

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
SPECIAL TERMS AND CONDITIONS  
Amended Effective January 1, 2014**

**NUMBER: 11-W-00193/9**

**TITLE: California Bridge to Reform Demonstration**

**AWARDEE: California Health and Human Services Agency**

**I. PREFACE**

**II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT**

As part of California's 2012-13 budget, the Coordinated Care Initiative (CCI) was adopted to better coordinate Medicare and Medicaid benefits for dual eligibles, mandatorily enroll dual eligibles into managed care plans and to include long term services and supports (LTSS) as managed care benefits [Chapter 33, Statutes of 2012, Senate Bill (SB) 1008 and Chapter 45, Statutes of 2012, SB 1036, Committee on Budget and Fiscal Review]. The primary goals and objectives of the CCI are to improve health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs), while achieving savings from rebalancing service delivery away from institutional care and into the home and community.

The CCI is authorized in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara and is effective no sooner than January 1, 2014.

The three major components of the CCI are:

- 1. *Cal MediConnect:*** A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries that will coordinate medical, behavioral health, long-term institutional, and home- and community-based services through a single health plan.

The framework for the Cal MediConnect program was approved by the federal Centers for Medicare & Medicaid Services (CMS) and documented in a Memorandum of Understanding (MOU) between CMS and the California Department of Health Care Services (DHCS). This waiver amendment requests approval of all provisions of the MOU as necessary to implement and operate the Cal Medi-Connect program. The MOU was signed on March 27, 2013 and is available at the following link: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>

- 2. *Mandatory Enrollment of Dual Eligibles into Medi-Cal Managed Care:*** All dual eligible beneficiaries, subject to certain exceptions, will be mandatorily enrolled in a Medi-Cal managed care organization to receive their Medi-Cal benefits. This includes beneficiaries who opt out or are excluded from enrollment in a Cal MediConnect plan.

- 3. *Inclusion of Long Term Services and Supports (MLTSS) in Managed Care (MLTSS):*** Beneficiaries enrolled in a Medi-Cal managed care organization or a participating Cal MediConnect plan will receive their long-term services and supports (LTSS) through the plans.

Long-term services and supports includes home- and community-based services such as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), 1915(c) waiver

programs, Multipurpose Senior Services Program (MSSP), in addition to nursing facility care services.

The sunset date for the three-year Demonstration is anticipated to be December 31, 2016. The 1115 waiver is approved through October 31, 2015, and will need to be assessed for a time extension as part of this amendment.

### III. GENERAL PROGRAM REQUIREMENTS

No changes necessary for this amendment.

### IV. GENERAL REPORTING REQUIREMENTS

**21. 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;

- a. The health care delivery system;
- b. The Medicaid Coverage Expansion (MCE) program;
- c. The Health Care Coverage Initiative (HCCI) program;
- d. The Seniors and Persons with Disabilities (SPD) Program
- e. The Community Based Adult Services (CBAS) Program, including Enhanced Case Management (ECM) Services;
- f. California Children's Services (CCS) Program;
- g. Healthy Families Children Transition to the Demonstration;
- h. Designated State Health Programs (DSHP) receiving federal financial participation. – as defined within these STCs;
- i. Enrollment, quality of care, access to care;
- j. The benefit package, cost-sharing;
- k. Audits, lawsuits;
- l. Financial reporting and budget neutrality issues;
- m. Progress on evaluations;
- n. State legislative developments;
- o. Any Demonstration amendments, concept papers or State plan amendments the State is considering submitting;
- p. **The Cal MediConnect Program; and**
- q. **The Managed Long-Term Services and Supports (MLTSS) Program.**

**24. Demonstration Annual Report.** The state will 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 will submit the draft annual report no later than 120 days after the end of each demonstration year. Within 60 days of receipt of comments from CMS, a final annual report will be submitted for the demonstration year to CMS. The annual report will also contain:

- a. The previous State fiscal year appropriation detail for those state programs referenced in paragraph 38.b.ii, which are permissible expenditures under the Safety Net Care Pool.
- b. The progress and outcome of program activities related to the:
  - a. MCE;

- b.HCCI;
- c.SPD program;
- d.CBAS program;
- e.CCS Program;
- f. Healthy Families Children Transitioning to the Demonstration;
- g. Cal MediConnect program; and
- h. Managed Long Term Services and Supports (MLTSS) program.

