

DRAFT AMENDMENT
Delivery System Reform Incentive Pool Category 5 HIV Transition Projects

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

Amend STC 35 subparagraph (c) as follows:

B. Safety Net Care Pool (SNCP)

35. **Safety Net Care Pool Expenditure.** California may claim FFP for expenditures in the defined categories of spending (subparagraphs a, b, and c) subject to the spending limits defined in this paragraph (subparagraphs a, b.iii, and c.v.) for each category and subject to the limitations in Section XI of these STCs entitles “Monitoring Budget Neutrality in the Demonstration.”
- a. **HCCI.** California may spend up to \$360 million total computable per year in DY 6-8 and \$180 million total computable in DY 9 on expenditures associated with defined services and populations under the Health Care Coverage Initiative, which is part of the LIHP, as described in paragraphs 48.a.ii.
 - i. Claims for expenditures in the counties participating in the HCCI program as of November 1, 2010 are subject to the funding and claiming protocols described in Attachment G, the coverage limits in paragraphs 63.b, 63.c, and 63 d, except during the transition period (described in 35.a.v.) the HCCI counties may provide health care services in accordance with paragraph 56 of the “Medi-Cal Hospital/Uninsured Care Demonstration,” until implementation of the new LIHP, and the eligibility limits in paragraph 48a.ii.
 - ii. Additional counties seeking to participate in the HCCI program must submit funding and claiming protocols to the State. The State must then submit the protocols to CMS and may not claim FFP prior to CMS’ approval of the funding and claiming protocols.
 - iii. Spending in the HCCI is subject to the limitations described in paragraph 47 describing the HCCI Allocations.
 - iv. To the extent counties are unable to utilize the full \$360 million per year in DY 6-8 and \$180 million in DY 9 on expenditures associated with defined services and populations under the HCCI for a Demonstration year, CA may request that such funds may be available for use in one of the other three categories of SNCP spending described in 35(b)(i), 35(b)(ii) and 35(c). The State must use the process described in paragraph 7. Such redirected SNCP funds may be available for allowable expenditures incurred during the Demonstration year for which the funds were initially reserved, or may be rolled over to subsequent Demonstration years for unrestricted use SNCP expenditures subject to CMS approval.
 - v. **Transition Period.** - From the period of the effective date identified in the Demonstration approval letter through October 1, 2011 counties currently participating in the HCCI through the prior period “Medi-Cal Hospital/Uninsured Care Demonstration” and in accordance with paragraph 56 may claim FFP subject to the SNCP limits for qualifying expenditures for enrollees with family incomes from 0-200 percent FPL as the counties implement the new MCE coverage requirements consistent with Attachments G and J of the STCs for the prior Demonstration until September 30, 2011. Effective October 1, 2011 Attachments F, G and J of the STCs will need to be revised for the continuation of claiming to reflect Demonstration activity after the Transition period.

By January 1, 2011, the State will submit to CMS a plan identifying:

- A. Which counties intend to offer MCE;
- B. The upper income levels and benefit packages that the county will cover for both MCE and HCCI coverage during DY 6;
- C. The counties' plans for implementing the new MCE coverage requirements, including the counties' plans to meet any requirements not enumerated in the Demonstration waiver and expenditure authorities so that MCE requirements are fully achieved by July 1, 2011.

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

For counties that do not elect to participate in the MCE category, FFP will be claimed against the HCCI in the SNCP, subject to the SNCP limits, for all member months or costs from the effective date identified in the Demonstration approval letter.

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

- b. **SNCP Uncompensated Care.** Expenditures may be made through the SNCP for uncompensated care provided to uninsured individuals with no source of third party coverage for the services they received furnished by hospitals or other providers identified by the State. To the extent that uncompensated care expenditures are made for services furnished by entities other than the designated public hospitals, the state must identify the provider and the source of the non-federal share of the SNCP Uncompensated Care payment.
 - i. **Safety Net Care Uncompensated Care Pool** - funds may be used for expenditures for care and services **that meet** the definition of 'medical assistance' contained in section 1905(a) of the Act that are incurred by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services provided to uninsured individuals, as agreed upon by CMS and the State. Expenditures are claimed in accordance with CMS-approved claiming protocols.
 - ii. **SNCP Designated State Health Programs (DSHP).** The State may claim FFP for the following State programs subject to the annual limits described below and the restrictions described in paragraph 40 "**Prohibited Uses of SNCP funds.**" Expenditures are claimed in accordance with CMS-approved claiming protocols. The State should modify Attachment F to account for any DSHP expenditure claiming in DYs 6 through 10. No FFP is allowed until the year 6-10 DSHP claiming protocol is approved by CMS.
 - iii. **SNCP Uncompensated Care Annual Limits** – Taken together, the total computable annual limits for Safety Net Care Uncompensated Care Pool and Designated State Health Programs cannot exceed the following:

