

FAMILY HEALTH ASSUMPTIONS
November 2013
FISCAL YEARS 2013-14 & 2014-15

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INTRODUCTION

The Family Health Estimate, which is based upon the Assumptions outlined in the following pages, provides information and state only costs for California Children’s Services, the Child Health and Disability Prevention program, the Genetically Handicapped Persons Program, and the Every Woman Counts Program. The Estimate also includes costs for the Healthy Families Program Title XXI portion of California Children’s Services. Costs for children eligible for Medi-Cal are not included. The Estimate can be segregated into two main components: (1) the base and (2) the adjustments to the base. The base estimate is the anticipated level of program expenditures assuming that there will be no changes in program direction, and is derived from a historical trend analysis of actual expenditure patterns. The policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the historical data base. The combination of these two estimate components produces the final Family Health Estimate.

California Children’s Services

The California Children’s Services (CCS) program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions (e.g., severe genetic diseases, chronic medical conditions, infectious diseases producing major sequelae, and traumatic injuries) from families unable to afford catastrophic health care costs. A child eligible for CCS must be a resident of California, have a CCS-eligible condition, and be in a family with an adjusted gross income of \$40,000 or less in the most recent tax year. Children in families with higher incomes may still be eligible for CCS if the estimated cost of care to the family in one year is expected to exceed 20% of the family’s adjusted gross income.

Base funding for the state only CCS program services and case management is composed of 50% county funds (CF) and 50% State General Fund (GF). Services and case management for Medi-Cal eligible children are funded by a combined 50% match of GF and Title XIX federal financial participation (FFP). Services and case management authorized for children who are enrolled in Healthy Families are funded by 65% federal Title XXI FFP and a combined 17.5% CF and 17.5% GF. In addition to the funding streams above, CCS is also supported by a fixed level of Federal Title V Maternal and Child Health (MCH) funding. In addition, GF expenditures are reduced by federal funding from the Safety Net Care Pool.

CCS benefit costs and administrative costs are budgeted on a cash basis.

Child Health and Disability Prevention

The Child Health and Disability Prevention (CHDP) program provides health screens (i.e., well child health assessments) and immunizations to Medi-Cal children under 21 years of age and non-Medi-Cal eligible children at or under 18 years of age whose family income is at or below 200% of the Federal Poverty Level (FPL).

Currently, the CHDP program is funded with a combination of State GF and Childhood Lead Poisoning Prevention (CLPP) funds.

Children from families with incomes at or below 200% of the FPL can pre-enroll in fee-for-service Medi-Cal under the presumptive eligibility for children provisions of the Medicaid program and the Healthy Families Program (HFP), the California Title XXI State Children's Health Insurance Program (SCHIP). This pre-enrollment will take place electronically over the Internet at CHDP provider offices at the time children receive health assessments. This process, known as the CHDP Gateway to Medi-Cal and Healthy Families, will shift most CHDP costs to the Medi-Cal program and to HFP. CHDP program funding will continue at a reduced level to cover services for children who are eligible for limited-scope Medi-Cal benefits.

The CHDP program is responsible for the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal program. The health assessments, immunizations, and laboratory screening procedures for full scope Medi-Cal children are funded 50% SF and 50% FFP and for limited scope Medi-Cal children are 100% SF. These screening costs funded through Medi-Cal are identified in the Medi-Cal estimate as EPSDT.

Additionally, Medi-Cal provides only emergency and pregnancy related services to beneficiaries with emergency Medi-Cal. CHDP provides 100% state funded health assessments for these beneficiaries.

Genetically Handicapped Persons Program

The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; chronic degenerative neurological diseases including Huntington's Disease, Friedreich's Ataxia, and Joseph's Disease; and metabolic diseases including phenylketonuria. GHPP also provides access to social support services that may help ameliorate the physical and psychological problems attendant to genetically handicapping conditions. Persons eligible for GHPP must reside in California; have a qualifying genetic disease; and be otherwise financially ineligible for CCS. GHPP clients with adjusted gross income between 200% and 299% of the federal income guidelines pay an enrollment fee that is 1.5% of their adjusted gross income; clients of families at an income level of 300% or greater pay an enrollment fee equal to 3% of their adjusted gross income.