**V. GENERAL FINANCIAL REQUIREMENTS PAYMENTS FOR MEDICAID-ELIGIBLE PATIENTS**

No changes necessary for this amendment.

**VI. STATE PLAN AND DEMONSTRATION POPULATIONS AFFECTED BY THE DEMONSTRATION**

51. **Eligibility:** Certain State plan eligibles and Demonstration populations authorized under the expenditure authorities are affected by the Demonstration. The Medicaid Coverage Expansion (MCE) population, described below in 51.a.i., and CCS with special health care needs population, described below in 51.b., are subject to all applicable Medicaid laws and regulations except as expressly waived or described herein. The Health Care Coverage Initiative (HCCI) population, described below in 51.a.ii., are subject to Medicaid laws or regulations except as specified in the expenditure authorities or described herein for these Demonstration populations.

g. Cal MediConnect eligible populations: are individuals age 21 and older with full-scope Medicare and Medi-Cal coverage and reside in one of the CCI authorized counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Populations excluded from enrollment in CalMediConnect include the following:

- Beneficiaries with other private or public health insurance.
- Beneficiaries with developmental disabilities receiving services through a Department of Developmental Services (DDS) 1915(c) waiver; regional center; state developmental center; or intermediate care facilities for the developmentally disabled (ICF/DD).
- Beneficiaries enrolled in the following 1915(c) waivers: Nursing facility/acute hospital waiver service, HIV/AIDS waiver services, assisted living waiver services, and In-Home Operations waiver services.
- Beneficiaries residing in designated rural zip codes.
- Beneficiaries residing in a veterans' home of California.
- Beneficiaries with end stage renal disease (ESRD) in all counties except for San Mateo and Orange. (If a beneficiary develops ESRD after enrolling in a Cal MediConnect plan, he or she may stay enrolled in that plan.)
- Beneficiaries enrolled in a Program of All-Inclusive Care for the Elderly (PACE).
- Beneficiaries enrolled in the AIDS Healthcare Foundation.

h. Managed Long-Term Services and Supports (MLTSS) Populations: are individuals age 21 and older and includes dual eligible beneficiaries who opt out or are excluded from the Cal MediConnect program and Medi-Cal only SPDs who were previously excluded from the mandatory managed care SPD transition program, and reside in one of the following counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San

Mateo, and Santa Clara. Populations excluded from mandatory managed care enrollment include:

- Beneficiaries with developmental disabilities residing in an intermediate care facility for the developmentally disabled (ICF/DD) in except for San Mateo and Orange counties.
- Beneficiaries residing in a veterans' home of California.
- Beneficiaries with other health insurance, except in San Mateo and Orange counties.
- Beneficiaries enrolled in PACE.
- Beneficiaries enrolled in the AIDS Healthcare Foundation.
- Beneficiaries in designated rural zip codes.
- Medi-Cal-only beneficiaries excluded due to an approved Medical Exemption Request.

## VII. DEMONSTRATION DELIVERY SYSTEMS

61. **Transition of the Multipurpose Senior Services Program (MSSP) 1915 (c) Home and Community Based Services (HCBS) program into the Demonstration.** Payment for the MSSP 1915 (c) waiver services will be included in the MCO capitation payments from the State. Eligible beneficiaries in the eight CCI counties who are participating in the MSSP waiver will be allowed to join the Cal MediConnect program, if eligible, or mandatorily enrolled in an MCO. The Cal MediConnect plans and Medi-Cal only managed care plans will be required to contract with MSSP providers to ensure on-going access to MSSP waiver services for enrolled beneficiaries. MSSP waiver providers will continue to provide the same services to MSSP Waiver participants/clients; however, they will receive payment for Medi-Cal managed care members from the MCOs. These requirements shall be outlined in the MCO and MSSP Waiver provider contracts.