1. DY 6 - \$1.633 billion
2. DY 7 - \$1.672 billion
3. DY 8- \$1.572 billion
4. DY 9 - \$1.422 billion
5. DY 10 - \$1.272 billion

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

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

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIALTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Prostate Cancer Treatment Program (PCTP)
Cancer Detection Programs; Every Woman Counts (CDP: EWC)
County Medical Services Program (CMSP) – for the period November 1, 2010 through December 31, 2011 only
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHDP) <ul style="list-style-type: none"> • Song Brown HealthCare Workforce Training Program • Steven M. Thompson Physician Corp Loan Repayment Program • Mental Health Loan Assumption Program

- v. **SNCP Workforce Development in Low Income/Underserved Communities.** The State may claim FFP for workforce development programs funded by the Universities of California, California State Universities and/or California community colleges to the extent those programs are targeted to benefit low income populations or underserved areas and this justification must be submitted to CMS for its review and approval. The State must then obtain prior CMS approval for the methodology used to capture the workforce development costs eligible for FFP. Once all relevant approvals are obtained, CMS will add this program to the approved DSHP list.
- c. **SNCP Delivery System Reform Incentive Pool (DSRIP) Payments.** Within the SNCP, a Delivery System Reform Incentive Pool (DSRIP) is available for the development of a program of activity that supports California’s public hospitals’ efforts in meaningfully enhancing the quality of care and the health of the patients and families they serve. The program of activity funded by the DSRIP shall be foundational, ambitious, sustainable and

directly sensitive to the needs and characteristics of an individual hospital's population, and the hospital's particular circumstances; it shall also be deeply rooted in the intensive learning and generous sharing that will accelerate meaningful improvement.

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

There are [five \(54\)](#) areas for which funding [is](#) available under the DSRIP, each of which has explicit connection to the achievement of three aims:

- i. **Infrastructure Development** – Investments in technology, tools and human resources that will strengthen the organization's ability to serve its population and continuously improve its services. Examples of such initiatives drawn from the hospitals' initial proposals are:
 - A. Increase in Primary Care Capacity
 - B. Introduction of Telemedicine
 - C. Enhanced Interpretation Services
 - D. Enhanced Improvement Capacity
- ii. **Innovation and Redesign** – Investments in new and innovative models of care delivery (e.g., Medical Homes) that have the potential to make significant, demonstrated improvements in patient experience, cost and disease management. Examples of such initiatives drawn from the hospitals' initial proposals are:
 - A. Expansion of Medical Homes
 - B. Expansion of Chronic Disease Management Systems
 - C. Primary Care Redesign
 - D. Redesign for Cost Savings
- iii. **Population-focused Improvement** - Investments in enhancing care delivery for the 5-10 highest burden (morbidity, cost, prevalence, etc.) conditions in public hospital systems for the population in question. Examples of such initiatives drawn from the hospitals' initial proposals are:
 - A. Improved Diabetes Care Management and Outcomes
 - B. Improved Chronic Care Management and Outcomes
 - C. Reduction of Readmissions
 - D. Improved Quality (with attention to reliability and effectiveness, and targeted to particular conditions or high-burden problems)
- iv. **Urgent Improvement in Care** – Broad dissemination of top-level performance on 2 or 3 interventions (preferably drawn from a superset of interventions) where there is deep evidence, including evidence from within the safety net, that major improvement in care is possible within 5 years, measurable and meaningful for almost all hospital populations such as those served by the California Public Hospitals. These are hospital specific initiatives and will be jointly developed by hospitals, the State and CMS, and need not be uniform across all of the hospitals or the initiative.

