

**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 State's title XIX plan. The expenditure authority period of this demonstration is from the effective date identified in the demonstration approval letter through December 31, 2013, except that the expenditure authority for the SNCP Uncompensated Care, Delivery System Reform Incentive Pool (Item I.c below.) and Designated State Health Care Programs (Item I.b below) extends through October 31, 2015, and the expenditure authority for the SNCP Uncompensated Care for certain services for Indian Health Service (IHS) and tribal facilities (Item I.f.2 below) extends through December 31, 2014.

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:

Provider and Program Support: Authority for (a) (b), and (c) shall apply from the effective date identified in the demonstration 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;

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- 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 System Reform Incentive Pool.** Expenditures for incentive payments from a Delivery System Reform Incentive Pool and from July 1, 2012, through December 31, 2013, expenditures for incentive payments for the HIV Transition Projects defined in STC 39.c.v. of the Delivery System Reform Incentive Pool.
- d. New Health Care Coverage Initiative (HCCI) Recipient:** From July 1, 2011 through December 31, 2013, expenditures for New HCCI Recipients defined in Paragraphs 39 and 52 of the STCs who have family incomes above 133 through 200 percent of the FPL based on available funding as described in the Safety Net Care Pool STCs.
- e. Existing Health Care Coverage Initiative (HCCI) Recipient:** From the effective date identified in the demonstration approval letter through December 31, 2013, expenditures for Existing HCCI Recipients defined in Paragraphs 39 and 52 of the STCs whose family income is above 133 through 200 percent of the FPL, based on available funding as described in the Safety Net Care Pool STCs.
- f. Uncompensated care for Indian Health Service (IHS) and tribal facilities:** Expenditures for supplemental payments to participating IHS and tribal facilities to take into account the burden of:
- 1) uncompensated primary care services furnished to uninsured individuals with incomes up to 133 percent of the Federal Poverty Line (FPL) who are not enrolled in a Low-Income Health Program (LIHP);and
 - 2) uncompensated services for which Medi-Cal coverage was eliminated by SPA 09-001, furnished to such uninsured individuals and to individuals enrolled in the Medi-Cal program.

Computation of such payments shall be based on the applicable published IHS encounter rate.

II. DEMONSTRATION POPULATION

A. **New and Existing Medicaid Coverage Expansion (MCE) Recipient:** From the effective date identified in the demonstration approval letter through December 31, 2013, 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.

B. **Healthy Family Program (HFP) Transition Children and New Enrollees:** Effective January 1, 2013 through no later than December 31, 2013, expenditures for medical assistance furnished to uninsured children with family income up to 250 percent of the FPL not otherwise eligible under the state plan who are either: a) transition children previously enrolled in the state's separate CHIP who meet the conditions for phased-in enrollment in the demonstration population described in Section XVIII.E of the STCs; or b) new enrollees who would otherwise meet the eligibility criteria for enrollment in the state's approved separate CHIP.

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

- A. 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:
1. 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 to the conditions detailed within STC paragraph 66 entitled "Disenrollment of Recipients."
 2. 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).
 3. 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.
 4. 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.
 5. 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.

6. 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.
7. 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.

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)(17)

To permit the state to apply differences in eligibility standards among counties for the Low Income Health program.

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.

8. Periodic Redeterminations of Medicaid Eligibility

Section 1902(a)(17)

To the extent necessary to enable the counties to not to perform redeterminations for Low Income Health program beneficiaries between October 1, 2013 and December 31, 2013.