GHPP benefit and administrative costs are budgeted on a cash basis beginning in FY 2005-06.

Every Woman Counts Program

The Every Woman Counts (EWC) program provides free breast and cervical cancer screening and diagnostic services to uninsured women with income at or below 200% of federal poverty level. Breast Cancer screening is available for women age 40 and older. Cervical Cancer screening is available for women age 25 and older.

EWC covered benefits and categories of service include office visits, screening mammograms, diagnostic mammograms, diagnostic breast procedures, such as ultrasound, fine needle and core biopsy, case management, and other clinical services for cervical cancer screening.

Currently, the EWC program is funded with a combination of Cigarette and Tobacco Products Surtax Unallocated Fund, Breast Cancer Fund, Centers for Disease Control and Prevention National Breast and Cervical Cancer Early Detection Program Grant, and General Fund.

EWC benefit and administrative costs are budgeted on an accrual basis.

BASE ESTIMATES

Historical cost data are used to make the base budget projections using regression equations. The general functional form of the regression equations is:

CASES	=	f(TND, S.DUM, O.DUM)
EXPENDITURES	=	f(TND, S.DUM, O.DUM)
TREATMENT \$	=	f(TND, S.DUM, O.DUM)
MTU \$	=	f(TND, S.DUM, O.DUM)

Where:

- TREATMENT \$ = Total quarterly net treatment expenditures for each county group.
- MTU \$ = Total quarterly medical therapy unit expenditures for each county group.
- TND = Linear trend variable.
- S.DUM = Seasonally adjusting dummy variable.
- O.DUM = Other dummy variables (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.).

California Children’s Services

A nine year data base of summary claim information on CCS treatment services and medical therapy unit expenditures is used to make the base budget projections using regression equations. Independent regressions are run on net treatment services expenditures (TREATMENT \$) and medical therapy unit expenditures (MTU \$). These expenditure categories are estimated separately for Alameda, Contra Costa, Fresno, Los Angeles, Monterey, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, other independent counties, and all other dependent counties as separate groups.

Following the estimation of coefficients for these variables during the base period, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The quarterly values for each expenditure category are then added together to arrive at quarterly expenditure estimates and summed to annual totals by county.

The net cost/savings for each Policy Change item is applied to the base estimate, after adjustment for the estimated percentage of each item reflected in the base.

Child Health and Disability Prevention

The estimate for CHDP screening consists of a base projection using the latest five years of monthly data to forecast average monthly screens and cost per screen. Separate forecasts utilizing multiple regression analysis are made for both screens and cost per screen for the CHDP program.

The net cost/savings for each Policy Change item is applied to the base estimate, after adjustment for the estimated percentage of each item reflected in the base.

Genetically Handicapped Persons Program

The most recent five years of actual GHPP caseload and expenditure data are used to make the budget projections using regression equations. The data system for GHPP includes only summary caseload and expenditure data for the base period. Independent regressions are run on each diagnosis category identified as follows: Cystic Fibrosis; Hemophilia; Sickle Cell; Huntington's Disease (includes Friedreich's Ataxia, and Joseph's Disease); and Metabolic Conditions.

Estimates for expenditures are based on a history of payment data which is projected into the budget year and a future year.

The net cost/savings for each Policy Change item is applied to the base estimate, after adjustment for the estimated percentage of each item reflected in the base.

Every Woman Counts Program

In the May 2012 Estimate, the EWC program uses actual paid clinical claims cost data from July 1, 2008 through December 31, 2009 and February 1, 2011 through February 29, 2012. Claims data for the period of January 1, 2010 through November 30, 2010 were excluded due to the interruption in clinical services when the moratorium on new enrollment was implemented. Claims data for December 2010 and January 2011 were excluded due to low claim volume during these months. Claims volume was low as it took a while for women to resume accessing services after the moratorium was lifted.