[v. HIV Transition – If a government hospital, as listed in Attachment C, chooses to implement HIV Transition DSRIP, the following two categories of activities must be](#)

implemented by the participating hospital system and must be in addition to any other DSRIP projects:

A. **Infrastructure & Program Design** - These activities will enhance the ability of participating hospital systems to provide care within patient-centered medical homes, an essential building block to ensuring delivery of high-quality medical care for patients diagnosed with HIV. Examples of such activities are:

- a. Place patients into medical homes with HIV expertise
- b. Establish electronic consultation systems
- c. Development of retention programs

B. **Clinical and Operational Outcomes** - These activities will enable participating hospital systems to pursue patient outcomes across several clinical domains in order to realize concrete gains in quality and operational effectiveness that will have lasting benefits for patients. Examples of such activities are:

- a. Increase assessment and counseling to improve patients' adherence to treatment
- b. Enhance health screening
- c. Enhance HIV/AIDS health care management

v. vi. **General Overview of Payments** - Payments for ~~both the~~ Infrastructure Development and Innovation Development, Innovation and Redesign, and HIV Transition Infrastructure and Program Redesign shall be tied to process measures (e.g., successful initiation of an enhanced interpretation program, enrollment of a majority of patients into a Medical Home model). Payments related to Innovation and Redesign shall recognize that the initiatives do not guarantee outcomes, but that the milestones will result in learning, adaptation and progress. Payments for HIV Transition Clinical and Operational Outcomes shall be tied to Health Resources and Services Administration HIV/AIDS Bureau (HRSA HAB) performance measures. The total Demonstration funding for DSRIP shall not exceed total computable expenditures of ~~\$6.506~~ \$6.671 billion over five years. Annual limits on this SNCP category of spending are:

1. DY 6 - \$1.006 billion
2. DY 7 - \$1.3 billion
3. DY 8 - ~~\$1.4~~ 1.51 billion
4. DY 9 - ~~\$1.4~~ 1.455 billion
5. DY 10 - \$1.4 billion

The total annual limits of DY 8 and DY 9 include sublimits of \$110 million for DY 8 and \$55 million for DY 9, with respect to HIV Transition. The total Demonstration funding for HIV Transition activities shall not exceed total computable expenditures of \$165 million over DY 8 and DY9. For DY 9, HIV Transition activities will end on December 31, 2013. The parameters for obtaining an HIV Transition activity payment shall be detailed in a forthcoming attachment to the STCs.

vii. **Payment for both the Population-Focused Improvement and Urgent Improvement in Care** shall be tied chiefly to an organization's absolute progress from the time it initiates its improvement activities with recognition of demonstrated advancement from each facility's starting point. In some cases, it may also be tied to outcome measures (e.g., an infection rate, the rate of reliable delivery of an evidenced-based care protocol). Payments for metrics may be graduated or based on making meaningful and significant

progress rather than full achievement of a particular metric. Organizations will have the opportunity to recapture a DSRIP payment in subsequent Demonstration years upon metric/milestone achievement if the Organization does not meet a milestone /metric in the specified or targeted Demonstration year for achievement. The parameters for such recapture shall be detailed in Attachment P For all categories of payment, metrics should, whenever possible, (1) reference a nationally or statewide accepted measurement, including but not limited to CHART, HEDIS, CMS, NQF, and the U.S. Task Force on Prevention; and (2) an individual plan must include the measurement specifications for each initiative.

- vii. **Total payment amounts** available for each of the public hospital system proposal will be determined prior to submission for final approval by CMS. Each public hospital system will be responsible for developing proposals that include proposed payment mechanisms based on the metrics guidelines developed in ~~future~~ Attachment P and, with respect to HIV Transition, in a forthcoming attachment to the STCs.

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

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

- ixviii. **Finalize DSRIP Protocol** - Within the 60 days following the acceptance of the terms and conditions, CMS, the State and the California Association of Public Hospitals will, through a collaborative process, develop a blueprint to move quickly forward to develop more specific standards, measures and evaluation protocols with the intention of clarifying requirements and expediting the approval of the plans. Specifically, the deliverable will be future Attachment Q and will:
- A. Develop standard metrics for both process measures and absolute improvement measures;
 - B. Finalization of scorecard process and metric grouping to measure project progress;
 - C. Finalization of payment mechanisms for projects based the agreed upon metrics;
 - D. Finalize a State review process that will assure action on the proposal within 30 days of submission by the hospitals. Approval results in submission to CMS by the State for approval of DSRIP funding.

