



State Demonstrations Group

November 9, 2016

Mari Cantwell
Chief Deputy Director
Department of Health Care Services
Director's Office, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

This letter is to inform you that the following attachments to the Special Terms and Conditions (STCs) for California's section 1115(a) demonstration, entitled "California Medi-Cal 2020 Demonstration" (11-W-00193/9), are approved as submitted by the state and as modified through our discussions.

- Disproportionate Share Hospital (DSH) Coordination Methodology (Attachment NN)
- Community-Based Adult Services (CBAS) Program Integrity (Attachment OO)

CMS finds these protocols to be in accordance with the STCs for the demonstration, and has no further questions or comments at this time.

A copy of the approved attachments are enclosed and will replace the corresponding attachments in the STCs.

We look forward to continuing to work with you and your staff on the California Medi-Cal 2020 Demonstration. If you have any questions, please contact your project officer Ms. Sandra Phelps at either 410-786-1968 or by email at Sandra.Phelps@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Angela D. Garner
Director Division of System Reform Demonstrations

Enclosure

cc: Henrietta Sam-Louie, Acting ARA Region IX

**Attachment NN:
Disproportionate Share Hospital (DSH) Coordination Methodology**

During any year in which the State of California conducts the Global Payment Program (“GPP”), the state shall make the modifications listed in this Attachment NN to its methodologies for making disproportionate share hospital payments under the DSH State Plan provisions (Attachment 4.19-A, commencing with page 18).

1. The state shall not make disproportionate share hospital payments during a state fiscal year to any designated public hospital listed in Attachment C that participates in the Global Payment Program during that year.
2. Prior to the start of the applicable GPP PY, or as soon thereafter as possible, the full amount of the federal DSH allotment under SSA § 1923(f) for the FFY that commences in the applicable GPP PY shall be determined. For this purpose, the allotment identified for California for the applicable FFY in the Preliminary Disproportionate Share Hospital Allotments that is published by CMS shall be initially used.
3. Hospitals that meet DSH eligibility criteria and are “non cost-based DSH facilities,” as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non cost-based DSH facilities, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.
4. Hospitals that meet DSH eligibility criteria and are “non-government operated hospitals,” as defined under the DSH State Plan provisions, will receive DSH payments pursuant to the applicable State Plan methodology. The state shall calculate the sum of the DSH payment amounts projected for non-government operated hospitals, less the non-federal share, which shall be the federal DSH allotment amount set aside for these DSH facilities.
5. The federal DSH allotment set-aside amounts determined above for non cost-based DSH facilities in paragraph 3, and for non-government operated hospitals in paragraph 4, will be subtracted from the full federal DSH allotment amount identified in paragraph 2.
6. Hospitals that meet DSH eligibility criteria, and are “cost-based DSH facilities” as defined under the DSH State Plan provisions, and which are licensed to the University of California, will receive DSH payments pursuant to the applicable State Plan methodology, subject to an annual aggregate cap on the associated federal DSH allotment for those payments. The annual aggregate cap is equal to an applicable percentage multiplied by the amount of the federal DSH allotment that is left after the set-asides for non cost-based DSH facilities and non-government operated hospitals, as calculated in paragraph 5, which shall be the DSH allotment amount set aside for the University of California DSH facilities. The applicable percentages for each GPP PY are as follows:

