 31, 2010 (amended October 5, 2007)

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY
Amended October 5, 2007

NUMBER: 11-W-00193/9

TITLE: California Medi-Cal Hospital/Uninsured Care Section 1115
Demonstration

AWARDEE: California Department of Human Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by California for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration extension, be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable California to implement the California Medi-Cal Hospital/Uninsured Care Section 1115 Demonstration.

I. DEMONSTRATION ADMINISTRATION

1. **Safety Net Care Pool – Uncompensated Care.** Expenditures for otherwise unreimbursed costs of medical care incurred by identified hospitals in treating Medicaid eligible or uninsured individuals, to the extent that those costs exceed the amounts paid to the hospital pursuant to section 1923 of the Act.
2. **Safety Net Care Pool – State Expenditures.** Expenditures for medical care under the Medically Indigent Long Term Care program, Breast and Cervical Cancer Treatment Program, the California Children Services program, and the Genetically Handicapped Persons program.
3. **Excess DSH Payments.** Expenditures for payments to public disproportionate share hospitals that exceed the applicable hospital-specific payment limits (175 percent of uncompensated costs of furnishing hospital services for Medicaid and uninsured individuals) under section 1923(g) of the Act.

For demonstration years 1 and 2 only, the calculation of uncompensated costs is made without regard to Safety Net Care Pool payments claimed for that hospital.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY
Amended October 5, 2007**

Title XIX Requirements Not Applicable to Demonstration Administration Expenditures

The following provisions of title XIX (and regulations promulgated thereunder whether or not explicitly listed) are not applicable:

1. Overall State Plan Requirements **Section 1902(a)**

To the extent that the State would be required to describe in its State plan the payment amount or methodology for the basic payment being made for the inpatient hospital component.

2. Statewideness **Section 1902(a)(1)**

To the extent necessary to enable the State to vary the demonstration as needed for different geographical areas of the State.

II. HEALTHCARE COVERAGE INITIATIVE (COVERAGE INITIATIVE)

Expenditures for direct service and administrative costs related to providing health care services to uninsured individuals who do not meet Medicaid or SCHIP eligibility requirements as administered by the Coverage Initiative awardees in the list below. This Demonstration Coverage Initiative expenditure authority expressly excludes uninsured individuals who are non-qualified aliens, inmates of a public institution, or residents of an institution for mental diseases:

Alameda County Health Care Services Agency (Alameda County Excellence)

Contra Costa County (Contra Costa Health Care Coverage)

Orange County (Medical Service for Indigents Coverage Initiative)

San Diego County Health and Human Services Agency (Safety Net Access Program)

Kern Medical Center (Kern County Camino de Salud Network)

Los Angeles County Department of Health Services (Healthy Way LA)

San Francisco City and County (Health Access Program)

San Mateo Medical Center (WELL-Plus Initiative)

Santa Clara Valley Health and Hospital System (Valley Care)

Ventura County Health Care Agency (Access Coverage Enrollment Program)

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY
Amended October 5, 2007

Title XIX Requirements Not Applicable to Healthcare Coverage Initiative Expenditures

The following provisions of title XIX (and regulations promulgated thereunder whether or not explicitly listed) are not applicable:

- 1. Statewideness** **Section 1902(a)(1)**

To enable California to vary the demonstration as needed for different geographical areas of the State.
- 2. Fair Hearings** **Section 1902(a)(3)**

To enable California to not afford notice to, nor the opportunity for, a hearing to individuals applying for benefits under the Coverage Initiative.
- 3. Reasonable Promptness** **Section 1902(a)(3) and
1902(a)(8)**

To enable California to cap enrollment and maintain waiting lists for individuals enrolled in the Coverage Initiative.
- 4. Amount, Duration, and Scope of Services** **Section 1902(a)(10)(B)**

To enable California to vary the amount, duration, and scope of services to individuals enrolled in the Coverage Initiative.
- 5. Cost Sharing Requirements** **Section 1902(a)(14) insofar
as it incorporates Section
1916**

To enable California to impose premiums, enrollment fees, deductions, cost sharing, and similar charges that exceed the statutory limitations to individuals enrolled in the Coverage Initiative.
- 6. Freedom of Choice** **Section 1902(a)(23)**

To enable California to restrict the choice of an enrollee in the Coverage Initiative to a provider participating in the Coverage Initiative.
- 7. Retroactive Eligibility** **Section 1902(a)(34)**

To enable California to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made.