Estimates for expenditures are based on the percent change model. The annual increase in claims costs was 5% using the time periods above. Therefore, 5% was used to project claims cost.

The net cost/savings for each Policy Change item is applied to the base estimate, after adjustment for the estimated percentage of each item reflected in the base.

CALIFORNIA CHILDREN'S SERVICES

CCS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

CCS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
CCS 1 (PC-1)	X	X	<p><u>Enrollment and Assessment Fees</u></p> <p>Budget Act language requires that enrollment and assessment fee revenues be shared 50/50 with the counties. It also requires the State to offset 50% of the allocated fee revenues against the State's portion of reimbursements to the counties.</p>
CCS 2 (PC-2A) (PC-2B)	X	X	<p><u>County Administrative Costs</u></p> <p>Pursuant to Health and Safety Code §123955, the State and the counties share the cost of administering the CCS program. The State reimburses counties for 50% of county administrative costs required to meet State-established staffing standards for CCS clients in the county CCS caseload who are ineligible for Medi-Cal or do not subscribe to the Healthy Families Program (HFP).</p> <p>The HFP is California's Title XXI SCHIP. Since 1997 CCS has provided services to treat CCS medically eligible conditions of children enrolled in HFP plans. CCS services are "carved out" of the HFP plans' capitation. These treatment services are funded 65% by federal Title XXI funds, 17.5% by the State General Fund, and 17.5% by county funds for HFP subscribers who meet the financial eligibility requirements of the CCS program; and 65% Federal Title XXI funds and 35% State General Fund for HFP subscribers who are not financially eligible for CCS.</p> <p>CCS State-Only case management costs are funded 50% by the State and 50% by the counties. In order to maximize FFP, Title XXI FFP is being claimed for case management costs for CCS/HFP clients.</p> <p>No sooner than January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition into Medi-Cal through a phase-in methodology.</p> <p><u>Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology.</u></p>
CCS 3 (PC-3A) (PC-3B)	X	X	<p><u>Fiscal Intermediary Expenditures</u></p> <p>The FI contractor adjudicates medical claims for the CCS program. The funding is based on actual claims and trends for CCS State Only and CCS Healthy Families clients.</p> <p>No sooner than January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition into Medi-Cal through a phase-in methodology.</p>

CCS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
CCS 4 (PC-4A) (PC-4B)	X	X	<p><u>Fiscal Intermediary Expenditures (Dental)</u></p> <p>Delta Dental adjudicates dental claims for the CCS program. The funding is based on actual claims and trends for CCS eligible and CCS-HFP eligible children.</p> <p>No sooner than January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition into Medi-Cal through a phase-in methodology.</p>
CCS 5 (PC-5A) (PC-5B)	X	X	<p><u>Children's Medical Services Network (CMS Net)</u></p> <p>The CMS Net automated eligibility, case management, and service authorization system is used by the CCS program to provide administrative case management for CCS clients. CMS Net was implemented in 1992 in the State regional offices and several counties. Currently, all 58 CCS counties, three State CCS regional offices, and the GHPP program utilize the system. CMS Net utilizes software called Caché for an operating system, script language, and certain database management functions. The Department purchases Caché licenses based on the estimated number of CMS Net system users.</p> <p>No sooner than January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition into Medi-Cal through a phase-in methodology.</p> <p><u>Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology.</u></p>
CCS 6 (PC-6)	X	X	<p><u>MH/UCD & BTR - Safety Net Care Pool</u></p> <p>Effective for dates-of-service on or after September 1, 2005, based on SB 1100 (Chapter 560, Statute of 2005), federal funding from the Safety Net Care Pool (SNCP) can be made available for the CCS State-Only program. The Department may claim federal reimbursement for expenditures for CCS State-Only services as certified public expenditures. The GF savings that accrue will be available to the SNCP for deposit into the Health Care Support Fund to provide funding for safety net hospitals.</p> <p>The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, CMS approved a new five-year demonstration, California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR). The Special Terms and Conditions of the new demonstration allow the State to claim FFP using the CPEs of approved Designated State Health</p>

