II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

With the approval of the State's section 1115(a) Demonstration in September 2005, the State was provided the authority to receive federal matching funding for a Safety Net Care Pool (SNCP) through which the State made total computable payments of up to $1.532 billion per year for 5 years (total of $7,660,000,000) for medical care expenditures for the uninsured and for the expansion of health care coverage to the uninsured. Of this annual $1.532 billion total computable expenditure, $360 million (total computable) per year was defined as "restricted use SNCP funds," and federal matching was conditioned on the State meeting specified milestones. In Demonstration Years 1 and 2 the restricted use funds were tied to goals associated with the expansion of managed care to the Aged, Blind, and Disabled population in the State. The State failed to meet these milestones. In Demonstration Years 3, 4, and 5 the restricted use funds were tied to goals for expansion of health care coverage to uninsured individuals.

In October 2007, the State (for Demonstration Years 3, 4 and 5) amended the Demonstration to meet the milestones for coverage expansion through the development and implementation of a Health Care Coverage Initiative (HCCI) that expanded coverage options for uninsured individuals in the State. The State designed the HCCI to utilize existing relationships between the uninsured and safety net health care systems, hospitals, and clinics and has been constructed to:

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.

During SFY 2009, California reported that it began to experience significant fiscal difficulties that impacted the Medi-Cal program, and the safety net health care system in the State. In July, 2009 the State requested amendments to the STCs in order to: 1) reflect the American Reinvestment and Recovery Act (ARRA) FMAP rates for Safety Net Care Pool (SNCP) expenditures; 2) expand the Health Care Coverage Initiative (HCCI), and 3) include in the Demonstration certain previously State-only funded health care programs. This amendment was approved by CMS effective February 1, 2010.

The July 2009 amendment request also included a proposal for CMS to recognize a new set of milestones in Demonstration Year (DY) 5. These milestone programs included: disease management pilot programs; and care coordination programs. In exchange for the State achieving various enrollment goals in the stated milestone programs, California proposed that CMS include in the Demonstration an array of Designated State Health Programs (representing $720 million total computable expenditures in Demonstration Year 5).

On June 3, 2010 the State submitted a section 1115 Demonstration proposal as a bridge toward full health care reform implementation in 2014. The State's proposal seeks to: phase in coverage in individual counties for adults aged 19-64 with incomes at or below 133 percent of the federal poverty level (FPL), who are eligible under the new Affordable Care Act State option and adults between 133 percent - 200 percent of the FPL who are not otherwise eligible for Medicaid; expand the existing Safety Net Care Pool (SNCP) that was established to ensure continued government support for the provision of health care to the uninsured by hospitals, clinics, and other providers; implement a series of infrastructure improvements through a new funding sub-pool, that would be used to strengthen care coordination, enhance primary care and improve the quality of patient care; create coordinated systems of care for

Seniors and Persons with Disabilities (SPDs) in counties with new or existing Medi-Cal managed care organizations through the mandatory enrollment of the population into Medicaid managed care plans.

On January 10, 2012 the State submitted an amendment to the Demonstration which was approved on March 31, 2012, to provide an outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to Medi-Cal beneficiaries enrolled in a managed care organization. The demonstration amendment will research and test whether individuals enrolled in CBAS who have an organic, acquired, or traumatic brain injury and/or chronic mental illness, maintain or improve the status of their health. Some beneficiaries who previously received adult day health care (ADHC) services (which will no longer be offered as an optional benefit under the State Plan) and, because a difference in the level of care criteria, will not qualify for CBAS services will instead receive a more limited "Enhanced Case Management" (ECM) benefit. ECM is a service that provides person centered planning including coordination of medical, social, and education supports.

Effective with the June 28, 2012 approval the State and CMS revised the demonstration to include the following amendments:

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

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

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

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

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement[s] will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation actually becomes effective, on the first day of the calendar quarter beginning after the legislature has met for six months in regular session after the effective date of the change in federal law, or such other date provided for in the applicable federal law.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If

1903(w) of the Social Security Act or using Federal funds other than Medicaid funds (unless the other Federal funding source by law allows use of federal funds for matching purposes, and the federal Medicaid funding is credited to the other federal funding source). To the extent that the funding source for expenditures is a state program funded through this Demonstration, expenditures may be certified only as a total computable expenditure under such program. The State may not claim federal matching funds for a payment to a provider and also claim federal matching funds on the underlying expenditure certified by the provider, except to the extent that the State has an auditable methodology to prevent duplicate claims (such as one that limits claims for federal matching based on the certified expenditure to the shortfall after accounting for the claimed payment). For this purpose, Federal funds do not include, DSRIP Payments, patient care revenue received as payment for other services rendered under programs such as DSHP, LIHP, Medicare or Medicaid. To ensure that there is no double claiming of federal funding under the DSHP and LIHP, a detailed protocol will be developed outlining the procedures to be followed for claiming under this paragraph.

37. **Payments to Hospitals.** Under this Demonstration, payments to hospitals may include supplemental 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 and 14085.57. To the extent that the State continues to make these payments, such payments may be funded by the State general fund, by CPEs and shall be considered Medicaid revenue that must be offset against uncompensated costs eligible for Disproportionate Share Hospital (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.

B. Safety Net Care Pool (SNCP)

38. **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 51.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 66.b, 66.c, and 66 d, except during the transition period (described in 38.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 51a.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 50 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

38(b)(i), 38(b)(ii) and 38(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 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 enrollees with family incomes from 0 to 133 percent FPL. For enrollees with family incomes above 133 up to 200 percent FPL, FFP claimed from November 1, 2010 will be subject to the SNCP limits.

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 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 43 "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 through10. No FFP is allowed until the year 6-10 DSHP claiming protocol is approved by CMS.

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

- Participating tribal facilities shall maintain policies for furnishing services to non-IHS beneficiaries that are in place as of January 1, 2013.

- Payments shall be based on the approved methodology set forth in Attachment F – Supplement 7.

iv. **SNCP Uncompensated Care Annual Limits** – Taken together, the total computable annual limits for Safety Net Care Uncompensated Care Pool and Designated State Health Programs cannot exceed the following:

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

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

Notwithstanding the total computable annual limits specified above, reallocated funds in the amount of $97 million and $26 million, from the HCCI component from DY8 and

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

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

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

v. **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 (OSHPD) • Song Brown HealthCare Workforce Training Program • Steven M. Thompson Physician Corp Loan Repayment Program • Mental Health Loan Assumption Program

vi. **<u>SNCP Workforce Development in Low Income/Underserved Communities</u>.** 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