CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00193/9

TITLE: California Bridge to Reform Demonstration

AWARDEE: California Health and Human Services Agency

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, be regarded as expenditures under the Stat's title XIX plan. The expenditure authority period of this Demonstration is from the approval date identified in the Demonstration approval letter through ~~December 31, 2013~~October 31, 2015, except that the expenditure authority for the ~~SNCP Uncompensated Care, Delivery Reform Incentive Pool and Designated State Health Care Programs~~Low Income Health Program (Medicaid Coverage Expansion and the Health Care Coverage Initiative) extends through ~~October 31, 2015~~December 31, 2013.

The following expenditure authorities shall enable California to implement the California Bridge to Reform Demonstration. There are additional individual limitations on expenditure authorities as outlined below.

I. SAFETY NET CARE POOL PROGRAM

Subject to an overall cap on the Safety Net Care Pool (SNCP), the following expenditure authorities are granted for the period of the Demonstration:

A. **Provider and Program Support:** Authority for (a) (b), and (c) shall apply from the date of the approval letter through October 31, 2015.

a. Uncompensated Care. 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, providers and clinics for uncompensated medical care costs of medical services provided to Medicaid eligible or uninsured individuals, and to the extent that those costs exceed the amounts paid to the hospital pursuant to section 1923 of the Act.

b. Designated State Health Care Programs (DSHP). Expenditures for DSHP, which are otherwise state-funded programs that provide services as specified in the funding and reimbursement protocol for the SNCP.

1. Expenditures for medical care under:

i. Breast and Cervical Cancer Treatment Program (BCCTP);
ii. Medically Indigent Adults/Long Term Care (MIA/LTC) Program;
iii. California Children's Services (CCS) Program, individuals in the Medicaid State plan are excluded;

iv. Genetically Handicapped Persons Program (GHPP);
v. Expanded Access to Primary Care (EAPC); and
vi. AIDS Drug Assistance Program (ADAP).
vii. Departmental of Developmental Services (DDS)
viii. County Mental Health Services

2. Expenditures for workforce development programs related to medically disadvantaged service areas:

i. Office of Statewide Health Planning & Development

a. Song Brown HealthCare Workforce Training
b. Health Professions Education Foundation Loan Repayment
c. Mental Health Loan Assumption.
d. Training program for medical professionals at CA Community Colleges, CA State Universities, and the University of California.

c. Delivery Reform Incentive Pool. Expenditures for incentive payments from a Delivery System Reform Incentive Pool.

d. New Health Care Coverage Initiative (HCCI) Recipient: From the date of the approval letter through December 31, 2013, expenditures for adults between 19 and 64 years of age who have family incomes above 133 through 200 percent of the FPL, or as set by an HCCI participating county, based on available funding as described in the Safety Net Care Pool STCs.

e. Existing Health Care Coverage Initiative (HCCI) Recipient: From the date of the approval letter through December 31, 2013, expenditures for individuals whose income is above 133 through 200 percent of the FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver," but who do not meet the income eligibility requirements under the Demonstration for the Low Income Health Program in their county of residence, based on available funding as described in the Safety Net Care Pool STCs.

f. Existing Medicaid Coverage Expansion (MCE) Recipient: From the date of the approval letter through December 31, 2013, expenditures for individuals whose income is at or below 133 percent of the FPL, and who were enrolled in the "Medi-Cal Hospital/Uninsured Care Waiver," but who do not meet the income eligibility requirements under the Demonstration for the Low Income Health Program in their county of residence, based on available funding as described in the Safety Net Care Pool STCs.

II. **DEMONSTRATION POPULATION**

a. **Medicaid Coverage Expansion (MCE) Recipient**: Expenditures for medical assistance furnished to individuals who meet county residency requirements of a participating county, U.S. citizenship or qualified alien requirements, are not eligible for Medicaid or CHIP, are

not pregnant, are between 19 and 64 years of age, have family incomes at or below a county-established standard that shall not exceed 133 percent of the FPL.