CCS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			Programs (DSHP). The CCS program is included in the list of DSHP.
CCS 7 (PC-7)	X	X	<p><u>Title V Reimbursement from CDPH</u></p> <p>The Maternal, Child, and Adolescent Health Title V grant is included in the CDPH budget Title V federal funding for the CCS Program will be shown as a reimbursement in the Department's budget.</p> <p>The CCS program is California's designated children and youth with special health care needs (CYSHCN) program. Therefore, CCS receives a portion of California's Title V funds.</p>
CCS 8 (PC-8A) (PC-8B)	X	X	<p><u>CCS and CCS-HFP Rebates</u></p> <p>Effective September 1, 2005, CCS began participation in the Medi-Cal blood factor rebates program.</p>
CCS 9 (PC-10A) (PC-10B)	X		<p><u>CCS Inpatient Reimbursement</u></p> <p>This assumption has been moved to the "Time-Limited/No Longer Applicable" section.</p>
CCS 10 (PC-11B) (PC-13B)	X	X	<p><u>Transition of Healthy Families Children to Medi-Cal</u></p> <p>No sooner than January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition into Medi-Cal through a phase-in methodology. Coverage of this population under Medicaid programs is permissible pursuant to the federal Social Security Act to provide full scope Medi-Cal benefits to such eligible children who are optional targeted low-income children with family incomes up to and including 200% of the federal poverty level (FPL). Assets will be exempt for these children and an income disregard will be available creating an effective income level not to exceed 250% of the FPL.</p>
CCS 11 (PC-14A) (PC-14B) (PC-FI)	X	X	<p><u>Diagnosis Related Group – Inpatient Hospital Payment Methodology</u></p> <p>SB 853 (Chapter 717, Statutes of 2010) mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon diagnosis related groups (DRGs). The DRG payment methodology will replace replaces the previous payment methods. For contract hospitals, DRGs will replace the per diem rates negotiated under the Selective Provider Contracting Program (SPCP). For non-contract hospitals, DRGs will replace the previous cost-based reimbursement methodology. The DRG implementation is</p>

~~scheduled to begin~~ **was implemented on** July 1, 2013 **for private hospitals and will be implemented on January 1, 2014 for Non-Designated Public Hospitals (NDPHs).**

The Medi-Cal Fiscal Intermediary, Xerox State Healthcare, LLC (Xerox), ~~will implement~~ **implemented** California Medicaid Management Information Systems (CA-MMIS) changes to comply with this legislation.

CCS 12
(PC-15)

X X

Cost Shift of CCS State-Only to Medi-Cal EPC

This assumption has been moved to the "Time-Limited/No Longer Applicable" section.

CHILD HEALTH & DISABILITY PREVENTION PROGRAM

CHDP: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

CHDP: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
CHDP 1 (PC-1)	X	X	<p><u>Fiscal Intermediary Expenditures</u></p> <p>The FI contractor adjudicates medical claims for the Child Health and Disability Prevention (CHDP) program.</p>
CHDP 2 (PC-2)	X	X	<p><u>CLPP Fund</u></p> <p>Medi-Cal provides blood lead tests to children who are at risk for lead poisoning and are full-scope Medi-Cal beneficiaries or are pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program. The CHDP State-Only program provides lead screenings to Medi-Cal beneficiaries who are eligible for emergency and pregnancy related services. The lead tests are funded by the CLPP Fund which receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of Equalization. The expenditures for the lead testing are in CHDP base trends and this policy change adjusts the funding.</p>