## VIII OPERATION OF DEMONSTRATION PROGRAMS

### F. Managed Care Delivery Systems for the Coordinated Care Initiative (CCI)

#### 119. CCI Enrollment Processes

- b. **Cal MediConnect Enrollment** – Effective no sooner than January 1, 2014, the State may begin enrollment of beneficiaries eligible for the Cal Medi-Connect program. Enrollment will be phased in over a 12-month period with enrollment periods specific to each county depending on the demographics and size of the eligible population. Beneficiaries will be passively enrolled into a participating Cal MediConnect plan if they do not make an active choice to opt out of the program. Beneficiaries who opt out of Cal MediConnect, will remain in their existing Medicare program and be enrolled in a Medi-Cal managed care plan for coverage their Medi-Cal benefits, including LTSS. Beneficiaries may opt out of the Cal MediConnect program at any time.
- b. **MLTSS mandatory enrollment** – Dual eligibles who opt out or are excluded from the Cal MediConnect program, and Medi-Cal only SPDs who were previously excluded from the SPD mandatory enrollment program will be mandatorily enrolled into a Medi-Cal managed care plan effective no sooner than January 1, 2014. The mandatory enrollment of the eligible

individuals will apply to new or existing Medi-Cal beneficiaries when the plan or plans in the geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access to care, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The enrollment may be tailored for each county as appropriate to address the specific demographics and population of each county.

Notwithstanding the provisions under paragraph 80, dual eligibles enrolled in a Medicare Advantage plan may be mandatorily enrolled in a Medi-Cal managed care plan that is not operated by the same parent organization for their Medi-Cal and Medicare wrap around benefits. This is applicable only in the eight authorized CCI counties.

- c. **Choice** - For counties that do not operate a County Organized Health Systems (COHS), the State will ensure that at the time of enrollment, the individuals will have an opportunity to choose from the managed care health plans and providers available to the specific population groups. If the beneficiary does not choose a health plan, they will receive a default plan assignment as described below. For counties that operate a COHS, the State will ensure individuals have a choice of providers.
- d. **Approaches to Default**
  - i. For individuals who do not make an affirmative choice, and after repeated efforts (letter, followed by at least 2 phone calls) to encourage choice, the State will identify individual claims and data to make a default selection into a plan based on usual and known sources of care, including previous providers, and utilization history, including use of particular specialty and LTSS providers data. Default enrollees will have the opportunity to see their existing Medi-Cal providers for a period of 12 months after enrollment. The default shall not occur until education and outreach efforts are conducted as noted above. When an assignment cannot be made based on affirmative selection or utilization history, plan assessment shall be based on factors such as plan quality and safety net providers in a plan's network.
  - ii. At least 60 days prior to the effective implementation date, the State will provide documentation and assurances for CMS review, that the infrastructure is in place at the State level, and across the plans, to effectively manage the default selection process.
  - iii. DHCS shall submit to CMS for review the enrollment broker protocol and business rules for default process, and documentation requirements for failed affirmative selection leading to plan default assignment. Such protocol should, in circumstances where available data and utilization is insufficient to provide a clear, reasonable default selection, provide for pre-default assessment to determine individual needs.
  - iv. DHCS shall inform individuals of their opportunity to change plans at any time.

## **120. Benefit Package**

- a. Beneficiaries enrolled in a Cal MediConnect plan or a Medi-Cal managed care plan will be eligible for Medi-Cal benefits as identified in Attachment N – Capitated Services List/Managed Care Benefit Package. Attachment N has been updated to include the additional long term services and supports authorized under the CCI. The State will assure that enrolled individuals have referral and access to State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and will also assure referral and coordination with services not included in the established benefit package.

- b. Effective in the authorized CCI counties, managed care benefits for the eligible Cal MediConnect and MLTSS populations will be expanded to include the following long term services and supports (LTSS) as specified in Attachment N:
- In-home supportive services (IHSS);
  - Multipurpose Senior Services Program (MSSP) services as defined in the 1915(c) waiver; and
  - Skilled Nursing Facility services and Intermediate Care Facility services.