- E. Finalize a review and approval process for proposals received by CMS that assures action on the proposal with 30 days from submission by the State; finalize a process for ongoing support and collaboration, annual reporting process and project coordination.

The provisions of this subparagraph ix shall be applicable to the new DSRIP payment provisions set forth in subparagraph 35.c. A blueprint for the development of a DSRIP protocol, as described in the first sentence of this subparagraph ix, will be developed within 60 days following the acceptance of the amendments to the terms and conditions that include changes to the payment provisions set forth in subparagraph 35.c.

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

Amend STC 103 subparagraph (b) as follows:

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

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

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

- a. All Demonstration expenditures claimed under the authority of Title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, costs settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.c. For any other costs settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on Lines 9 and 10.c., as instructed in the SMM. The term "expenditures subject to the budget neutrality cap," is defined in paragraph 104.

- b. For each Demonstration year, twenty-nine^{five} (29²⁷) separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed to report expenditures for the following Demonstration expenditures. The specific waiver names to be used to identify these separate Forms CMS-64.9 Waiver and/or 64.9P Waiver appear in brackets below:
- i. Safety Net Care Pool – Hospital Services [SNCP-Hosp.];
 - ii. Safety Net Care Pool – Non-Hospital Services [SNCP – Non-Hosp.];
 - iii. Family & Children – [Families];
 - iv. Existing Seniors & People with Disabilities [Existing SPD];
 - v. Newly Mandatory Seniors & People with Disabilities [Mandatory SPD];
 - vi. Low Income Health Program/ Medicaid Expansion [MCE]
 - vii. Low Income Health Program / Health Care Coverage Initiative [SNCP - HCCI];
 - viii. California Children Services [CCS – State Plan]
 - ix. California Children Services - Designated State Health Program [CCS - DSHP]
 - x. Genetically Handicapped Persons Program - Designated State Health Program [GHPP – DSHP]
 - xi. Medically Indigent Adult Long Term Care - Designated State Health Program [MIALTC – DSHP]
 - xii. Breast & Cervical Cancer Treatment Program - Designated State Health Program [BCCTP – DSHP]
 - xiii. AIDS Drug Assistance Program - Designated State Health Program [ADAP- DSHP]
 - xiv. Expanded Access to Primary Care - Designated State Health Program [EAPC- DSHP]
 - xv. Department of Developmental Services - Designated State Health Program [DDS – DSHP]
 - xvi. Workforce Development Programs - Designated State Health Program [Work – DSHP]
 - xvii. Private and Non-Designated Government-Operated Hospital Payments [P/ND Govt. Hosp];
 - xviii. Designated Government-Operated Hospital Payments [D. Govt. Hosp];
 - xix. Delivery System Reform Incentive Pool - Infrastructure Development [DSRIP - Cat 1];
 - xx. Delivery System Reform Incentive Pool - Innovation & Redesign [DSRIP – Cat 2];
 - xxi. Delivery System Reform Incentive Pool – Population –focused Improvement [DSRIP – Cat 3];
 - xxii. Delivery System Reform Incentive Pool – Urgent Improvement in Care [DSRIP – Cat 4];
 - xxiii. [Delivery System Reform Incentive Pool – HIV Transition, Improvements in Infrastructure and Program Design \[DSRIP – Cat 5A\]](#)
 - ~~xxii-xxiv.~~ [Delivery System Reform Incentive Pool – HIV Transition, Improvements in Clinical and Operational Outcomes \[DSRIP – Cat 5B\]](#)
 - ~~xxiii-xxv.~~ County Mental Health Services [CMHS – DSHP];
 - ~~xxiv-xxvi.~~ Every Woman Counts [EWC – DSHP]
 - ~~xxv-xxvii.~~ IMProving, Counseling & Treatment [IMP – DSHP]
 - ~~xxvi-xxviii.~~ Community Based Adult Services [CBAS]
 - ~~xxvii-xxix.~~ Enhanced Case Management [ECM]

- c. For each Demonstration year, a separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver must be completed to report expenditures for the following Demonstration expenditures. The

specific waiver names to be used to identify these separate Forms CMS-64.21U Waiver and/or 64.21UP Waiver appear in brackets below:

- i. MCHIP [MCHIP]