GENETICALLY HANDICAPPED PERSONS PROGRAM

GHPP: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

GHPP: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
GHPP 1 (PC-1)	X	X	<p><u>Enrollment Fees</u></p> <p>Since July 1, 1993, families receiving GHPP services have been subject to enrollment fees if they meet certain requirements pursuant to Health and Safety Code section 125166. It is mandated that failure to pay or arrange for payment of the enrollment fee within 60 days of the due date shall result in disenrollment and ineligibility for coverage of treatment services effective 60 days after the due date of the fee. An assessment of the enrollment eligibility of each client will be performed on the anniversary date of the opening of their case. Eligibility will trigger an enrollment fee collection.</p> <p>Effective December 1, 2009, the Department increased GHPP enrollment fees by requiring that GHPP clients with adjusted gross income between 200% and 299% of the federal income guidelines pay an enrollment fee that is 1.5% of their adjusted gross income; clients of families at an income level of 300% or greater pay an enrollment fee equal to 3% of their adjusted gross income.</p>
GHPP 2 (PC-2)	X	X	<p><u>Fiscal Intermediary Expenditures</u></p> <p>The FI contractor adjudicates claims for the GHPP program.</p>
GHPP 3 (PC-3)	X	X	<p><u>Blood Factor Drug Rebates and Contract Savings</u></p> <p>Effective September 1, 2005, GHPP began participation in the Medi-Cal blood factor rebates program.</p>
GHPP 4 (PC-4)	X	X	<p><u>MH/UCD & BTR - Safety Net Care Pool</u></p> <p>Effective for dates-of-service on or after September 1, 2005, based on SB 1100, federal funding from the SNCP can be made available for the GHPP State-Only program. The Department may claim federal reimbursement for expenditures for GHPP State-Only services as certified public expenditures (CPE). The GF savings that accrue will be available to the SNCP for deposit into the Health Care Support Fund to provide funding for safety net hospitals.</p> <p>The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, CMS approved a new five-year demonstration, California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR). The Special Terms and Conditions of the new demonstration allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP). The GHPP program is included in the list of DSHP.</p>

GHPP: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
GHPP 5 (PC-5) (PC-6)	X	X	<p><u>GHPP Premium Payments</u></p> <p>Effective December 1, 2009, GHPP implemented a process for enrolling GHPP clients who are not eligible for employer-sponsored insurance or full-scope no share of cost Medi-Cal or Medicare into commercial insurance plans. The insurance premiums will be funded by the program and will cover the GHPP clients' full range of health care services.</p>
GHPP 6 (PC-8)	X		<p><u>GHPP Inpatient Reimbursement</u></p> <p>This assumption has been moved to the "Time-Limited/No Longer Applicable" section.</p>
GHPP 7 (PC-11)	X		<p><u>United States of America v. Bio-Med Plus, Inc.</u></p> <p>The Department will receive restitution as the result of a federal criminal conviction in an inter-state conspiracy to defraud health insurers including the GHPP and Medi-Cal programs.</p> <p>The 11th Circuit Court of Appeals affirmed the convictions of all defendants on June 29, 2011. In September 2011, the 11th Circuit denied the defendants request for an en banc review. The defendants have filed a petition for a writ of certiorari with the U.S. Supreme Court (SCOTUS). SCOTUS is expected to deny this petition. The United States Attorney's Office in Savannah expects the restitution to be paid in FY 2012-13. <u>On August 8, 2013, the Department collected the restitution.</u></p>
GHPP 8 (PC-10) (PC-FI)	X	X	<p><u>Diagnosis Related Group – Inpatient Hospital Payment Methodology</u></p> <p>SB 853 (Chapter 717, Statutes of 2010) mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon diagnosis related groups (DRGs). The DRG payment methodology will replace <u>replaces</u> the previous payment methods. For contract hospitals, DRGs will replace the per diem rates negotiated under the Selective Provider Contracting Program (SPCP). For non-contract hospitals, DRGs will replace the previous cost-based reimbursement methodology. The DRG implementation is scheduled to begin <u>was implemented on July 1, 2013 for private hospitals and will be implemented on January 1, 2014 for NDPHs.</u></p> <p>The Medi-Cal Fiscal Intermediary, Xerox State Healthcare, LLC (Xerox), will implement <u>implemented</u> California Medicaid Management Information Systems (CA-MMIS) changes to comply with this legislation.</p>