All services will be provided in a manner that is fully compliant with requirements of the Americans with Disabilities Act (ADA), as specified by the *Olmstead* decision. DHCS will ensure, through ongoing surveys and readiness and implementation monitoring, that Participating Plans provide for enrollees long-term services and supports in care settings appropriate to their needs.

## **121. Consumer Assistance**

- a. **Initial and On-going Outreach and Communication Strategy** – The State shall develop an outreach and education strategy to explain the changes to individuals who are impacted by the Coordinated Care Initiative. The strategy shall describe the State’s planned approach for advising individuals regarding health care options utilizing an array of outreach techniques (including in person as needed) to meet the wide spectrum of needs identified within the specific populations. The strategy will further articulate the State’s efforts to ensure that the individuals have access to information and human assistance to understand the new systems and their choices, their opportunities to select a health plan or particular providers and to achieve continuity and coordination of care. The strategy will include a timeline for initial implementation and on-going operation of the CCI. All updates or modifications to the outreach and education strategy shall be submitted to CMS for review.
- d. **Informing/Education Materials** - The State shall develop and submit for CMS review informational and educational materials that meet the requirements of 42 CFR 438 to explain the changes in service delivery. Such materials must comport with 42 CFR 438, and be developed in collaboration with stakeholders.

The State shall submit to CMS all public communication tools (both State issued, or State-directed from plans) to be used to explain all facets of mandatory and passive enrollment in the authorized CCI counties, plan choice, benefit packages, rights, safeguards and how to receive assistance with understanding the program and process.

Beneficiaries will be notified at least 90-days of the effective date of enrollment of upcoming changes in delivery systems; mailed choice packets and enrollment guidebooks at least 60-days prior to enrollment; reminder notices 30 days prior to enrollment, and final enrollment confirmation notices prior to the enrollment effective date.

- e. **Readability and Accessibility-** All informing and educational materials should be clear and easy to read at no more than a sixth-grade reading level, provide information to beneficiaries need to help them navigate the transition, and be made available in the twelve Medi-Cal threshold languages, in formats, and at reading levels that ensure materials provide clear information.

## **122. Efforts to Ensure Seamless Transitions**

- a. The State will provide CMS its methodology for providing plans with a maximum of available data on service utilization and provider utilization for CCI eligible enrollees. This includes Medi-Cal administered services that are administered through sister agencies. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.
- b. The State shall provide documentation that information technology systems and infrastructure-are in place and can effectively manage the data exchange expectations set forth in this section to support smooth transition.
- c. The State shall provide data to plans to assist plans in identifying enrollees with complex, multiple, chronic or extensive health care needs or high risk enrollees upon assignment or enrollment.

## **123. Plan Readiness and Contracts**

- a. **Plan Readiness – Initial and Ongoing**
  - i. The State shall consult with CMS to determine the final procedures for establishing and monitoring initial and ongoing network adequacy to serve the mandatorily enrolled MLTSS population that ensures compliance with 42 CFR 438 and the Knox Keene Act.
  - ii. The State will provide support to CMS in its review and determination of appropriateness of all contract amendments including the provision of documentation.
  - iii. The State will complete network certifications for each county. Each county network certification will be done across the geographic area covered by the county.
  - iv. The State will submit any updates to the network adequacy procedures upon changes.
- b. At any time, CMS may require mandatory enrollment freezes based upon review of State reports if it is evident that network adequacy targets are unmet. At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that network adequacy is not met. Any available statutory or regulatory appeal procedures will apply.
- c. The State will submit to CMS for review a list of deliverables/submissions for readiness that is being requested from plans (presently and on regular intervals), and a description of State approach to analysis and verification.
- d. The State shall submit to CMS its plan for ongoing monitoring of plans. Beginning in year one of mandatory enrollment, monitoring must occur quarterly, with assessment and reports on network adequacy submitted to CMS no later than 60 days after the close of each calendar quarter.
- e. The State will submit to CMS for review the State’s contingency plan for addressing insufficient network issues.

f. Items Necessary for plan readiness:

- i. **Care Coordination** - The State shall submit to CMS their procedures for ensuring that each plan has sufficient resources available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the CCI population and include capacity to provide linkages to other necessary supports outside of each plan's benefit package (e.g., mental health and behavioral health services above and beyond the benefits covered within the plan, personal care, housing, home delivered meals, energy assistance programs, services for individuals with intellectual and developmental disabilities and other supports necessary). The needs may be identified through the risk assessment process. Care shall be coordinated across all settings including services outside the provider network.
- ii. **Standardized Assessments** - The State shall provide detailed information regarding the process to conduct health risk assessments for individuals at risk based on FFS data.  
The State shall direct the plans to engage in a preliminary assessment process that assesses each new enrollee's risk level and needs; assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings; and uses a mechanism or algorithm to determine the health risk level of members. Based on the results of the health risk assessment, the plans shall be directed to develop individual care plans for higher risk beneficiaries.  
The State shall ensure minimum assessment/screen components to be included in any assessment/screen administered by the plans to enable comparability and standardization of elements considered and included in all plan assessments.
- iii. **Care Continuity – Initial and Ongoing** - The State shall ensure that the plans have mechanisms to provide continuity of care to enrolled individuals in order to furnish seamless care with existing providers for a period of 12 months after enrollment-and established procedures to bring providers into network.  
The State shall submit to CMS the policies and procedures that will establish and maintain a statewide, standardized exception process for an extended period of care continuity for individuals with significant, complex or chronic medical conditions.
- iv. **Person-Centered Planning and Service Design** - The State ensures that all contracts will include an assurance that the plans will have protocols in place to require person-centered planning and treatment approaches for each enrollee. While definitions and models of person-centered planning vary, the protocols shall, at a minimum, address the following: 1) How the plan will identify each enrollee's preferences, choices and abilities and the strategies to address those preferences, choices and abilities; 2) How the plan will allow the enrollee to participate fully in any treatment or service planning discussion or meeting, including the opportunity to involve family, friends and professionals of the enrollee's choosing; 3) How the plan will ensure that the enrollee has informed choices about treatment and service decisions; and 4) How the planning process will be collaborative, recurring and involve an ongoing commitment to the enrollee.
- v. **Physical Accessibility** - The State will ensure, using the facility site review tool, that each plan has physically accessible accommodations or contingency plans to meet the array of needs of all individuals who require accessible offices, examination or diagnostic equipment and other accommodations as a result of their disability or condition, and that they are advised of their obligations under the Americans with Disabilities Act and other applicable Federal statutes and rules regarding accessibility.



- vi. **Interpreter Services - Information Technology** - The State will ensure that each plan offers interpreter services for individuals who require assistance communicating, as a result of language barriers, disability, or condition. The State will ensure that each plan has capacity to utilize information technology including teleconferences and electronic options to ensure that delays in arranging services do not impede or delay an individual's timely access to care.
- vii. **Transportation – Specialized** - The State will ensure that each plan offers a limited number of non-emergency medical transportation so that individuals have easily accessible and timely access for scheduled and unscheduled medical care appointments.
- viii. **Fiscal Solvency** - The State shall ensure a plan's solvency prior to implementing mandatory enrollment and shall continue to monitor on a quarterly basis.
- ix. The State shall continue to ensure that all capitation rates developed for the Medicaid managed care program are actuarially sound and adequate to meet population needs pursuant to 42 CFR 438.6 (c).
- x. **Transparency** - The State shall require that plan methods for clinical and administrative decision-making are publicly available in a variety of formats, as well as elements of contractual agreements with the State related to benefits, assessments, participant safeguards, medical management requirements, and other non-proprietary information related to the provision of services and supports to the CCI eligible population.  
The State shall require that each plan utilize its community advisory committee, and that the plans engage in regular meetings with its stakeholder advisory committees.
- xi. **Timing** - The State will ensure that plans are able to serve individuals, including specialty providers, within reasonable and specified timeframes for appointments, including expanded appointment times as needed to meet the individuals' particular needs.