III. **Expenditures Related to Delivery Systems for the Low Income Health Populations.**

1. Expenditures under contracts with county-based delivery systems that do not meet the requirements in section 1903(m)(2)(A) of the Act regarding managed care organizations (MCOs), specified below. The county-based delivery systems providing services under this demonstration shall meet all requirements of section 1903(m)(2)(A) except the following:

- Section 1903(m)(2)(A)(vi) insofar as it requires compliance with section 1932(a)(4) of the Act regarding the ability of enrollees to disenroll from a managed care entity. Enrollees" right to disenroll from a county-based delivery system will be restricted.
- Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(a)(3)(A) in counties without health-insuring organizations by offering a choice of at least two managed care organizations to enrollees. Enrollees shall have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c).
- Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(b)(2) regarding payment of emergency services furnished by non-contracted providers. Payments made by county-based delivery systems for out-of-network emergency services may differ from the requirements in statute.
- Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(b)(5) regarding network adequacy. The State will be required to ensure that county-based delivery systems comply with the network adequacy requirements set forth in the STCs.
- Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(c)(1) and Federal regulations at 42 CFR 438.200-204 regarding development of a State quality strategy. The State will not be required to develop a quality strategy but will be required to ensure that county-based delivery systems comply with the standards and requirements set forth in the STCs.
- Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(c)(2) regarding an external independent review of managed care activities. The State will not be required to provide for an external quality review of county-based delivery systems.
- Section 1903(m)(2)(A)(xii) but only insofar as it requires compliance with section 1932(d)(2) regarding marketing restrictions. The county-based delivery systems do not have to comply with the limitations on marketing activities.

IV. Expenditures Related to Community Based Adult Services (CBAS) and Enhanced Case Management (ECM).

A. CBAS Benefits – From April 1, 2012 through August 31, 2014, expenditures for CBAS services furnished to individuals who meet the level of care or other qualifying criteria.
B. ECM Benefits – From April 1, 2012 through August 31, 2014, expenditures for ECM services furnished to individuals who meet the level of care or other qualifying criteria.

V. Expenditures Related to Targeted Low-Income Children (TILC) eligible under 1902(a)(10)(A)(ii)(XIV).

A. Beginning January 1, 2013, expenditures for children enrolled in a Healthy Families Health Program (HFP) health plan that is also a Medi-Cal managed care health plan in their county of residence (Phase 1).
B. Beginning April 1, 2013, expenditures for children enrolled in a HFP health plan that is also a subcontractor of a Medi-Cal managed care health plan in their county of residence (Phase 2).
C. Beginning August 1, 2013, expenditures for children enrolled in a HFP health plan that is not a Medi-Cal managed care health plan and does not contract or subcontract with a Medi-Cal managed care health plan (Phase 3).
D. Beginning September 1, 2013, expenditures for children enrolled in a HFP health plan that is not a Medi-Cal managed care health plan and for uninsured children ages 6 and older residing in a county that was not a Medi-Cal managed care county at the time of the approval of this Amendment to the Bridge to Health Care Reform (Waiver number 11-W00193/9) but becomes a Medi-Cal managed care county (Phase 4).
E. From the date of approval of the waiver amendment authorizing the TILC Program, expenditures for children who are not enrolled in a HFP health plan and are eligible for the TILC Program.

Title XIX Requirements not Applicable

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to expenditures for the Low Income Health (HCCI and MCE) populations.

1. **Reasonable Promptness** — **Section 1902(a)(8) only waived for purposes below**

   To enable individual counties to cap enrollment and maintain waiting lists for applicants.

2. **Amount, Duration, and Scope of Services** — **Section 1902(a)(10)(B)**

   To enable California to vary the level of benefits to individuals within each Demonstration population by county and to provide benefit packages in the Low Income Health program that differ from the State Plan benefit package and vary among the Low Income Health program.

3. **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 Low Income Health program.

4. **Retroactive Eligibility** — **Section 1902(a)(34)**

To enable California to waive or modify the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for the Low Income Health program.

5. **Early Periodic Screening Diagnosis and Treatment (EPSDT) Section 1902(a)(43)**

To the extent necessary to enable the State to not provide coverage of early and periodic screening, diagnostic and treatment services to 19- and 20-year-old individuals in the Low Income Health program.

6. **Comparability Section 1902(a)(10)(B) and (a)(17)**

To permit the State to apply differences in eligibility standards among counties for the Low Income Health program and to permit the State to transition Healthy Families Program subscribers into its Medi-Cal Targeted Low-Income Children's (TLIC) Program in phases.

7. **Single State Agency Section 1902(a)(5)**

To the extent necessary to enable the California to allow county health department employees to determine eligibility for the Low Income Health program.