GPP PY 1: 26.296%

GPP PY 2: 24.053%

GPP PY 3: 23.150%

GPP PY 4: 21.896%

GPP PY 5: 21.896%

7. The full federal DSH allotment amount, less the aggregate DSH allotment set-aside amounts determined for non cost-based DSH facilities in paragraph 3, for non-government operated hospitals in paragraph 4, and for cost-based DSH facilities licensed to the University of California in paragraph 6, shall constitute the initial “Adjusted DSH” component of the funding for the GPP described in STC 167. The initial “Adjusted DSH” component is determined no later than May 15 prior to the start of each GPP program year.
8. The final Adjusted DSH component of the GPP shall be determined pursuant to the steps in paragraphs 1 – 7 above, which shall take into account the following:
 - a. The allotment identified for California for the applicable FFY in the Final Disproportionate Share Hospital Allotments that is published by CMS;
 - b. The actual amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the results of the applicable DSH audits for the hospitals, including any adjustments that increase or decrease DSH payments to the hospitals.
9. Adjustments shall be made to the GPP total computable annual limit and GPP annual budgets to take into account the final Adjusted DSH component for the applicable GPP PY determined in paragraph 8, and, notwithstanding the final payment timeline set forth in Attachment EE, all final reconciliation payments for the applicable GPP PY made pursuant to Attachment EE shall be subject to these adjustments.
10. Within 30 days of its determination of the initial “Adjusted DSH” component discussed in step 7, the state will submit a report to CMS stating the amount of the initial “Adjusted DSH” component for the applicable GPP PY (with explanation for how “Adjusted DSH” component was calculated) and projected DSH payment amounts for all hospitals that will receive DSH payments.
11. Within 30 days of its determination of the final “Adjusted DSH” component discussed in step 7, the state will submit a report to CMS stating the amount of the final “Adjusted DSH” component for the applicable GPP PY, the actual and final amount of DSH payments paid or payable to the hospitals described in paragraphs 3, 4 and 6 for the applicable state fiscal year, and the final GPP total paid to each GPP hospital.
12. The state will report all DSH payments to “non cost-based DSH facilities,” “non-government operated hospitals,” “cost-based DSH facilities” licensed to the University of California, and designated public hospitals not participating in the Global Payment Program, on Forms CMS-64.9 WAIVER, with waiver number 11-W-00193/9, under

Waiver Name “DSH,” and with project number extension indicating the demonstration year corresponding to the federal fiscal year of the DSH allotment for which the payments were made.

**Attachment OO:
Community-Based Adult Services (CBAS) Program Integrity**

Following a determination that a credible allegation of fraud exists with respect to a CBAS provider, and that there is no good cause not to suspend payments, the State will initiate an email notification within one business day to all contracted Managed Care Plans (MCPs) that have provider networks in which the CBAS provider participates. Commencing with payments made by an MCP on or after April 1, 2016, MCPs will be required to report to the State all payments made to a CBAS provider for whom a credible allegation of fraud exists for dates of services rendered after the date the MCP was notified. The procedures below outline details regarding the reporting and recoupment process:

- The State's notification email to the MCPs will contain specific instructions for reporting requirements. MCPs will utilize the "Total MCP Payments to CBAS under Credible Allegation of Fraud" form to track total payments made to the applicable CBAS provider on a quarterly basis, commencing with the first quarter that the MCP was notified of the credible allegation of fraud. Reports for all subsequent quarters will indicate the total payments made for the given quarter, as well as the cumulative total payments made to the CBAS provider from the date following initial notification of the credible allegation of fraud.
- MCPs will submit quarterly reports to the State within seven business days from the end date of each quarter. The State will, in turn, submit quarterly reports to CMS reflecting all MCP payments made to applicable CBAS providers within fifteen business days from the end date of each quarter.
- Reporting requirements will remain in effect until the State notifies the MCP that the law enforcement agency investigating the credible allegation of fraud has either charged the CBAS provider with fraud or has informed the State that there is insufficient evidence to bring charges. Upon receipt of such information from the investigating agency, the State will notify the MCPs of the determination via email within three business days.
- The notification of the MCP by the State that there no longer exists a credible allegation of fraud against a CBAS provider will immediately extinguish the MCP's responsibility for quarterly reporting to the State and the State's responsibility for quarterly reports regarding payments to that CBAS provider to CMS.
- If, after investigation, the law enforcement agency brings charges against a CBAS provider for fraud, and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs, the following actions will be required to ensure recovery of all payments made to the CBAS provider:

Recoupment to the State	Recoupment to CMS
<ol style="list-style-type: none"> 1. The MCP will submit to the State within 15 business days of notification of a final report reflecting payments for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement agreement indicating fault by the provider occurs. 2. Within 90 days of receiving the final report, the State will recoup the CBAS provider fraud amount from the MCP capitated payment. The statement issued to the MCP will reflect the CBAS provider fraud amount. 	<ol style="list-style-type: none"> 1. The State will submit to CMS within 15 business days of receipt of a final report reflecting MCP payments made to the applicable CBAS provider for dates of services rendered up until the date the MCP was notified by the State that the law enforcement agency has charged the CBAS provider with fraud and the provider is either found guilty by the court or enters into a settlement indicating fault by the provider occurs. 2. The State will reimburse CMS in accordance with its established repayment system by: A. Setting up an Accounts Receivable to reimburse the State General Fund through the MCP's recoupment for the Total Computable (federal and state share), and B. When applicable, completing Federal repayment paper work to reimburse CMS from the State General Fund.