**124. Contract Requirements** - Each of the elements noted above as essential to determine plan readiness will be included in the State's contracts with each of the plans in a manner that ensures consistency of services, operations, participant rights and safeguards, quality and access to services. In addition to these elements, the State will ensure that each plan contract contains:

- a. Transition Services and Care Coordination requirements to address discharge planning and transition requirements to ensure that:
  - i. Discharge planning occurs with individuals, or their representatives, as applicable, starting from the time individuals are admitted to a hospital or institution; and
  - ii. Appropriate care, services and supports are in place in the community before individuals leave the hospital or institution.
- b. Linkage expectations for linking beneficiaries to providers, for the purposes of assigning members to providers and for ongoing care coordination and/or disease management, using FFS claims data as a source of clinical data on CCI enrollees. The provision and/or exchange of such data shall be done in accordance with Federal and State privacy and security requirements.
- c. Requirements for Person-Centered Planning/Consultation, including uniform approach to be used by all plans as required in Plan Readiness Section.
- d. Each plan shall be required to submit service encounter data, for individuals enrolled, as determined by the State and as required by 42 CFR 438 and 1903 of the Act as amended by the Affordable Care Act. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion within 90 days after initial plan enrollment, or as specified by the State.

- e. The State must ensure that the notices to beneficiaries are standardized and meet all Federal and State legal requirements.
- f. The State must ensure that a uniform Grievance System is in place and monitored by the State for enrolled individuals in each plan that includes a grievance process, an appeal process and access to the State's Fair hearing process as defined in the Medicaid statutory and regulatory requirements per 42 CFR 438 subpart F. This includes, but is not limited to the following:
  - i. Protocols for receiving, tracking and resolving grievances (complaints)
  - ii. Protocols for what to include in a Notice of Action when a service request is denied or reduced
  - iii. Protocols for receiving tracking and responding to Member Appeals including Notice of Decision including State Fair Hearing Request instructions
- g. Grievance and appeal procedures must comply with Medicaid statutory and regulatory requirements per 42 CFR 438.400-424, Medi-Cal statutory and regulatory requirements and the Knox-Keene Act as applicable.
- h. Eligible beneficiaries in the authorized CCI counties will be substantially involved in plan advisory groups and committees.
- i. Provisions outlining when out-of-network care be provided.
- j. Comprehensive health assessments for eligible CCI populations.
- k. Coordination of carved out services based on FFS data.

## **125. Participant Rights and Safeguards**

- a. **Information** - All information provided to enrollees, inclusive of and in addition to educational materials, enrollment and disenrollment materials, benefit changes and explanations and other communication, will fully comport with 42 CFR 438.10, and be accessible and understandable to individuals enrolled or potentially enrolled in the Demonstration.

## **126. Quality Oversight and Monitoring** - In addition to all quality requirements set forth in 42 CFR 438, the State will ensure the following:

- a. **Encounter Data** - The State shall require each plan to submit comprehensive encounter data at least monthly, on all service utilization by impacted beneficiaries in the authorized CCI counties, in a manner that enables the State to assess performance by plan, by county, and Statewide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State shall ensure sufficient mechanisms and infrastructure in place for the collection, reporting, and analysis of encounter data provided by the plans. The State shall have a process in place to monitor that encounter data from each plan in the authorized CCI counties is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion. The State will provide summaries of this data in its regular meetings with CMS regarding the implementation of the CCI Cal MediConnect and MLTSS program. Such data will be submitted as required in Section 1903 of the Social Security Act as amended by the Affordable Care Act.

- b. **Measurement Activities** - The State will collect data information on the following measures to ensure ongoing monitoring of individual well being and plan performance. The State will use this information in ongoing monitoring and quality improvement efforts, in addition to quality reporting efforts.

The State will submit a plan for developing and implementing additional HEDIS and QIP measures specific to the CCI population. The plan must be submitted to CMS and must include the timelines for developing and implementing such measures.

- c. **Stratification and Analysis by County and Plan** - For all data collected from the MCOs, and COHS the State will be able to stratify information by population, plan, and county. The State must also ensure that the data is collected in a manner that enables aggregation and reporting to ensure comprehensive plan oversight by the State of the counties and the plans.