EVERY WOMAN COUNTS PROGRAM

EWC: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

EWC: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
EWC 1 (PC-1)	X	X	<u>Fiscal Intermediary Expenditures</u> The Fiscal Intermediary (FI) contractor adjudicates medical claims for the Every Woman Counts (EWC) program. The funding is based on actual claims and trends.
EWC 2 (PC-2)	X	X	<u>Cigarette and Tobacco Products Surtax Fund</u> Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) Unallocated Funds are allocated to aid in the funding for the EWC program. The amounts may vary from year to year.
EWC 3 (PC-3)	X	X	<u>Breast Cancer Control Account</u> Breast Cancer Control Account (BCCA) is funded by a two cent tobacco tax; one cent goes to the BCCA for the EWC program and the other one cent goes to the Breast Cancer Research Account. BCCA funds breast cancer screening and diagnostic services to uninsured women. The amounts may vary from year to year.
EWC 4 (PC-4)	X	X	<u>Center for Disease Control and Prevention Fund</u> Funding from the Center for Disease Control and Prevention (CDC) began in 1990. The program, known as the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), offers funding to states for cervical and breast cancer outreach, education, early detection, and quality assurance services.
EWC 5 (PC-5)	X	X	<u>Consumer Toll-Free Line</u> The Department contracts with the Cancer Prevention Institute of California (CPIC) to fund the toll-free line for the EWC program. The consumer toll-free line provides pre-screening, referrals to primary care providers, and takes complaints.
EWC 6 (PC-6)	X	X	<u>Regional Contracts</u> The Department contracts with regional contractors to provide breast and cervical cancer tailored health education to priority populations, quality clinical follow-up to recipients, and primary care provider network support in 10 geographic regions of California.
EWC 7 (PC-7)	X	X	<u>San Diego State University Research Foundation</u> The Department has a contract with San Diego State University Research Foundation (SDSURF), a private non-profit organization that is an auxiliary to California State University, San Diego.

EWC: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The contract provides professional education to California primary care providers regarding breast and cervical cancer screening and diagnostic clinical care guidelines.

EWC 8
(PC-11)

X X

Dense Breast Notification Supplemental Screening

SB 1538 (Chapter 458, Statutes of 2012) would require health facilities administering mammograms to notify patients whose breasts are categorized as being heterogeneously or extremely dense and inform the patients that they may benefit from supplementary screening due to the level of dense breast tissue (DBT) seen on the mammogram. The generated notices will result in patients requesting additional screening tests, such as magnetic resonance imaging (MRIs) and ultrasounds. The provisions of this bill ~~will become~~ **became** operative April 1, 2013 and **will** sunset on January 1, 2019.

EWC 9
(PC-8)

X X

Digital Mammography Rate Change

AB 359 (Chapter 435, Statutes of 2009) requires the EWC program to reimburse providers for breast cancer screening and diagnostic mammograms using digital technology at the Medi-Cal analog mammography rate. This provision will sunset on December 31, 2013.

Effective January 1, 2014, the program will reimburse providers using digital mammography at the current Medi-Cal digital mammography rate, which is higher than the analog mammography rate.

EWC 10
(PC-4)
(PC-10)

X

One-Time Prevention and Public Health Grant Fund

The EWC program received a one-time supplemental grant from the Prevention and Public Health Fund to increase breast and cervical cancer screening and diagnostic services to serve more women in the EWC program. The grant does not allow funds to be used to supplant existing state funding for breast and cervical cancer screening services. Funding is available from September 2012 through September 2013.

INFORMATION ONLY:

CALIFORNIA CHILDREN'S SERVICES

CHILD HEALTH AND DISABILITY PREVENTION

GENETICALLY HANDICAPPED PERSONS PROGRAM

1. GHPP Caseload Adjustments

Caseload counts have been adjusted due to the January 24th, 2011 system conversion for the GHPP case management system which added the functionality to sync eligibility status with MEDS and accurately calculate active cases from the State Only and Medi-Cal GHPP funding categories. Corrections to program eligibility segments in MEDS were also implemented to reflect accurate historical GHPP eligibility. The additional decline in caseload beginning in March 2011 is due to an ongoing effort of annual caseload review and closes cases that are delinquent in responding with their current financial status.

EVERY WOMAN COUNTS PROGRAM

1. Breast Cancer Awareness License Plates

Assembly Bill 49 requires the Department to apply, to the Department of Motor Vehicles, to sponsor a breast cancer awareness license plate program. Once approved by the Legislature, revenue generated from the sales of the plates shall be deposited into the Breast Cancer Control Account in the Breast Cancer Fund.

The Department must collect a minimum of 7,500 license plate applications in 12 months. If the minimum number of applications is not met, the fees must either be refunded or the collection date will be extended for another 12 months.

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

CALIFORNIA CHILDREN'S SERVICES

CHILD HEALTH DISABILITY PREVENTION

GENETICALLY HANDICAPPED PERSONS PROGRAM

EVERY WOMAN COUNTS PROGRAM

DISCONTINUED ASSUMPTIONS

Time-Limited/No Longer Applicable

CALIFORNIA CHILDREN'S SERVICES

1. Cost Shift of CCS State-Only to Medi-Cal EPC

In June 2012, the Department identified payment problems for CCS State-Only services:

- The system erroneously paid Medi-Cal claims with CCS State-Only GF and matching County funds instead of Medi-Cal funds.
- The system denied claims that should have been approved for payment.

The Department is currently completing the first stage of the Erroneous Payment Correction (EPC) to adjust the funding shift.

2. CCS Inpatient Reimbursement

Prior to January 1, 2011, the CCS State-Only and CCS-HFP program reimbursed contract hospitals for inpatient services rendered to CCS State-Only and CCS-HFP clients at the Medi-Cal interim rates as required in Section 14105.18 of the Welfare and Institutions Code. This provision sunsetted on January 1, 2011. Welfare and Institutions Code Section 14105.18 requires rates of payment to hospitals for CCS, GHPP, and other programs to be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program. The provisions of this Section became operative on January 1, 2011.

System modifications for the erroneous payment correction (EPC) to recover CCS inpatient reimbursement overpayments made between January 2011 and May 2012 are currently in process.

CHILD HEALTH DISABILITY PREVENTION

GENETICALLY HANDICAPPED PERSONS PROGRAM

1. GHPP Inpatient Reimbursement

Prior to January 1, 2011, the GHPP State-Only program reimbursed contract hospitals for inpatient services rendered to GHPP State-Only clients at the Medi-Cal interim rates as required in Section 14105.18 of the Welfare and Institutions Code. This provision sunsetted on January 1, 2011. Welfare and Institutions Code Section 14105.18 requires rates of payment to hospitals for CCS, GHPP, and other programs to be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program. The provisions of this Section became operative on January 1, 2011.

System modifications for the erroneous payment correction (EPC) to recover GHPP inpatient reimbursement overpayments made between January 2011 and May 2012 are currently in process.

EVERY WOMAN COUNTS PROGRAM

DISCONTINUED ASSUMPTIONS

Withdrawn

CALIFORNIA CHILDREN'S SERVICES

CHILD HEALTH DISABILITY PREVENTION

GENETICALLY HANDICAPPED PERSONS PROGRAM

EVERY WOMAN COUNTS PROGRAM