**127. Notice of Change in Implementation Timeline** - The State must notify CMS of any potential changes in the implementation and deliverables timelines as specified above.

**128. Withholding Approval** - At any time, CMS reserves the right to withhold approval of contracts/contract amendments and/or Federal financial participation (FFP) if CMS determines that implementation timelines are not being met. Any available statutory or regulatory appeal procedures will apply.

## IX. OTHER ADMINISTRATIVE REQUIREMENTS

No changes necessary for this amendment.

## X GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

**119. 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. For each Demonstration year, ~~twenty-five~~ **forty-three (2743)** 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 – COHS counties– [Families COHS];
  - iv. Family & Children – TPM/GMC [Families TPM/GMC];
  - v. Existing Seniors & People with Disabilities – COHS counties [Existing SPD COHS];
  - vi. Existing SPD TPM/GMC [Exist SPD TPM/GMC]
  - vii. Special Populations – SPDs [Special Pops – SPDs]
  - viii. Special Populations Special Needs Child [Special Pops – Child]

- ix. Low Income Health Program/ Medicaid Expansion [MCE]
- x. Low Income Health Program / Health Care Coverage Initiative [SNCP - HCCI];
- xi. California Children Services [CCS – State Plan]
- xii. California Children Services - Designated State Health Program [CCS - DSHP]
- xiii. Genetically Handicapped Persons Program - Designated State Health Program [GHPP – DSHP]
- xiv. Medically Indigent Adult Long Term Care - Designated State Health Program [MIALTC – DSHP]
- xv. Breast & Cervical Cancer Treatment Program - Designated State Health Program [BCCTP – DSHP]
- xvi. AIDS Drug Assistance Program - Designated State Health Program [ADAP-DSHP]
- xvii. Expanded Access to Primary Care - Designated State Health Program [EAPC-DSHP]
- xviii. Department of Developmental Services - Designated State Health Program [DDS – DSHP]
- xix. Workforce Development Programs - Designated State Health Program [Work – DSHP]
- xx. Private and Non-Designated Government-Operated Hospital Payments [P/ND Govt. Hosp];
- xxi. Designated Government-Operated Hospital Payments [D. Govt. Hosp];
- xxii. Delivery System Reform Incentive Pool - Infrastructure Development [DSRIP - Cat 1];
- xxiii. Delivery System Reform Incentive Pool - Innovation & Redesign [DSRIP – Cat 2];
- xxiv. Delivery System Reform Incentive Pool – Population –focused Improvement [DSRIP – Cat 3];
- xxv. Delivery System Reform Incentive Pool – Urgent Improvement in Care [DSRIP – Cat 4];
- xxvi. Delivery System Reform Incentive Pool – HIV Transition, Improvements in Infrastructure and Program Design [DSRIP – Cat 5A];
- xxvii. Delivery System Reform Incentive Pool – HIV Transition, Improvements in Clinical and Operational Outcomes [DSRIP – Cat 5B];
- xxviii. County Mental Health Services [CMHS – DSHP];
- xxix. Every Woman Counts [EWC – DSHP];
- xxx. IMProving, Counseling & Treatment [IMP – DSHP];
- xxxi. Community Based Adult Services [CBAS];
- xxxii. Enhanced Case Management [ECM]; and
- xxxiii. Uncompensated care payments to IHS and 638 Facilities [IHS].
- xxxiv. **Duals—COHS Counties [Duals COHS]**
- xxxv. **Duals—TPM/GMC [Duals TPM/GMC]**
- xxxvi. **CCI—Duals COHS counties [CCI Duals COHS]**
- xxxvii. **CCI—Duals TPM/GMC [CCI Duals TPM/GMC]**
- xxxviii. **CCI—Duals COHS counties opt-out [CCI Duals COHS opt Out]**
- xxxix. **CCI—Duals TPM/GMC opt-out [CCI Duals TPM/GMC Opt Out]**
- xl. **CCI—SPDs COHS counties [CCI SPDs COHS]**
- xli. **CCI—SPDs TPM/GMC [CCI SPDs TPM/GMC]**

- xlii. CCI—Families COHS counties [CCI Family COHS]
- xliii. CCI—Families TPM/GMC [CCI Family TPM/GMC]

## **X. Monitoring Budget Neutrality for the Demonstration**

**135. Limit on Title XIX Funding.** California will be subject to a limit on the amount of Federal title XIX funding that California may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The selected Medicaid expenditures consist of the expenditures for the range of services included in the managed care contracts and used to develop the without waiver per member per month limits under the Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual diverted upper payment limit determined for designated public hospitals in California. Spending under the budget neutrality limit is authorized for managed care population expenditures for the following groups – family and children, SPD, and CCS, **dual eligible**, public hospital expenditures and for spending under the SNCP, and for the CBAS/ECM services to SPDs and dual eligibles. Spending under the SNCP is for uncompensated care, DSHP, HCCI and DSRIP. Attachment C lists the designated public hospitals. Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by California using the procedures described in the section for Monitoring Budget Neutrality. The data supplied by the State to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS’ assessment of the State’s compliance with these annual limits will be done using the Schedule C report from the MBES/CBES system.

**136. Risk.** California will be at risk for the per capita cost for Demonstration enrollees (Medicaid State plan or hypothetical populations) under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, California will not be at risk for changing economic conditions which impact enrollment levels. However, by placing California at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

**137. Budget Neutrality Annual Expenditure Limit.** For each DY, two annual limits are calculated.

- a) **Limit A.** For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each eligibility group (EG) described as follows:
  - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under section entitled General Reporting Requirements for each EG, including the hypothetical population, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (iii) below;
  - ii. Starting in SFY 2011, actual expenditures for the MCE EG will be included in the expenditure limit for California. The amount of actual expenditures to be included will be the actual MCE per member per month cost experience for DY 6-10;
  - iii. Starting in the fourth quarter of SFY 2012 (March-June), and continuing through August 31, 2014, actual expenditures for the CBAS and ECM benefit will be included in the expenditure limit for the demonstration project. The amount of actual expenditures to be

included will be the actual cost of providing the CBAS and ECM services (whether provided through managed care or fee-for-service) to the SPD Medicaid-only population and to dual eligibles;

- iv. Starting in January 2014 and continuing through December 2016, actual expenditures for the CCI Dual Demonstration COHS and TPM/GMC EGs will be included in the expenditure limit for California. The amount of actual expenditures to be included will be the actual per member per month cost experience for this time period.
- v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration is specified below.

Eligibility Group (EG)	Trend Rate	DY 6 PMPM *	DY 7 PMPM *	DY 8 PMPM*	DY 9 PMPM*	DY 10 PMPM*
<b>Mandatory State Plan Groups</b>						
Families - COHS	5.30%	\$171.68	\$180.78	\$190.36	\$200.45	\$211.07
Families – TPM/GMC	5.3%	\$150.40	\$158.37	\$166.76	\$175.60	\$184.91
Existing SPD – COHS	7.4%	\$1,069.73	\$1,148.89	\$1,233.91	\$1,325.22	\$1,423.29
Existing SPDs – TPM/GMC and Special Populations SPDs	7.4%	\$730.43	\$784.48	\$842.53	\$904.88	\$971.84
CCS – State Plan Special Needs Child	3.28%	\$1,390.66	\$1,436.27	\$1,483.38	\$1,532.04	\$1,582.29
Duals -COHS						
Duals –TPM/GMC						
CCI—Duals COHS						
CCI—Duals TPM/GMC						
CCI—Duals COHS counties opt-out						
CCI—Duals TPM/GMC opt-out						
CCI—SPDs COHS						
CCI—SPDs TPM/GMC						
CCI—Families COHS						
CCI—Families TPM/GMC						
<b>Hypothetical Populations*</b>						
MCE	5.00%	\$300.00	\$315.00	\$330.75	\$347.29	\$0
CBAS	3.16%		\$916.60	\$945.57	\$975.45	\$1,006.27
ECM			\$10.00	\$10.00	\$10.00	\$10.00

Key: TPM = Two Plan Model counties, GMC = Geographic Managed Care counties

\*These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit.