

**MEDI-CAL  
MAY 2007  
LOCAL ASSISTANCE ESTIMATE  
for  
FISCAL YEARS  
2006-07 and 2007-08**

# **ASSUMPTIONS**

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**MEDI-CAL ASSUMPTIONS  
MAY 2007  
FISCAL YEARS 2006-07 & 2007-08**

**INTRODUCTION**

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, 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 36-month historical trend analysis of actual expenditure patterns. The adjustments to the base 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 Medi-Cal Estimate.

*Note: A list of acronyms and abbreviations has been provided following the Assumptions Section.*

**BASE ESTIMATES**

The base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, claims/user or units/user and \$/claim or \$/unit for each of 18 aid categories within 12 different service categories. The general functional form of the regression equations is as follows:

$$\begin{aligned} \text{USERS} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}, \text{Eligibles}) \\ \text{CLAIMS/USER} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}) \\ \text{\$/CLAIM} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}) \end{aligned}$$

WHERE:	USERS	= Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	= Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	\\$/CLAIM	= Total monthly \$ divided by total monthly claims or units by service and aid category.
	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.).
	Eligibles	= Actual and projected monthly eligibles for each respective aid category incorporating various lags based upon lag tables for aid category within the service category.

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 monthly values for users, claims/user and \$/claim are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

**ELIGIBILITY: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
E 0.1 (PC-CA)	X	<p><u>Deficit Reduction Act of 2005 – Citizenship/Identity Requirement</u></p> <p>Assembly Bill (AB) 1807 (Chapter 74, Statutes of 2006) implements a provision of the federal Deficit Reduction Act of 2005 (DRA) that requires evidence of citizenship and identity as a condition of Medicaid eligibility for individuals who are applying for or currently receiving Medi-Cal benefits and who declare that they are citizens of the United States (U.S.). The Department received interim final federal regulations on July 6, 2006 for states to implement the new requirement, effective July 1, 2006.</p> <p>Under this new provision, applicants are required to show proof of identity and citizenship at the time of application and are not to be determined eligible until the documentation is provided. Current beneficiaries are required to provide documentation at the time of their next annual redetermination. Beneficiaries remain eligible for full-scope services as long as they are cooperative in obtaining the documentation. This provision does not apply to, or otherwise affect, people who are applying for or receiving Medi-Cal as immigrants, Supplemental Security Income recipients, or Medicare beneficiaries.</p> <p>Budget bill language allows the Department to move available funding, if needed, from that allocated to Medi-Cal Benefits and the Medi-Cal Fiscal Intermediary to fund the county administrative cost of implementing this requirement. Because eligibility determinations for the Breast and Cervical Cancer Treatment Program (BCCTP) are made by the Department for statewide eligibles and not by the counties, special processes will be developed to obtain the citizenship and identity documentation. This may include initiation of county coordination procedures.</p>
E 0.2 (PC-114)	X	<p><u>Deficit Reduction Act of 2005 – Minor Consent</u></p> <p>The All County Welfare Directors Letter to implement DRA exempts Minor Consent applicants and beneficiaries from presenting evidence of citizenship and identity. This creates a state-only minor consent program for minors who declare that they are citizens or nationals of the United States and who would otherwise be eligible for federally funded Minor Consent services.</p>

“PC” refers to “Policy Change”.

“PC-1” means the fiscal impact of this assumption is in Policy Change 1.

“PC-BA” indicates the fiscal impact is a base adjustment or other part of the base.

“PC-CA” means there is a fiscal impact on County Administration.

“PC-OA” means there is a fiscal impact on Other Administration.

“PC-NA” means there is no fiscal impact or that the fiscal impact is unknown.

**ELIGIBILITY: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u> <u>B/Y</u>	
E 0.3 (PC-CA)	X	<p><u>FY 2004-05 County Administration Reconciliation</u></p> <p>Two years following the end of a fiscal year, county administrative expenditures are reconciled to the county administration allocation for the applicable fiscal year. FY 2004-05 was reconciled and resulted in the identification of \$19,152,000 in unspent county administration funds to be returned during the current fiscal year.</p>
E 0.4 (PC-152)	X	<p><u>PE for HFP Disenrollees</u></p> <p>The Healthy Families Program (HFP) to Medi-Cal Bridge provides children with two additional months of HFP coverage when HFP has determined that a child's household income is below HFP eligibility requirements at the annual eligibility review. Approximately 2,000 new children per month currently receive coverage through the Bridge.</p> <p>The Bridge was approved in 2002 by the Centers for Medicare and Medicaid Services (CMS) as a component of the parental waiver. The parental waiver was scheduled to expire on January 24, 2007. The CMS has agreed to extend the parental waiver through June 30, 2007 to provide the state sufficient time to determine a strategy for continuing to provide coverage to children that would go through the bridge. As a condition of the extension, CMS required the state to send written confirmation by Friday February 9<sup>th</sup> accepting specific terms of the extension. As part of the extension, CMS is seeking a condition that the cost sharing of the Bridge be changed from 65/35 to 50/50 retroactive to 2002 when the Bridge was implemented. The Managed Risk Medical Insurance Board (MRMIB) sent a letter on February 9<sup>th</sup> stating that (1) the state wanted the extension, (2) would agree to a prospective change in the cost sharing arrangement, and (3) could not agree to a retroactive change in the cost sharing arrangement. CMS has rejected MRMIB's request that the cost sharing change only be implemented on a prospective basis.</p> <p>The HFP to Medi-Cal Bridge will be replaced by this policy change. Medi-Cal already has authority for Single Point of Entry (SPE) to grant presumptive eligibility (PE) in its State Plan, and current processes are already in place to transfer case information to the 58 counties for final determination. The administrative costs for this option would be minimal since administrative processes are already established; however, the existing Accelerated and CHDP Gateway cases transferred to the counties currently take an average of five months to complete. This will result in additional costs associated with Medi-Cal cases remaining on PE for more time than they do currently.</p> <p>There will be savings reflected in the MRMIB Budget for no longer providing the HFP to Medi-Cal Bridge coverage.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 1 (PC-OA)	X	X	<p><u>Single Point of Entry</u></p> <p>The Department and the Managed Risk Medical Insurance Board (MRMIB) have developed a revised family application form that can be used for both the Healthy Families Program (HFP) and Medi-Cal. This form is sent to a Single Point of Entry (SPE), where it will be screened to determine whether it should be forwarded to a county welfare department (CWD) for a Medi-Cal determination or to MRMIB for a Healthy Families determination.</p> <p>As part of the Governor’s FY 2005-06 initiative to expand health insurance coverage for children, the Department updated the joint Healthy Families/Medi-Cal application to further reduce the barriers to families applying for HFP and Medi-Cal. To accommodate these changes, the SPE requires systems modifications to accept the revised application and the determination of funding at MRMIB. These changes to the joint application will also result in changes to the electronic application (Health-e App). The additional cost for systems enhancements for the joint application revision <del>will be</del> <b>was</b> a one-time development cost in <del>the current year</del> <b>FY 2006-07</b>. The Department <del>will pay</del> <b>paid</b> the federal Title XIX share of this cost via an interagency agreement with MRMIB.</p>
E 2 (PC-5)	X	X	<p><u>Bridge to HFP</u></p> <p>The one-month Bridge from Medi-Cal to Healthy Families is currently for children who become ineligible for full-scope, zero share-of-cost (SOC) Medi-Cal. To be eligible for this Bridge, a child must have income at or below the Healthy Families income standard of 200% of poverty (although the use of an income disregard effectively raises the upper limit to 250% of poverty). Title XXI federal funding is used for this additional coverage. Medi-Cal managed care plan members remain enrolled in the managed care plan during the months of additional eligibility. Plans receive an additional <del>computation</del> <b>capitation</b> payment for each of these member months. This program may be replaced by the SB 437 Healthy Families Presumptive Eligibility Program, after <del>approval</del> of the <b>completion of an internal FSR</b>, and <b>needed</b> system development <b>changes, and issuance of instructions to the counties</b>.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 3 (PC-8) (PC-CA)	X	X	<p><u>Medi-Cal/Healthy Families Bridge Performance Standards</u></p> <p>To ensure that all children who are discontinued from Medi-Cal due to increased income have the opportunity to apply for the Healthy Families Program, the Department will implement county performance standards for compliance with the Medi-Cal-to-Healthy Families Bridge program, effective January 2007. Implementation of the standards is expected to increase the number of children eligible under the bridge program. It is anticipated the CWDs' first Bridging report for <del>March</del> <b>the review month of February</b> 2007 will be due on June 4 <del>29</del>, 2007. Thereafter, the report for October will be due the following January 1<sup>st</sup> of each year. If the CWDs do not meet the performance standards, the Department may reduce the county allocation of funds by up to 2% in the following year.</p>
E 4 (PC-13)	X	X	<p><u>Resource Disregard – % Program Children</u></p> <p>Based on the provisions of Senate Bill (SB) 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits. Enhanced federal funding is available through State Children's Health Insurance Program (SCHIP).</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 5 (PC-15)	X	X	<u>New Qualified Aliens</u>

The Personal Responsibility and Work Opportunity and Reconciliation Act of 1996 (PRWORA), as amended by the ~~Welfare Reform Bill~~, specifies that federal funding is not available for full-scope Medi-Cal services for most Qualified Nonexempt Aliens who enter the country on or after August 22, 1996, for the first five years they are in the country. Federal financial participation (FFP) is not available for nonemergency services for Not Qualified Aliens. These aliens are eligible for FFP for emergency services only. California is continuing to provide full-scope Medi-Cal services to aliens who have satisfactory immigration status under the pre-Welfare Reform laws. The cost of nonemergency services provided to the New Qualified Aliens is being identified through a retroactive tracking system and the federal government is being reimbursed on a retroactive basis for the FFP paid that is not available for these services.

Welfare Reform requires deeming an alien's sponsor's income and resources for Medicaid. Once a New Qualified Alien has been in the country for five years and the federal sponsored alien rules are applied, FFP is available for all services. The ~~CMS~~ **Centers for Medicare & Medicaid Services (CMS)** has not issued instructions on how the sponsored alien rules are to be implemented by the states. The Department will continue to claim FFP for nonemergency services for persons who have been here for more than five years until those instructions are issued.

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 6 (PC-14)	X	X	<p><u>Refugees</u></p> <p>Under the federal Refugee Act of 1980, the federal government will reimburse the State for 100 percent of the State's portion of the cost of Medi-Cal services for a limited period. For refugees in aid codes 01, 02 and 08, this federal funding is available during the first 8 months after admission effective December 1991. Effective June 20, 2000, Refugee Medical Assistance (RMA) provides 8 months of coverage even if Refugee Cash Assistance is discontinued or terminated. Asylees now receive 8 months of RMA from the date asylum is granted. Under the Trafficking Victims Protection Act of 2000, an individual who has been certified as a victim of a severe form of trafficking is considered a refugee and may receive refugee benefits. Certain immediate family members of victims of a severe form of trafficking will also be eligible for refugee benefits under the Trafficking Victims Protection Act of 2003.</p> <p>In 2004, the Department took over the monitoring of RMA/Entrant Medical Assistance (EMA) cases, beginning with the four counties with the highest number of cases. Monitoring will be done annually. The first review found that counties have allowed refugees to remain on RMA/EMA longer than the 8-month eligibility period. A total of \$63,147 was repaid to the federal Office of Refugee Resettlement (ORR) in FY 2005-06 for Federal Fiscal Year (FFY) 2001-02, 2002-03, and 2003-04. At ORR's request, the Department is conducting a review of all RMA/EMA cases in all counties from FFY 2003-04 through FFY 2005-06. The three-year review is expected to be completed in January 2007.</p> <p><b><u>Beginning July 1, 2007, the Refugee Resettlement Program (RRP) federal grant will be administered by the new California Department of Public Health (CDPH). The federal ORR will only allow one grant award to the State. Therefore, the Department of Health Care Services will invoice CDPH for reimbursement of refugee expenditures.</u></b></p>
E 7 (PC-OA)	X	X	<p><u>SSA Costs for Health Coverage Information</u></p> <p>The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 8 (PC-OA)	X	X	<p><u>Postage &amp; Printing</u></p> <p>Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Postage and printing costs may be charged to local assistance if the postage and printing is for items that will be sent to or used by Medi-Cal beneficiaries. <b><u>The reprographics functions for composing, printing, and mailing formerly performed by the Department's Central Issuance Distribution Mass Mailing Unit will be performed by the Office of State Publishing beginning in February 2007.</u></b></p> <p>Postage and printing costs for <i>Conlan, Schwarzmer, Stevens v. Bontá</i> lawsuit notices are included in this item.</p> <p>Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal, Breast and Cervical Cancer Treatment Program (BCCTP) and Family PACT enrollees, and at least every 3 years to existing beneficiaries. Postage and printing costs for the HIPAA NPP are included in this item.</p> <p>Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are included as a 100% General Fund cost.</p>
E 9 (PC-CA)	X	X	<p><u>Systematic Alien Verification for Entitlement System</u></p> <p>The federally mandated Systematic Alien Verification for Entitlement (SAVE) system was implemented in California on October 1, 1988. This system allows State and local agencies to make inquiries from a federal database to obtain information on the immigration status of aliens applying for entitlement benefits. The Department conducted an evaluation of the various modes available to access SAVE, and chose the existing <del>HEVS</del> system <b><u>Income and Eligibility Verification System</u></b> to provide that access. County administrative costs for using the SAVE system for Medi-Cal eligibility purposes are reimbursed 100% by the federal government.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 10 (PC-OA)	X	X	<p><u>Maternal and Child Health</u></p> <p>Federal matching funds are available for county administrative costs relating to the following services for Medi-Cal eligible women: (1) reduction of high death rate for African-American infants; (2) case management and follow-up services for improving access to early obstetrical care for pregnant women; (3) recruitment and technical assistance for providers under the Comprehensive Perinatal Services Program; (4) general maternal and child health scope of work local program activities, including perinatal education, services and referral; and (5) case management for pregnant teens, education and prevention of subsequent pregnancies.</p>
E 11 (PC-OA)	X	X	<p><u>Outreach – Children</u></p> <p>As a result of the Budget Act of 1997 and AB 1572 (Chapter 625, Statutes of 1997), the Healthy Families and Medi-Cal education and outreach campaign was launched in May 1998. The campaign included media, public relations, collateral, certified application assistants and training, a toll-free line for interested persons to call to request information and obtain an application, and contracts with community-based organizations and schools to provide outreach to enroll eligible children.</p> <p>The Budget Act of 2002 eliminated the advertising budget, including general market and ethnic advertising, parental expansion advertising, and immigrant community advertising; public relations; and collateral. The budget also eliminated the community-based and school outreach contracts. The 2002-03 Mid-Year Reduction eliminated funding for training of application assistants. The 2002-03 outreach was limited to funding of application assistance fees and a reduced toll-free line. In the Budget Act of 2003 outreach funding is limited to funding of a toll-free line.</p> <p>An Interagency Agreement with MRMIB was executed to fund the toll-free line with MAXIMUS starting January 1, 2004.</p> <p>The Budget Act of 2005 included funding for the reinstatement of application assistance fees. The Interagency Agreement with MRMIB was amended to include the federal funding for Medi-Cal costs for application assistance fees for children placed on accelerated enrollment and for the Medi-Cal related costs of processing the application assistance payments. The General Fund is budgeted by MRMIB.</p> <p>The Budget Act of 2006 increased the amount of the application assistance fees, including additional fees for those certified application assistants who use Health-e App.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 12 (PC-CA)	X	X	<u>Statewide Automated Welfare System (SAWS)</u>

The Statewide Automated Welfare Systems (SAWS) consist of four county consortium systems: the Los Angeles Eligibility Automated Determination Evaluation and Reporting (LEADER), the Consortium-IV (C-IV), the CalWORKs Information Network (CalWIN), and the Interim Statewide Automated Welfare Systems (ISAWS). The four consortium systems may be reduced to three by ~~2009~~ **2010** when the counties who currently use ISAWS (in operation since 1998), complete their planned migration to C-IV.

The LEADER Consortium has been in the maintenance and operation stage since May 1, 2001. Los Angeles County successfully completed the automation of the Section 1931 (b) program, the Continuous Eligibility for Children (CEC) program, and the Medi-Cal application in the LEADER system in June 2004. The initial vendor contract for LEADER expired in April 2005. However, the County executed a 24-month extension to its base contract commencing May 2005 and ending April 2007. As a result of a county study and discussions with the State, the County intends to replace the LEADER system with another existing SAWS system. The County anticipates awarding a contract to a development vendor by April 2007. While the proposed replacement system is modified and implemented, the County projects that the existing LEADER maintenance and operations contract will have to be extended for an additional ~~three~~ **five** years, through April ~~2010~~ **2012**, **with up to three optional one-year extensions beyond that date.**

The CalWIN consortium has been fully implemented in all 18 counties, with Fresno County being the last county to implement CalWIN, on July 5, 2006. The first county underwent case conversion and system implementation on the CalWIN system in January 2005. **CalWIN is currently in the maintenance and operation phase.**

The C-IV consortium is currently in the maintenance and operation phase.

The ISAWS consortium is currently in the maintenance and operation phase. In December 2004, the ISAWS counties made the decision to migrate to the C-IV system. The ISAWS counties' Consortium Migration Project (ICMP) is currently in the planning stage. **The ISAWS migration planning costs are currently identified for FY 2006-07 and FY 2007-08.**

In 1996, the Health and Human Services Data Center (HHSDC) was designated the lead State agency and project manager over the four county consortia systems. SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The Department and the California Department of Social Services (CDSS), which fund the four consortia, approved a cost allocation agreement based on person counts, rather than case counts.

E 13 (PC-CA)    X    X

CalWORKs Applications

The Budget Act of 1998 assumed that a portion of the costs for CalWORKs applications can be charged to Medi-Cal. CDSS has amended the claim forms and time study documents completed by the counties to allow CalWORKs application costs that are also necessary for Medi-Cal eligibility to be shared between the two programs.

E 14 (PC-OA)    X    X

State Hospital Eligibility Activities

The Medi-Cal Program is funding administrative activities at Napa State Hospital and Metropolitan State Hospital related to ensuring that patients in the hospital receive any assistance necessary to gather data needed for the determination of Medi-Cal eligibility, and that Medi-Cal requirements are complied with.

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 15 (PC-4) (PC-FI)	X	X	<p><u>CHDP Gateway</u></p> <p>In order to help ensure that all children have access to medical care, the CHDP Gateway program was implemented July 1, 2003. Through this program, approximately 669,000 children receiving a CHDP screen in 2005 were pre-enrolled in Medi-Cal/Healthy Families for up to two months of full-scope benefits, during which time the family could choose to apply for continuing Medi-Cal/Healthy Families coverage. Additionally, approximately 61,000 infants were deemed eligible for Medi-Cal/Healthy Families through the CHDP Gateway in 2005 for up to one year of full-scope benefits without applying. The total number pre-enrolled or deemed in 2005 was 730,000. To facilitate this application, each child for whom the family indicates a desire for continuing Medi-Cal/Healthy Families coverage is sent a joint Medi-Cal/Healthy Families application and cover letter insert. The application contains a toll-free telephone number available to families who have questions about the program, and is printed in eleven languages. The application is returned to the SPE for Medi-Cal/Healthy Families.</p> <p>The state-funded CHDP Program continues to provide screens to children eligible for limited-scope Medi-Cal. Effective October 1, 2003, the federal share of funding for the pre-enrollment costs is Title XXI funds, as required by federal statute. Sharing ratios are 65% FFP/35% GF for children with income between Medi-Cal limits and 250% of poverty. For children with income below Medi-Cal limits, the sharing ratio is 50% FFP/50% GF.</p> <p>Medi-Cal receives funding from the Childhood Lead Poisoning Prevention (CLPP) Fund to cover blood lead testing as part of the CHDP Health Assessment for young children with risk factors for lead poisoning.</p>
E 16 (PC-OA)	X	X	<p><u>Merit System Services for Counties</u></p> <p>Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. As many counties do not have a civil service system, the Department contracts with the State Personnel Board for Merit System Services to perform as a personnel board for those counties. Merit System Services administers a civil service system for employment and retention of Medi-Cal staff in 30 CWDs and oversight in the other 28 counties. In order to mirror the funding for this service included in the CDSS budget, beginning in FY 2003-04, funds for the contract with Merit System Services are being budgeted in the Department's local assistance budget, rather than in the state support budget where they had previously been budgeted.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 17 (PC-16)	X	X	<p><u>Accelerated Enrollment – SCHIP Title XXI</u></p> <p>Applications received by the SPE are screened for Medi-Cal eligibility. Effective July 2002, if a child appears to be Medi-Cal eligible without a SOC, the SPE will establish accelerated enrollment for the child and input an eligibility transaction to the MEDS database. Effective October 1, 2003, the 50% federal share of the accelerated enrollment costs is funded from Title XXI, as required by federal statute.</p>
E 18 (PC-CA)	X	X	<p><u>IHSS County Administration Costs</u></p> <p>Federal regulations require that Medi-Cal eligibility for non-SSI Medicaid beneficiaries be determined by Medicaid eligibility workers using Medi-Cal rules. In twenty counties, applicants for In-Home Supportive Services (IHSS) have their Medi-Cal application and personal care needs assessment determined by IHSS social service workers. The Department instructed counties by an All-County Welfare Directors' Letter (ACWDL) to change their procedures effective August 2004 so that Medi-Cal eligibility and SOC will be determined by Medi-Cal eligibility workers following Medi-Cal rules. IHSS social service workers will complete the personal care needs assessment for the in-home care applicants. The Medi-Cal determinations by Medi-Cal eligibility workers were completed for just over 39,000 beneficiaries in January 2006. All new applicants now receive Medi-Cal eligibility determinations by Medi-Cal eligibility workers.</p>
E 19 (PC-3) (PC-CA)	X	X	<p><u>Redetermination Form Simplification</u></p> <p>The Medi-Cal annual redetermination form (MC 210 RV) has been revised to make it more user friendly, shorter, and easier for beneficiaries to complete. As a result of the changes in the form, more beneficiaries who would have otherwise not completed the form and therefore would no longer be eligible will now complete the annual redetermination process and maintain coverage.</p>
E 20 (PC-CA)	X	X	<p><u>County Cost of Doing Business</u></p> <p><b><u>Based on the Medi-Cal County Administration Cost Control Plan,</u></b> county welfare department administrative costs cost increases for Medi-Cal eligibility determinations are expected to increase at the rate <b><u>were limited to a maximum increase</u></b> of 4.17% for FY 2006-07. The FY 2007-08 increase is anticipated to be 3.26% <b><u>limit will be 3.70%</u></b> The rate of increase is based on <b><u>the final Department of Finance</u></b> California Necessities Index <del>projections</del> <b><u>projection for 2007-08.</u></b></p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
E 21 (PC-OA)	X	X	<p><u>Children's Outreach Initiative</u></p> <p>Despite increases in Medi-Cal applicants and HFP enrollment over the past several years, a number of California children continue to have no health care coverage. Many of these children would be eligible for Medi-Cal or HFP, but have not pursued coverage. If the State can persuade families to apply or enroll, the number of children without health care coverage in California would be reduced.</p> <p>The Department <del>will engage</del> <b>is engaging</b> in two activities to increase participation in the public programs:</p> <ul style="list-style-type: none"> <li>• County allocations</li> <li>• Toll-free telephone line</li> </ul> <p>The Department will allocate funding to the 20 counties with the greatest number of uninsured children to partner with public and private community organizations for outreach, streamlined enrollment, retention of health coverage, and appropriate utilization of health care; and to <del>5 to</del> <b>40</b> other counties that have established community networks and infrastructures. The Medi-Cal/HFP toll-free line will be augmented to handle the increased volume of calls generated by the county allocation activities.</p>
E 22 (PC-CA)	X	X	<p><u>Los Angeles County Hospital Intakes</u></p> <p>Los Angeles County uses Patient Financial Services Workers (PFSWs) to process Medi-Cal applications taken in Los Angeles County hospitals. Welfare and Institutions (W&amp;I) Code Section 14154 limits the reimbursement amount for PFSW intakes to the rate that is applied to Medi-Cal applications processed by the Los Angeles County Department of Social Services eligibility workers. The federal share for any costs not covered by the Department of Social Services rate is passed through to the county. Cases are referred to the County Department of Social Services for case maintenance.</p>
E 23 (PC-CA)	X	X	<p><u>Eligible Growth</u></p> <p>The county administrative cost base estimate does not include costs anticipated due to the growth in the number of Medi-Cal only eligibles. Funds are added through a policy change item based on the cost impact of the expected growth in the average monthly number of Medi-Cal only eligibles. The number is adjusted with each Estimate with updates of the latest base eligible count. The policy change presumes that counties will hire staff to process the new applications and maintain the new cases.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 24 (PC-12)	X		<p><u>Hurricane Katrina Section 1115 Demonstration Waiver</u></p> <p>The federal government has approved California's participation in the Hurricane Katrina Section 1115 Demonstration Waiver. Under this waiver, an evacuee may apply for coverage between August 28, 2005 and January 31, 2006. Coverage continues for five months from month of application. The final date of coverage is May 31, 2006. There are over 300 Medi-Cal evacuees and 2,500 CalWORKs evacuees that have Medi-Cal linkage that are eligible under the waiver. The total costs of the Medi-Cal services provided to these evacuees will be shared between FFP at the Federal Medical Assistance Percentage for the home state of the evacuee and a federal grant award, resulting in 100 percent coverage of those Medi-Cal costs.</p>
E 25 (PC-7)	X	X	<p><u>Eligibility for Children in Month Prior to SSI/SSP Grant</u></p> <p>Currently automatic eligibility for Medi-Cal is provided to SSI/SSP program recipients in the month in which they receive their first SSI/SSP check. This is the month following the month of application for SSI/SSP, or the month in which their SSI/SSP eligibility is determined, whichever is later. This eligibility is established and notices of action generated systematically on the MEDS based upon information that comes from the Social Security Administration through monthly transmission of computer files.</p> <p>The Deficit Reduction Act (DRA) of 2005 creates a mandatory program for disabled individuals under 21 years of age who are determined to be eligible for SSI/SSP and receive their first check in the following month. The DRA provides these individuals with Medicaid in the month prior to the first month in which they receive a grant. CMS has given the Department its approval to establish this eligibility systematically based upon the dates included in the monthly computer data files received from SSA. This mandatory coverage group will be effective with the February 2007 month of eligibility.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 26 (PC-6)	X	X	<p><u>Shift of CCS State/County Costs to Medi-Cal</u></p> <p>With implementation of the enhancements to the CMS Net system to utilize eligibility data stored on the MEDS, claims for California Children's Services (CCS)-Only children determined to be retroactively eligible for Medi-Cal may be processed in the claim payment system as CCS-Only prior to the Medi-Cal determination becoming effective in MEDS. In order to properly charge these costs to the Medi-Cal program, beginning in April 2006 these claims are being periodically reprocessed at the Medi-Cal Fiscal Intermediary. The reprocessing results in crediting the CCS Program for claims previously paid as CCS-Only and charging the costs to Medi-Cal. This reprocessing to capture retroactive Medi-Cal coverage will be an ongoing process and will occur every year.</p>
E 27 (PC-OA)	X	X	<p><u>CHDP Gateway Electronic Application FSR</u></p> <p>AB 1948 (Chapter 332, Statutes of 2006) requires the Department to conduct or contract for a FSR of technological requirements for modifying the CHDP Gateway electronic application to allow simultaneous preenrollment and application for Medi-Cal or the Healthy Families Program (HFP) over the Internet, without submitting a follow-up paper application. The Department is required to consult with representatives of consumers, counties and medical providers in the development of the policies and procedures prior to development of the FSR. The FSR itself will take six months to complete. The results of the FSR are to be provided to the fiscal and health policy committees of the Legislature by March 1, 2008. Additionally, two full-time contract staff are required to provide support to efforts such as policy discussions, requirements, and technical expertise. The contract staff will be needed for six months.</p> <p>The Department will enter into contracts for the development of this FSR.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
E 28 (PC-OA)	X	X	<p><u>SB 437 WIC Gateway and Presumptive Eligibility Programs FSR</u></p> <p>SB 437 (Chapter 328, Statutes of 2006) requires the Department and the MRMIB to make several program changes to streamline, simplify, and enhance the application process for Medi-Cal and HFP. The provisions of the bill that require systems changes involve the Women, Infants and Children (WIC) Gateway and two new Presumptive Eligibility (PE) programs to replace the current Medi-Cal to HF Bridging process and the HF Accelerated Enrollment process (under development).</p> <p>Systems modifications require the completion of a technological FSR to determine the amount and types of systems resources needed for these projects. The FSR requires the services of a project management consultant <del>for nine months</del> to develop and complete the FSR. Additionally, two full-time contract staff are required to provide information data processing guidance to stakeholders, Department and MRMIB staff, the counties, and others involved in developing policies and procedures for the technological modifications to the CHDP Gateway and the two PE programs, in preparation for the development of the FSR. The contract staff are needed for nine months.</p>
E 29 (PC-11) (PC-CA)		X	<p><u>SB 437 Self-Certification</u></p> <p>SB 437 (Chapter 328, Statutes of 2006) establishes a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without the need to submit income or asset documentation. The first phase will be a pilot program to be implemented in two counties in July 2007. The second phase will implement statewide in July 2009 provided the evaluation of the pilot shows that the pilot increased enrollment and protected the integrity of the program, and the Legislature appropriates funding for the expansion.</p>
E 30 (PC-OA)		X	<p><u>SB 437 WIC Staffing FFP</u></p> <p>SB 437 (Chapter 328, Statutes of 2006) requires that a system be developed so that children applying for the WIC program can submit a simple electronic application to simultaneously obtain presumptive eligibility for the Medi-Cal and Healthy Families programs. The WIC program will require three staff positions to implement this change. Title XIX Medicaid matching funds are available for the positions. Because the WIC program will be in a different department (Department of Public Health) from the Medi-Cal program (Department of Health Care Services) beginning in July 2007, an interagency agreement between the departments will be required to allow for the provision of federal funds as a reimbursement to the WIC program. The matching GF will be budgeted in the WIC program in the Department of Public Health.</p>

**BENEFITS: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 0.1 (PC-NA)	X	X	<u>In-Home Operations Waiver</u>

CMS has approved a new waiver, the In-Home Operations (IHO) Waiver, for a three-year period effective January 1, 2007 through December 31, 2009. The IHO Waiver has a capacity of 210 participants, and consists of two groups of eligibles:

1. Eligible individuals from two prior waivers, the NF A/B and NF Subacute Waivers, have transitioned either to this waiver or the Nursing Facility/Acute Hospital (NF/AH) Waiver in February 2007. The individuals transferring to the IHO Waiver are those who were enrolled in the NF A/B and NF Subacute Waivers, have been enrolled since June 1, 2002, have services comprised almost entirely of nursing services, and whose Menu of Health Services (MOHS) costs are in excess of the Level of Care (LOC) cost cap for the new NF/AH Waiver. Each current participant's LOC and waiver costs will remain the same as previously authorized.
2. The second group of eligibles is individuals who are currently in an acute hospital, have been receiving 36 consecutive months of care in the acute hospital and have physician-ordered direct care services in excess of the NF/AH Waiver cost neutrality for the individual's LOC. The Department has identified one individual who meets these criteria. Little or no future enrollment is expected after the initial transition/enrollment period, as any new participant must meet the criteria of at least 36 consecutive months of care in an acute hospital.

## BENEFITS: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
B 0.2 (PC-141)		X
		<u>Home Tocolytic Therapy</u>
		<p>SB 1528 (Chapter 666, Statutes of 2006) mandates Medi-Cal coverage of home infusion treatment with tocolytic agents for pregnant women. Tocolytic agents, such as terbutaline, which is used for home infusion treatment, are used to arrest and control preterm labor. A select group of women are stable for discharge, but have failed a trial of oral medication. For these women, one option is home infusion of terbutaline via a subcutaneous pump as used for some diabetic patients. While at home, these women also use a home uterine activity monitor to detect any uterine contractions. This information is transmitted telephonically each day to a service center staffed by trained registered nurses. Telephonic nursing and pharmacy support is available to the beneficiary around the clock. Finally, home visits are performed as needed, the tocolytic medication, educational and other supplies are provided, and the patient's physician is routinely updated.</p> <p>As there are currently no Medi-Cal providers who provide this service, it is anticipated that costs will not begin until approximately July 2007. An evaluation of the medical and cost effectiveness of the treatments is due to the Legislature on October 1, 2009. The statute sunsets January 1, 2010.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
B 1 (PC-OA)	X	X	<p><u>Public Health Nurses for Foster Care</u></p> <p>The Budget Act of 1999 included funds for the CDSS to establish a program utilizing foster care public health nurses in the child welfare program to help foster care children gain access to health-related services. The public health nurses are employed by the counties and funded through CDSS General Funds and Title XIX matching funds. The program is administered by the Children's Medical Services Branch in CDHS, via an interagency agreement with CDSS.</p>
B 2 (PC-18)	X	X	<p><u>Local Education Agency (LEA) Providers</u></p> <p>Through the LEA Billing Option, LEAs can become Medi-Cal providers and submit claims for services to Medi-Cal beneficiaries within their jurisdiction. LEA providers may bill retroactively for services rendered up to one year prior to their date of enrollment as long as claims are billed within the statutory billing limit. <del>The Medi-Cal program will provide matching federal funds to the LEAs.</del> <b><u>LEAs claim FFP for specific services as authorized in W&amp;I Code Section 14132.06.</u></b></p> <p>State Plan Amendment 03-024, approved in March 2005, implemented a new methodology for reimbursement. The system changes <del>are</del> <b><u>were</u></b> effective as of July 2006, <del>retroactive to April 2003.</del> <b><u>The retroactive claiming will depend on the LEA's ability to meet CMS's documentation requirements.</u></b> Interim rates based on a rate study <del>will be</del> <b><u>are</u></b> used for covered LEA services and costs will be reconciled against reimbursements.</p> <p>AB 2950 (Chapter 131, Statutes of 2006) amends W&amp;I Code, Section 14115, to eliminate reductions in reimbursement rates for TCM and LEA Billing Option claims submitted between <del>6</del> <b><u>7</u></b> and 12 months after the month of service. AB 2950 will result in additional FFP costs due to elimination of the reductions as a result of late invoice submittal.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 3 (PC-109)	X	X	<p><u>Medi-Cal TCM Program</u></p> <p>The Targeted Case Management (TCM) program assists Medi-Cal beneficiaries in accessing needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, linkage and consultation, assistance with accessing services, crisis assistance planning, and periodic review. Through rates established in the annual cost reports, local governments claim FFP for these case management services. The TCM Program is regulated by W&amp;I Code section 14132.44. The existing target populations of Medi-Cal beneficiaries that can receive TCM services are public health, public guardian, linkages, outpatient, adult probation and community.</p> <p>SB 308 (Chapter 253, Statutes of 2003) redefines Local Governmental Agencies to include Native American Indian tribes <b><u>and tribal organizations as well as subgroups of these entities</u></b>. This allows these tribes to participate in the Targeted Case Management (TCM) programs. The staff augmentation in July 2005 focused on the preliminary phased-in implementation of this bill. <del>With the augmentation of staff in June 2006, the Department will be requesting federal approval to implement this program.</del> <b><u>Staff appropriated for SB 308 implementation are currently focused on Tribal MAA implementation. After CMS approves the Tribal MAA Implementation Plan, staff will begin discussions with the Tribal community regarding Tribal TCM.</u></b></p> <p>AB 2950 (Chapter 131, Statutes of 2006) amends W&amp;I Code, Section 14115, to eliminate reductions in reimbursement rates for TCM and LEA Billing Option claims submitted between 6 and 12 months after the month of service. AB 2950 would result in additional FFP costs due to elimination of the reductions as a result of late invoice submittal.</p>
B 4 (PC-106)	X	X	<p><u>Targeted Case Management Services – CDDS</u></p> <p>The Department provides Title XIX FFP for regional center case management services, as provided to eligible developmentally disabled clients via contract with the California Department of Developmental Services (CDDS) and authorized by the Lanterman Act. CDDS conducts a rate study every three years to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible. FFP for Medi-Cal eligibles is authorized by a SPA.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 5 (PC-OA)	X	X	<p><u>Disease Management Program</u></p> <p>W &amp; I Code Section 14132.27 requires the Department to apply for a federal waiver to test the efficacy of providing a disease management (DM) pilot benefit to fee-for-service Medi-Cal beneficiaries. In response to CMS and industry input, the Department has elected to implement the pilot program to test the disease management benefit through the administrative model, instead of through a waiver. The administrative model does not require CMS approval. The effectiveness of this benefit includes demonstration of the cost neutrality of the DM program. To achieve this goal, the Department will enter into contracts with one or more disease management organizations (DMO) and one or more independent evaluation contractors. One DMO contract will cover the following conditions: advanced atherosclerotic disease syndrome, asthma, coronary artery disease, diabetes and chronic obstructive pulmonary disease (DM1). A second DMO contract will focus on HIV/AIDS separately (DM2). DM1 <del>started in August 2006</del> <b>began in February 2007</b>. The assessment for DM1 is scheduled to begin in <del>FY 2006-07</del> <b>March 2007</b>. DM2 is scheduled to begin in <del>January</del> <b>June 2007</b>.</p>
B 6 (PC-OA)	X	X	<p><u>Medi-Cal Administrative Activities</u></p> <p>AB 2377 (Chapter 147, Statutes of 1994) authorizes the State to implement the Medi-Cal Administrative Claiming process. The Medi-Cal program will submit claims on behalf of local governmental agencies (LGAs) to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the Medi-Cal program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of Medi-Cal services.</p> <p>Section 105 of AB 2780 (Chapter 310, Statutes of 1998), allows school districts the option of claiming Medi-Cal Administrative Activities through their local educational "consortium" (LEC), or through the LGA.</p> <p>Both LGAs and LECs <b><u>contract with the Department for reimbursement and</u></b> may amend prior year contracts up to the two-year retrospective federal claiming limitation. Prior year contract amendments are generated when additional funds, such as special local initiatives and Proposition 10 funds, are made available as the certified public expenditure.</p> <p>SB 308 (Chapter 253, Statutes of 2003) redefines Local Governmental Agencies to include Native American Indian tribes <b><u>and tribal organizations, as well as subgroups of these entities</u></b>. This allows these tribes to participate in the Medi-Cal Administrative Activities (MAA) program. With the augmentation of staff in July 2005, the Department has requested federal approval to implement this program.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 7			<u>Home and Community-Based Services Waivers</u>
			SB 2012 (Chapter 94, Statutes of 1982) added home and community-based services to Medi-Cal when federal waivers are granted.
(PC-103)	X	X	A. <u>Home and Community Based Services – CDDS</u>
			CMS approved the renewal of the waiver for another five years, effective October 1, 2006 through September 30, 2011. The enrollment cap for the first year of the waiver is estimated to be 75,000, and the cap will increase to 95,000 by the fifth year. The FY 2006-07 estimate includes a 3% provider rate increase effective July 1, 2006.
(PC-19) (PC-OA)	X	X	B. <u>Multipurpose Senior Services Program – CDA</u>
			On April 9, 2004, CMS approved the renewal of the Multipurpose Senior Services Program (MSSP) Waiver, for the period of July 1, 2004 through June 30, 2009. MSSP provides waiver services to individuals 65 years or older who are Medi-Cal eligible and who, in the absence of this waiver and as a matter of medical necessity, would otherwise require care in a nursing facility. MSSP is operated by the California Department of Aging with mandated CDHS oversight.
			The Department pays the MSSP claims and, prior to FY 2006-07, both the GF and FFP were budgeted in the CDHS budget. The Budget Act of 2006 removed the GF from the CDHS budget and included it in the CDA budget beginning with FY 2006-07. The Budget Act also increased the CDHS reimbursement authority so that the CDA GF can be transferred back to CDHS as a reimbursement at the beginning of the fiscal year and CDHS can pay the MSSP claims.

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
(PC-23) (Reworded)	X	X	<p>C. <u>Nursing Facility/Acute Hospital (NF/AH) Waiver</u></p> <p>CMS approved the renewal of the Nursing Facility A and B (NF A/B) Waiver for a five-year period effective January 1, 2007 through December 31, 2011. At the time of renewal, the NF/Subacute and In Home Medical Care (IHMC) Waivers were combined with the NF A/B Waiver and the name was changed to the Nursing Facility/Acute Hospital (NF/AH) Waiver. The NF/AH Waiver maintains the NF A/B, NF Subacute, and Acute Hospital level of care (LOC) that were previously in the separate waivers.</p> <p>The NF/AH Waiver currently has a maximum enrollment of 2,392 participants, with 1,240 slots reserved for NF A/B LOC, 852 reserved for NF Subacute LOC and 300 reserved for the Acute Hospital LOC.</p> <p>Currently, 549 individuals are receiving services at the NF A/B LOC, 348 individuals are being assessed for enrollment and 772 individuals are on the NF A/B LOC waiting list. Of the 549 receiving NF A/B LOC services, 150 individuals have transitioned to the IHO Waiver. Of the 348 NF A/B LOC individuals being assessed, approximately 213 are beneficiaries currently residing in the community and the Department expects to enroll the individuals being assessed at a rate of approximately 28 slots per month.</p> <p>The 500 NF A/B LOC slots, as required by SB 643 (Chapter 551, Statutes of 2005), will be filled by alternating a Medi-Cal beneficiary transitioning from a facility with an individual from the community.</p>
(PC-NA) (Reworded)	X	✗	<p>D. <u>Nursing Facility Subacute Waiver</u></p> <p>The Nursing Facility Subacute (NF/SA) Waiver has been combined with the NF A/B and IHMC Waivers and all waiver participants have transitioned to the NF/AH or IHO Waivers. The NF/SA waiver terminated effective February 28, 2007.</p>
(PC-NA) (Reworded)	X	✗	<p>E. <u>In-Home Medical Care Waiver</u></p> <p>The In-Home Medical Care (IHMC) Waiver has been combined with the NF A/B and NF Subacute Waivers and all waiver participants are transitioned to the NF/AH Waiver. The IHMC Waiver terminated effective February 28, 2007.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
(PC-NA) (Reworded)	X	X	F. <u>AIDS Waiver</u>  This waiver serves Medi-Cal eligible HIV/AIDS patients who otherwise would need NF or acute hospital care. CMS first approved the waiver effective January 1, 1989, after which clients began receiving services in early June of 1989. On December 26, 2006, CMS approved the most recent renewal for the term January 1, 2007 through December 31, 2011.
B 8 (PC-OA)	X	X	<u>Health-Related Activities</u>  Health-related activities are services that aid Medi-Cal eligibles to gain access to medical services or to maintain current levels of treatment. Title XIX federal funds are passed through to CDSS for health-related activities performed by social workers in the counties.
B 9 (PC-112)	X	X	<u>Waiver Personal Care Services</u>  AB 668 (Chapter 896, Statutes of 1998) required Medi-Cal to add personal care services to the NF A/B and NF SA Waivers. On September 23, 2004, CMS approved an amendment effective April 1, 2004, renaming the benefit "Waiver personal care services" to "Home and Community-Based Services Personal Care (HCBSPC)". <b><u>With the approval of the NF/AH and IHO Waivers, the benefit has again been renamed "Waiver Personal Care Services (WPCS)". This service is not available to those individuals at the Hospital LOC due to their extensive medical needs.</u></b> HCBSPC <b><u>WPCS</u></b> is one option on the menu of services <b><u>MOHS</u></b> that waiver participants may choose from, to the extent that waiver cost neutrality is assured. This benefit was redefined to include services that differ from those in the State Plan, and that help support a <b><u>Medi-Cal</u></b> beneficiary's choice to remain in the home and community. There is no longer a requirement that waiver consumers receive the maximum of 283 hours of State Plan Personal Care Services (SPPCS) prior to receiving HCBSPC <b><u>WPCS</u></b> . However, waiver consumers <b><u>participants</u></b> must be receiving some amount of SPPCS to be eligible for HCBSPC <b><u>WPCS</u></b> . These services are provided through the counties' IHSS programs, and will be paid via an interagency agreement with CDSS or are provided by home health agencies, <b><u>employment or personal care agencies.</u></b>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
B 10 (PC-99) (PC-OA)	X	X	<p><u>Personal Care Services</u></p> <p>As of April 1993, the Medi-Cal program has covered personal care services as a benefit. This is accomplished by making Title XIX funds available to the In-Home Supportive Services (IHSS) Program under the administrative control of CDSS. The Department still retains authority over the provider reimbursement rates.</p> <p><del>CMS has revised its interpretation of the State Plan Personal Care Services Program (PCSP) to include protective supervision and domestic and related services, effective August 1, 2004. The Terms and Conditions of the new IHSS Plus Waiver include the authority for a one-time claim of retroactive FFP for these services as State Plan PCSP services. The retroactive claiming is limited by 1) the amount of FFP that would have been claimed if the new waiver, with protective supervision and domestic and related services included, had been approved effective May 4, 2004, through the actual effective date of August 1, 2004; and 2) the allowable two-year retroactive federal claiming period. After August 1, 2004, protective supervision and domestic and related services will be ongoing State Plan PCSP services. The retroactive claiming was fully funded in 2004-05.</del></p>
B 11 (PC-17) (PC-OA)	X	X	<p><u>Adult Day Health Care – CDA</u></p> <p>ADHC is a community-based day program providing a variety of health, therapeutic, and social services designed to serve those at risk of being placed in a nursing home. ADHC became an optional Medi-Cal benefit in 1978. ADHC rates, which are set at 90% of the NF-A weighted average rate, increased by 3.62% effective August 1, 2006.</p> <p>In December 2003, CMS notified the Department that ADHC must be approved under a waiver or State Plan Amendment (SPA), with specified changes to the program in order to continue receiving federal funding. SB 1755 (Chapter 691, Statutes of 2006), which was signed by the Governor in September of 2006, <del>will authorize CDHS</del> <b>authorizes the Department</b> to make major reforms to the ADHC program over the next three years. A SPA will be submitted to CMS in 2009 that details the authorized reforms.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
B 12 (PC-34)	X	X

SCHIP Funding for Prenatal Care

In order to maximize revenues, the Budget Act and Health Trailer Bill of 2005, require MRMIB to file a SPA in the SCHIP to claim 65% federal funding for prenatal care provided to women currently ineligible for federal funding for this care. The cost for this care is currently 100% General Fund. The SPA which was filed on June 30, 2005 allows SCHIP funding to be claimed for both 2004-05 and 2005-06 in 2005-06. Funding is being claimed for undocumented women, and for legal immigrants who have been in the country for less than five years. CMS approved the SPA in March 2006.

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 13 (PC-20) (PC-FI) (Reworded)	X	X	<p><u><i>Conlan v. Bontá; Conlan v. Shewry</i></u></p> <p>In <i>Conlan v. Bontá</i> and <i>Conlan v. Shewry</i>, the petitioners sought an administrative process for directly reimbursing Medi-Cal beneficiaries who incurred out of pocket medical expenses. After two appellate court decisions, <i>Conlan v. Bontá</i> (2002) 102 Cal.App.4th 745; <i>Conlan v. Shewry</i> (2005) 131 Cal.App.4th 1354, and a series of hearings at the trial court level, the Department was ordered to implement a process by which Medi-Cal beneficiaries may obtain prompt reimbursement for paid medical expenses for Medi-Cal covered services.</p> <p>On November 16, 2006, the California Superior Court, County of San Francisco, approved the Department's Revised Implementation Plan (Plan) to establish a Medi-Cal beneficiary reimbursement process.</p> <p>The Plan details a beneficiary reimbursement process under which the Department will ensure Medi-Cal beneficiaries are promptly reimbursed for out of pocket paid medical expenses for covered Medi-Cal services/benefits. The Plan includes Medi-Cal services/benefits administered by other departments. Under the approved Plan, beneficiary reimbursement may occur as the result of: 1) voluntary reimbursement by the provider (whereby the provider who received the payment from the beneficiary will reimburse the beneficiary the full out of pocket payment); 2) "recoupment" (whereby the designated department diverts funds from the provider and reimburses the beneficiary the full out of pocket payment); or 3) direct payment (whereby the designated department determines that recoupment is not feasible and reimburses the beneficiary at the amount paid by the beneficiary, not to exceed the Medi-Cal rate for the applicable service/benefit).</p> <p>On December 26, 2006, the Department sent notices to all current and former Medi-Cal beneficiaries who were eligible at any time since June 27, 1997. The notice was sent to an estimated 11 million households and will provide information regarding the availability of the new reimbursement process as well as contact information for assistance to file a claim. Claims for reimbursement which are denied in whole or in part may be appealed by the beneficiary through the fair hearing process.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
B 14 (PC-99)	X	X	<p><u>In-Home Supportive Services Plus §1115 Waiver Demonstration Program</u></p> <p>The Department submitted a federal Medicaid §1115 demonstration waiver application to CMS in May 2004 to cover previously county and state-funded In-Home Supportive Services (IHSS) Program costs under Medi-Cal. The waiver was approved for the period of August 1, 2004 through July 30, 2009. When recipients have any unit of personal care service provided by a parent/spouse, are cashed out for a restaurant meal (in lieu of meal preparation), or are cashed out through the advance pay option, all of their personal care services are covered under the waiver. The demonstration waiver enables federal financial participation for both allowable services and waiver administration.</p> <p>The state funded IHSS residual program now covers only in-home services for individuals not eligible for federally funded full-scope Medi-Cal coverage.</p>
B 15 (PC-35)	X	X	<p><u>CDSS Share of Cost Payment for IHSS</u></p> <p>The CDSS and the California Department of Health Services (CDHS) have implemented a process that enables Medi-Cal In-Home Supportive Services (IHSS) recipients who have a Medi-Cal share-of-cost (SOC) higher than their IHSS SOC to be eligible for Medi-Cal at the beginning of each month. Each IHSS recipient with a Medi-Cal SOC that exceeds his/her IHSS SOC must meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.</p> <p>Prior to the complete automation of the Case Management, Information, and Payrolling System (CMIPS), the IHSS chore service worker payroll computer system, an interim process, has begun to reconcile the difference between the IHSS and Medi-Cal SOC, where the Medi-Cal SOC exceeds the IHSS SOC, and to allow the IHSS recipients to access Medi-Cal eligibility on the first day of each month. An Interagency Agreement between CDSS and CDHS has established the process for the transfer of CDSS funds to prepay the Medi-Cal SOC for IHSS recipients.</p> <p>Effective June 1, 2006, CMIPS became fully automated to work as a Point of Service device. IHSS individuals no longer are certified at the beginning of the month and their shares of cost are spent down with both medical expenses and IHSS. CDSS will only fund services for each IHSS recipient in an amount equal to the difference between the monthly Medi-Cal SOC and the IHSS SOC.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
B 16 (PC-27)	X	X

Elimination of TARs for Podiatry Services

The Health Budget Trailer Bill of 2006 amended the W&I Code, section 14133.07, to remove certain podiatry services from prior authorization. Prior authorization for podiatric services provided on an outpatient or inpatient basis shall not be required when all of the following conditions are met:

- (1) The services are provided by a podiatrist acting within the scope of his/her practice.
- (2) The services are related to trauma, infection management, pain control, wound management, diabetic foot care, or limb salvage.
- (3) The services are medically necessary.
- (4) An urgent need for services exists at the time the service is provided.
- (5) The patient was referred to the doctor of podiatric medicine by a physician.
- (6) Prior authorization is not required for a physician providing the same service.

Prior to implementation of this legislation, podiatric office visits, certain laboratory and radiology services, orthotic costs less than \$250, and prosthetic costs less than \$500 were covered without the need for prior authorization. All other outpatient and inpatient podiatry services were subject to prior authorization, and limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, that are secondary to or complicating chronic medical diseases, or that significantly impair the ability to walk.

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 17 (PC-36)		X	<p><u>Adult Day Health Care Reforms</u></p> <p>The Department will institute several adult day health care (ADHC) reforms as a result of passage of SB 1755 (Chapter 691, Statutes of 2006). The reforms are:</p> <ul style="list-style-type: none"> <li>• Unbundling of the current all-inclusive ADHC procedure code into its component services. A single bundled procedure code representing unskilled services would remain with skilled services having their own procedure codes. Only the bundled procedure code that includes the ADHC centers' overhead and unskilled services would require prior authorization, with the ADHC centers being able to "bill direct" for the skilled services.</li> <li>• Tightening medical necessity criteria so that only those recipients that truly require specific services can receive authorization for ADHC.</li> <li>• Performance of post-payment reviews of participant charts by CDA during their regular surveys to ensure that services billed and paid for were actually provided and were medically necessary. The Department would institute an audit recovery process when services are found to have been paid that were not provided and/or not medically necessary.</li> <li>• Change in reimbursement to a prospective cost-based methodology.</li> <li>• Clarify (1) the role of the patient's personal care doctor and that of the staff doctor at the ADHC center; and (2) the responsibility of the ADHC center to assist in establishing a personal care doctor for the patient.</li> </ul>
B 18 (PC-37) (Reworded)	X	X	<p><u>Expansion of <del>NF A/B</del> <b>NF/AH</b> Waiver (SB 643)</u></p> <p>SB 643 (Chapter 551, Statutes of 2005) requires the Department to increase the number of NF A/B Waiver slots by 500, reserving 250 for Medi-Cal beneficiaries transitioning from facilities, and adding community transition services and habilitation services as available waiver services. CMS approved the renewal of the NF A/B Waiver for a five-year period effective January 1, 2007, through December 31, 2011. At the time of renewal, the NF/Subacute and IHMC Waivers were combined with the NF A/B Waiver and the name was changed to the NF/AH Waiver. The NF/AH Waiver maintains the NF A/B, NF Subacute, and Acute Hospital levels of care that were previously in the separate waivers. The above slot increases were approved for the NF/AH Waiver. The new services will be implemented on May 1, 2007 when new procedure codes are implemented. For every slot filled by a Medi-Cal beneficiary in a facility there will be a slot filled by an individual from the community. This approach will ensure that the Department will demonstrate fiscal neutrality within the overall Department budget for these slots, and federal fiscal neutrality as required under the terms of the federal waiver.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 19 (PC-28)	X	X	<u>New Services and Provider Types for Nursing Facility A/B, NF Subacute and In-Home Medical Care NF/AH and IHO Waivers</u>

**CMS approved the renewal of the NF A/B Waiver. At the time of renewal, the NF/Subacute and IHMC Waivers were combined with the NF A/B Waiver and the name was changed to the NF/AH Waiver. The NF/AH Waiver maintains the NF A/B, NF Subacute, and Acute Hospital LOC that were previously in the separate waivers.**

The Department has submitted a request for a Systems Design Notice (SDN) to create HIPAA-compliant procedure codes to allow for the payment of additional services and provider types previously approved by CMS in the three waivers **for the NF/AH and IHO Waivers.** The new services to be implemented are:

- Respite-Facility
- Respite
- Transitional Case Management
- ~~Waiver Services Coordination~~
- Community Transition Services
- ~~Habilitative~~ **Habilitation** Services

Although it is anticipated that these procedure codes will be operational by November 1, 2006, the Department foresees actual implementation on March 1, 2007. **Procedure Codes for Respite-Facility, Respite, and Transitional Case Management were implemented on November 1, 2006. Procedure Code implementation for Community Transition Services and Habilitation Services is expected to be May 1, 2007.**

No increase in costs resulting from the implementation of new services and provider types is expected for the **NF/AH Waiver, NF A/B Waiver LOC, and the IHO Waiver,** as beneficiaries **waiver participants** enrolled in that waiver **those waivers** currently expend up to their cost neutrality program budget with the current service package. The addition of these new services and provider types merely allows beneficiaries **waiver participants** to choose the service/provider that best fits **meets** their needs. For the NF Subacute and In-Home Medical Care waivers **Hospital LOC,** there will be minor annual cost increases for these new services and provider types.

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
B 20 (PC-72)	X	<p><u>Increase to Waiver Cap for <b>NF/AH (NF A/B LOC) Waiver</b></u></p> <p>In response to the enactment of AB 1629 and recent cost neutrality data, the Department will increase the annual individual waiver program budget for <b>Medi-Cal</b> beneficiaries in the <del>NF A/B Level of Care</del> <b>NF/AH</b> Waiver effective July 1, 2007, by \$4,997, from \$24,551 to \$29,548, for <del>beneficiaries</del> <b>waiver participants</b> at Nursing Facility Level <b>NF A LOC</b>, and \$12,232, from \$35,948 to \$48,180, for <del>beneficiaries</del> <b>waiver participants</b> at Nursing Facility Level <b>NF B LOC</b>. This increase will allow <del>beneficiaries</del> <b>waiver participants</b> to absorb recent increases in IHSS and WPCS rates so they may continue to receive safe and appropriate home care in lieu of long-term institutional placement.</p>
B 21 (PC-OA)	X	<p><u>Coordinated Care Management Demonstration Project</u></p> <p>The Budget Act of 2006 includes approval to establish and implement a Coordinated Care Management (CCM) Demonstration Project. The key elements of the CCM Project include maintaining access to medically necessary and appropriate services, improving health outcomes, and providing care in a more cost-effective manner for two populations enrolled in the Fee for Service Medi-Cal Program who are not on Medicare:</p> <ul style="list-style-type: none"> <li>• Seniors and persons with disabilities who have chronic conditions, or who may be seriously ill and near the end of life; and</li> <li>• Persons with chronic health condition(s) and serious mental illnesses.</li> </ul> <p>In FY 2007-08, <del>the</del> <b>The</b> Department <u><b>anticipates it</b></u> will begin to <del>contract with one or more provider organizations to design and implement the proposed five-year CCM Project</del> <u><b>in January 2008. Payments are expected to begin in March 2008. The Department will contract with one or more organizations to implement the project.</b></u></p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 22 (PC-21)	X	X	<p><u>Human Papillomavirus Vaccine</u></p> <p>The Food and Drug Administration approved the first vaccine for cervical cancer prevention, human papillomavirus (HPV) vaccine (Gardasil™), for non-pregnant females, ages 9 to 26 years. Effective with provider notification, Medi-Cal will be covering quadrivalent (four strain types) HPV vaccine to prevent HPV infection, strains of which have been identified as the cause of cervical cancer. The Department expects that this vaccine will be covered under the federal Vaccines for Children (VFC) Program for females age 9 to 18 years of age. The vaccine is administered in 3 intramuscular injections over 6 months. For VFC funded vaccine, Medi-Cal will pay providers a \$9 administration fee. For females not covered under VFC, Medi-Cal will pay the full fee for the three-dose series.</p>
B 23 (PC-31)		X	<p><u>Newborn Hearing Screens Expansion</u></p> <p>Existing statute requires general acute care hospitals with CCS approved licensed perinatal services to offer hearing screening to parents of all newborns delivered at these hospitals.</p> <p>AB 2651 (Chapter 335, Statutes of 2006) expands the requirement to the estimated additional 100 general acute care hospitals that are not currently CCS-approved.</p>
B 24 (PC-22)	X	X	<p><u>Prenatal Screening Expansion</u></p> <p><del>Existing statute requires the State Prenatal Screening Program to use the triple serum marker test in the second trimester (maternal serum alpha-fetoprotein (AFP), human chorionic gonadotrophin (hCG), and unconjugated estriol (uE3)).</del></p> <p>SB 1555 (Chapter 484, Statutes of 2006) expands current prenatal screening to include all tests that meet or exceed the current standard of care as recommended by nationally recognized medical or genetic organizations <b><u>and provided for a fee increase on January 1, 2007 to accomplish these improvements</u></b>. <del>The Department will screen pregnant women using the quadruple serum marker test that consists of the triple serum marker test plus inhibin A, during the first trimester of pregnancy, beginning January 1, 2007.</del></p>
B 25 (PC-108)	X	X	<p><u>CLPP Funding for EPSDT Lead Screens</u></p> <p>Medi-Cal receives funding from the CLPP Fund to cover EPSDT blood lead testing for beneficiaries with risk factors for lead poisoning. CLPP funding will be used for the non-federal share of the cost.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 26 (PC-25)	X	X	<p><u>Genetic Screening Fee Increase</u></p> <p>Effective January 1, 2007, the newborn and prenatal genetic screening fees will each increase an additional \$7.00. This increase is in accordance with Health and Safety Code Section 124977 which requires the program to be fully supported from fees collected and states that the amount of the fee shall be established by regulation and periodically adjusted by the Director.</p>
B 27 (PC-30)		X	<p><u>Independence Plus Self-Directed Services Waiver - CDDS</u></p> <p>Subject to approval by the Centers for Medicare &amp; Medicaid Services (CMS) of a 1915(c) Waiver, beginning in FY 2007-08 the Department will implement a Self-Directed Services (SDS) model of funding and service delivery that will cap individual budgets in exchange for increased consumer control over services. The Budget Act of 2005 contains trailer bill language to implement the SDS program. Since then, the Administration has continued to refine its proposal based on input from legislative staff and stakeholders. The Department anticipates a phased-in enrollment of an estimated 600 consumers in the SDS program during the latter portion of FY 2007-08.</p>

**FAMILY PACT: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**FAMILY PACT: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FP 1 (PC-1)	X	X	<p><u>Family Planning Initiative (Family PACT)</u></p> <p>Originally implemented as a state-only program in 1997, Family PACT became a Section 1115 demonstration project effective December 1, 1999. It provides family planning services to eligible, uninsured Californians with income at or below 200% of poverty. FFP at 90% has been assumed for family planning services, <del>and testing for sexually transmitted infections (STIs),</del> <b>and sterilizations</b>. The Federal Medical Assistance Percentage (FMAP) has been assumed for treatment of STIs and other family planning companion services. No FFP has been assumed for <del>sterilizations and</del> the treatment of some family planning-related medical conditions, including inpatient care for complications from family planning services. Costs for undocumented persons (currently assumed to be 13.95% of the Family PACT expenditures in 2005-06 and 17.79% in 2006-07 ) have been budgeted at 100% GF. Family PACT Waiver drugs will be included in the Medicaid Drug Rebate Program.</p> <p>The waiver was approved in 1999 for a five-year period and expired on November 30, 2004. The Department has been in negotiations with CMS since May 2004 regarding the terms of a three year renewal of the waiver. <del>Although Family PACT has been operating on approved extensions of the original waiver, CMS has indicated that approval of a waiver renewal would be retroactive to December 1, 2004 and expire in November 2007. These new terms and conditions, when agreed upon, may be applied retroactively to all federal funds claimed since the expiration of the original waiver.</del> The Department continues to work with CMS to finalize the terms and conditions of the renewal of the Family PACT waiver. <b><u>Costs associated to comply with CMS eligibility requirements would be significant. The Waiver is currently operating under one-month extensions.</u></b></p>
FP 2 (PC-OA)	X	X	<p><u>Family PACT Medicaid Waiver Demonstration Evaluation</u></p> <p>An important component of the Family PACT Medicaid Waiver Demonstration Project is evaluating the effectiveness of the program. The University of California, San Francisco conducts the program evaluation. The evaluation includes, but is not limited to, analyzing: the changes in birth rates; access by targeted populations; change in provider base for targeted geographical areas; provider compliance; claims analysis; and the cost effectiveness of the services.</p> <p>A contract to provide data for the Family PACT evaluation was negotiated for a five year term beginning July 1, 2005.</p>

## FAMILY PACT: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FP 3 (PC-OA)	X	X	<p><u>Family PACT Support, Provider Education and Client Outreach – Support Services</u></p> <p>CDHS statewide support services consist of services to the <u>The Family PACT Medicaid Waiver Demonstration Project has two main objectives. One is to increase access to services in targeted populations of adolescents, males, and medically underserved women. The other is to increase the number of providers who serve these clients. A formal plan for provider recruitment, education, and support is a requirement under the special terms and conditions of the waiver. CDHS education and support services are provided to</u> Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to: public education, and awareness, <u>and direct client outreach (TeenSmart Outreach)</u>; provider enrollment, recruitment and training; training and technical assistance for medical and non-medical staff; education and counseling services; and preventive clinical services; <u>sexually transmitted infection/HIV training and technical assistance services; and the toll-free referral number.</u> The Office of Family Planning contracts with a variety of entities to provide these services. The costs are projected for the duration of the Family PACT Waiver Demonstration Project.</p>
FP 4 (PC-FI)	X	X	<p><u>Family PACT Materials Distribution</u></p> <p>An important component of the Family PACT Program is the distribution of client education materials to approximately 2,700 providers. The state, through the fiscal intermediary, has the responsibility to develop, print, purchase, and distribute over 150 different publications.</p>
FP 5 (PC-FI)	X	X	<p><u>Family PACT Systems</u></p> <p>The establishment of the Family PACT Waiver Demonstration Project and the expansion to include additional services required fiscal intermediary systems enhancements and modifications. The system changes have been made and are ongoing, as required for program maintenance.</p>
FP 6 (PC-46)	X	X	<p><u>Family PACT Drug Rebates</u></p> <p>The Department collects rebates for family planning drugs covered through the Family PACT program.</p> <p>The Department began invoicing for Family PACT drug rebates on June 7, 2001. These invoices covered all quarters back to December 1, 1999.</p>

## FAMILY PACT: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FP 7 (PC-OA)	X	X	<p><u>Family PACT Male Involvement <b>and</b> I&amp;E Programs and TSO Programs</u></p> <p>The Health Trailer Bill of 2003 requires the Department to require contractors and grantees under the Office of Family Planning, Male Involvement Program (MIP); <b>and</b> Information and Education (I&amp;E) <b>Programs</b> Program and Teen Smart Outreach (TSO) Program, to establish and implement a clinical <del>services linkage</del> <b>linkages</b> to the Family PACT program, effective in the 2003-04 fiscal year. <b><u>This linkage includes planning and development of a referral process for program participants, to ensure access to family planning and other reproductive health care services. The MIP and I&amp;E Programs expect to utilize approximately 25% of their funding for this purpose.</u></b></p>
FP 8 (PC-OA)	X	X	<p><u>Family PACT HIPAA Privacy Practices Beneficiary Notification</u></p> <p>Under the federal HIPAA, it is a legal obligation of the Medi-Cal program to provide a NPP to each Family PACT beneficiary explaining the rights of beneficiaries regarding the protected health information created and maintained by the program. Medi-Cal has an ongoing responsibility to provide this Notice to all new enrollees, and inform all beneficiaries about how to get a copy of this Notice at least every 3 years, or whenever a substantial change is made to the Notice. Due to confidentiality concerns, distribution of the NPP to these beneficiaries is accomplished by distribution at the clinic. This assumption is to cover the cost of printing and mailing the NPPs to the clinics.</p>
FP 9 (PC-32)	X	X	<p><u>Family PACT State Only Services</u></p> <p>CMS has informed the Department that FFP will no longer be available for several services that have been part of the Family PACT program benefit package. These include mammography, Hepatitis B vaccines, five procedures related to complications of particular contraceptive methods, and diagnostic testing to distinguish cancer from genital warts. Many of these services are necessary to diagnose cancer and prevent and treat contraceptive complications, and are part of nationally accepted standards of care and responsible clinical practice. Therefore, the services will continue to be provided with 100% State GF.</p>

**BREAST AND CERVICAL CANCER TREATMENT: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

**BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
BC 1 (PC-2)	X	X	<p><u>Breast and Cervical Cancer Treatment Program</u></p> <p>The Budget Act of 2001 includes funding for the creation of the BCCTP effective January 1, 2002, for individuals with a diagnosis of breast and/or cervical cancer who need treatment and have income under 200% of FPL. Enhanced Title XIX funding is claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope, no cost Medi-Cal benefits for the duration of treatment for women under age 65 who are citizens or immigrants with satisfactory immigration status and who have no other health coverage. The BCCTP also includes a state funded program that provides cancer and cancer-related treatment services only to persons not eligible for Medi-Cal. This program receives Safety Net Care Pool funding under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver. Coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Women with inadequate health coverage, undocumented women, and males are eligible for the state funded program. Undocumented women under age 65 are also eligible for federally funded emergency services and pregnancy-related and state-only long-term care services for the duration of their cancer treatment.</p> <p>Enrollment of BCCTP applicants is performed by Centers for Disease Control (CDC)-approved screening providers, which in California are Every Woman Counts and Family PACT Program providers, using an electronic Internet-based application form. Those women who appear to meet federal eligibility requirements receive immediate temporary full-scope no cost Medi-Cal coverage under accelerated enrollment. DHS Eligibility Specialists (ES) review the Internet-based application forms and determine regular BCCTP eligibility under the state and federal components. The ES may need to request additional information from the applicant to determine appropriate eligibility under the BCCTP.</p> <p>Due to the receipt of additional staffing, the Department began processing annual redeterminations. <b><u>Redeterminations are done for beneficiaries in the BCCTP federally-funded aid codes, as well as for those in the BCCTP State-funded aid codes who receive federally-funded emergency coverage.</u></b> Those persons <b><u>determined</u></b> no longer BCCTP <b><u>program</u></b> eligible are referred to the counties to determine if they are eligible for any other Medi-Cal program. For those determined by the counties not to be eligible for any other Medi-Cal program, a determination will be made if they are eligible for the State-funded BCCTP.</p> <p>Current managed care rates fully incorporate BCCTP costs.</p>

## BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
BC 2 (PC-2)	X	X	<p><u>Breast and Cervical Cancer Treatment Program – Premium Payment</u></p> <p>Effective January 1, 2002, under the state funded portion of the Breast and Cervical Cancer Treatment Program funded by the Budget Act of 2001, the Department began payment of the premium cost for individuals with breast and cervical cancer who have other health insurance but are underinsured. The criteria for participation in the state funded premium payment program include the following:</p> <ul style="list-style-type: none"> <li>• Family income at or below 200% of FPL as determined by the enrolling provider</li> <li>• California resident</li> <li>• Other health coverage with premiums, deductibles and copayments exceeding \$750 in a 12-month period beginning from the month in which the Eligibility Specialist commences the eligibility determination</li> <li>• Diagnosis of breast and/or cervical cancer and in need of treatment</li> <li>• Not eligible for full-scope, no cost Medi-Cal</li> </ul>
BC 3 (PC-OA)	X	X	<p><u>BCCTP Postage and Printing</u></p> <p>Postage and printing costs related to the eligibility determination process for the Breast and Cervical Cancer Treatment Program are budgeted in local assistance. Costs for the State-funded component of the program are 100% General Fund, and are included in the Postage and Printing policy change. Mailings include letters sent to applicants to request additional information, as well as notices of approval or denial of eligibility.</p>
BC 4 (PC-10)	X	X	<p><u>BCCTP Retroactive Coverage</u></p> <p>Due to the receipt of additional staffing, the Department began processing requests for the three months of retroactive BCCTP coverage that are available under federal law for persons who met federal eligibility requirements in the months for which retroactive coverage is requested.</p>

**MEDICARE MODERNIZATION ACT OF 2003: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

## MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

### Medicare Prescription Drug, Improvement, and Modernization Act of 2003

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was signed into law by the President on December 8, 2003. The purpose of this statute is to provide a prescription drug benefit to all Medicare beneficiaries. Since the Medi-Cal program covers those beneficiaries that have eligibility for both Medi-Cal and Medicare (dual eligibles), this statute will have a significant fiscal impact on the program. The Medicare drug benefit began January 1, 2006. The fiscal effects began in FY 2003-04 and have continued through subsequent fiscal years. There are a number of changes in the new law that will affect the Medi-Cal program.

MM 1 (PC-101)    X        X        MMA – Phased-Down Contribution

**With the implementation of Medicare Part D, The the federal government requires a phased down contribution (~~clawback~~) from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal program. In 2006, the “clawback” will be **phased-down contribution was** 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015. **An annual inflation factor is also applied to the phased-down contribution. In CY 2006, the first year of Medicare Part D and the phased-down contribution, Medi-Cal’s Per Member Per Month (PMPM) cost was \$89.02. In CY 2007, the contribution rate was lowered to 88⅓% and a CMS determined 6.36% inflation rate was applied, for a PMPM of \$93.36.****

MM 2 (PC-OA)        X        MMA – DSH Annual Independent Audit

MMA requires an annual independent certified audit that primarily certifies:

- (1) That Disproportionate Share Hospitals (DSH) (approximately 150+ hospitals) have reduced their uncompensated care costs by the amount equal to the total amount of claimed expenditures made under section 1923 of the MMA.
- (2) That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments. For Demonstration Years 1 and 2 of the Medi-Cal Hospital/ Uninsured Care Demonstration, the Safety Net Care Pool payments to the designated public hospitals will not be considered as revenue when OBRA limits are calculated.

CMS will finalize the federal regulations to provide guidance on criteria to validate the reduction in the uncompensated care costs by hospitals.

**MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MM 3 (PC-OA)	X	X	<p><u>MMA – Beneficiary Outreach</u></p> <p>The Department distributed several mailings to the Medi-Cal and Medicare (dual) eligible population to inform them of the Medicare Part D drug benefit and to instruct the dual eligibles of the need to enroll in a Part D plan. Mailings to notify beneficiaries who are not full-benefit dual eligibles to enroll prior to June 2006 have been completed.</p> <p>The Department distributed a flyer in FY 2006-07 to notify full-benefit dual eligibles that their Medicare Part D drugs may be covered by the Emergency Drug Benefit if all the appropriate steps have been taken to bill Medicare, and Medicare does not pay.</p> <p>The Department will distribute up to three more flyers in FY 2006-07 and three flyers in FY 2007 to full-scope dual eligibles to notify them of CMS changes to Part D and the Low Income Subsidy.</p>
MM 4 (PC-FI)	X	X	<p><u>MMA – Provider Relations</u></p> <p>Provider relations is an essential component of the activities relating to the implementation of the Medicare Modernization Act. Additional provider relations resources are required at EDS to support the major change in pharmacy benefits for dually eligible beneficiaries and the providers who serve them. During the development and implementation phases, providers and other trading partners will need to be notified of the changes made in the California Medicaid Management Information System (CA-MMIS). Additional EDS staffing will also be necessary to provide training and offer telephone assistance and clarification on CA-MMIS and claims processing changes. There will also be costs for printing, postage and other costs of provider notification and education including provider bulletins, notices via mail, and the Internet. <del>On a cash budgeting basis, payments will be made beginning in FY 2005-06.</del></p>

## MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MM 5 (PC-OA)	X	X	<u>MMA – Eligibility Systems Changes</u>

The Department entered into contracts for eligibility systems changes necessary to implement MMA. Medi-Cal processing continues to be modified to ensure proper identification, tracking and reporting of the recipient population to be covered by Medicare Part D.

- The MEDS, which maintains eligibility information for the over six million current beneficiaries, has been modified to identify the individuals with the Medicare Part D coverage on the database (using a new Medicare Status Code and prescription drug plan (PDP) code) to allow for proper processing and reporting of recipients with Medicare Part D prescription drug coverage.
- The Fiscal Intermediary Access to Medi-Cal Eligibility (FAME) file, an extract of payment-related eligibility data from MEDS provided to EDS (the Fiscal Intermediary) for claims payment processing, has been modified to ensure the new Part D coverage is properly identified on the records for the impacted population.
- CMS requires the State to submit a monthly file of dual eligibles for verification processing. This is the basis for the monthly phased-down state contribution payment to CMS. A new process has been developed to capture Medicare Part D eligibility data from MEDS and create the verification file (per CMS standards) for CMS processing. In addition, the current process for electronic data exchange has been modified and tested to allow the new file to be exchanged.
- A ~~new process is being~~ **has been** developed to provide CMS with monthly data on individuals who are likely to become Medicare eligible. CMS ~~will begin~~ **has begun** transmitting monthly data of individuals who CMS confirms will be eligible in two months. This information may be used to issue prospective Notices of Action for Reduction in Benefits in those cases where individuals are known to Medi-Cal prior to Medicare eligibility.
- CMS generates a monthly return file to the State. Ongoing changes are required to capture Medicare Part D eligibility information and plan codes from the return file and insert the information into appropriate fields on MEDS to adjust to CMS changes.
- CMS generates a new monthly file containing individuals it believes may be eligible for Medicare Savings Programs (MSP). Systems changes were developed to systematically send MSP applications to these individuals.

## MEDICARE MODERNIZATION ACT OF 2003: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- **A new process allowing for the receipt of real time SSN, Title II, and Title XVI information from SSA is being developed and implemented.**

MM 6 (PC-FI)	X	X	<p><u>MMA – TAR Reductions</u></p> <p>Because the Medicare program will provide prescription drug coverage for Medicare/Medi-Cal dual eligibles beginning January 1, 2006, there will be a reduction in Treatment Authorization Request volume. This will impact staffing levels for EDS pharmacists and office staff, although staffing standards and the 24-hour turnaround time required by federal statute still must be maintained.</p>
MM 7 (PC-OA)	X	X	<p><u>MMA System-Generated Notices of Action</u></p> <p>Beginning January 1, 2006, Medi-Cal beneficiaries who are newly entitled to the Medicare Part D prescription drug benefit must be notified of the reduction in their Medi-Cal benefits. Medi-Cal is now being required by CMS to provide Notices <b>of</b> Action regarding the reduction of <b>Medi-Cal</b> benefits that reflect the actual Part D effective date, even if retroactive. In October 2006, monthly Notices of Action were generated to new dual eligibles when the Department confirmed Part D eligibility, with effective dates that are <b>on or before</b> the first of the month the notice was sent. System changes are underway to pick up the actual Part D effective date confirmed by CMS on the CMS monthly report.</p>

## HOSPITAL FINANCING: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 0.1 (PC-OA)	X	X	<u>Health Care Coverage Initiative – Administrative Costs</u>
			FFP is available for costs incurred on or after March 1, 2007 through August 31, 2010, that are associated with the implementation and ongoing administration of approved Health Care Coverage programs. The administration activities for which FFP is being requested were submitted to CMS on December 22, 2006, and are currently pending approval by the Medicaid National Institutional Reimbursement Team.

## HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 1 (PC-75)	X	X	<u>Safety Net Care Pool</u>

Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a Safety Net Care Pool (SNCP) was established to support the provision of services to the uninsured. SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503.

The federal funds that the Department claims from the SNCP are based on the following Certified Public Expenditures (CPEs):

- The CPEs of the DPHs.
- The CPEs of the following four state-only programs:
  - Medically Indigent Adult Long-Term Care Program
  - Breast and Cervical Cancer Treatment Program
  - Genetically Handicapped Person's Program
  - California Children's Services Program

Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

**Each DPH's 2005-06 interim SNCP payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year ending June 30, 2006.**

**The interim reconciliation process and payments for Demonstration Year 1 will occur in June 2007 and may result in an overpayment or underpayment to a DPH, which will be handled as follows:**

- **For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.**
- **For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the Safety Net Care Pool (SNCP) payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.**

**The interim reconciliation process for Demonstration Years 2-5 will occur in April each year.**

## HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 2 (PC-74)	X	X	<u>Hospital Financing DSH Payments</u>

Effective for dates of services on or after July 1, 2005, based on SPA 05-022, approved in May 2006, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by Disproportionate Share Hospitals (DSH). Non-emergency services for unqualified aliens are eligible for DSH program funding.

DPHs ~~will~~ claim reimbursement from the DSH allotment for up to 100 percent of their uncompensated care costs based on CPEs. These CPEs ~~will~~ constitute the non-federal share of payments. Under this new methodology, each DPH ~~will certify~~ **certifies** its Medi-Cal Managed Care and psychiatric inpatient and outpatient shortfall and its uninsured costs to the Department. The Department ~~will submit~~ **submits** claims for federal reimbursement based on the DPHs' CPEs. The federal reimbursement that is claimed based on the CPEs ~~will be~~ **is** drawn from the Federal Trust Fund and ~~will pass~~ **passes** through the Demonstration DSH Fund, Item 4260-601-7502.

Twenty of the 22 designated public hospitals also may claim up to 175 percent of uncompensated care costs. (Two University of California hospitals are not eligible for 175 percent reimbursement.) Intergovernmental transfers (IGTs) from the government entity with which the DPH is affiliated ~~will~~ constitute the non-federal share of these payments. These IGTs ~~will be~~ **are** deposited into the MIPA Fund, Item 4260-606-0834 and ~~will be~~ **are** used to claim federal reimbursement. The federal reimbursement that is claimed based on the IGTs ~~will be~~ **is** drawn from the Federal Trust Fund.

NDPHs will claim reimbursement from the DSH allotment for up to 100 percent of their uncompensated Medi-Cal and uninsured costs using GF as the non-federal share of payments. The federal reimbursement that is claimed based on the GF ~~will be~~ **is** drawn from the Federal Trust Fund.

Based on SPA 05-022, ~~approved in May 2006~~, private hospitals on the final DSH list ~~will~~ receive a total funds payment of \$160.00 in annual DSH payments. The total payment of \$160.00 is comprised of 50 percent FFP payments from the federal DSH allotment and 50 percent GF. CMS required that some portion, no matter how small, of the annual DSH allotment go to the private hospitals. They indicated that the amount designated ~~from~~ **to** private hospitals could be as little as \$1.00 per hospital. Since there were approximately 160 private hospitals eligible for DSH payments, it was agreed that \$160.00 would be specified in the SPA. This dollar amount was also agreed to by the DSH Task Force. The requirements of sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code shall be satisfied through the provision of payment adjustments as described in this paragraph.

## HOSPITAL FINANCING: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

**Each Designated Public Hospital's (DPH's) 2005-06 interim Disproportionate Share Hospital (DSH) payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year ending June 30, 2006.**

**The interim reconciliation process and payments for Demonstration Year 1 will occur in June 2007 and may result in an overpayment or underpayment to a DPH, which will be handled as follows:**

- **For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.**
- **For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DSH payments that the DPHs have received and the DSH payments estimated in the interim reconciliation process.**

**The interim reconciliation process for Demonstration Years 2-5 will occur in April each year.**

HF 3 (PC-76)	X	X	<p><u>Private Hospital DSH Replacement</u></p> <p>Effective for dates of service on or after July 1, 2005, private hospitals <del>will</del> receive DSH replacement payments, the non-federal share of which is funded by the GF. The DSH replacement payments, along with \$160.00 of the DSH payments (see assumption for Hospital Financing DSH Payments), <del>will</del> satisfy the payment obligations with respect to those hospitals under <u>the</u> Federal DSH statute. The federal share of the DSH replacement payments <del>will be</del> <u>is</u> regular Title XIX funding and <del>will not be</del> <u>is not</u> claimed from the federal DSH allotment.</p>
HF 4 (PC-77)	X	X	<p><u>Private Hospital Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, private hospitals <del>will</del> receive payments from the Private Hospital Supplemental Fund, Item 4260-601-3097. SB 1100 provides a continuous appropriation of \$118,400,000 annually from the GF to the Private Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. This funding replaces the aggregate amount the private hospitals received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/Voluntary Governmental Transfers (VGT)), Graduate Medical Education Supplemental Payment (Teaching Hospitals), and Small and Rural Hospital Supplemental Payment programs.</p>

## HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 5 (PC-82)	X	X	<p><u>NDPH Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, NDPHs receive payments from the Nondesignated Public Hospital Supplemental Fund, Item 4260-601-3096. SB 1100 provides a continuous appropriation of \$1,900,000 annually from the GF to the Nondesignated Public Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. This funding replaces the aggregate amount the NDPHs received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/VGT) program.</p>
HF 6 (PC-78)	X	X	<p><u>DPH Physician and Non-Physician Costs</u></p> <p>Effective for dates of service on or after July 1, 2005 <del>supplemental reimbursement based on CPEs will be available to DPHs</del> <b>each DPH</b> for <del>their</del> <b>the</b> costs incurred for physician and non-physician practitioner professional services. <del>The supplemental reimbursement will be available only for costs provided</del> <b>rendered</b> to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. A SPA <b>05-023</b> that authorizes federal funding for this supplemental reimbursement was submitted in September 2005 and is currently pending approval by CMS. <b><u>The Department anticipates CMS approval by July 2007.</u></b></p> <p><b><u>For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA.</u></b> It is anticipated that the Department will begin payments by <del>June</del> <b>August</b> 2007.</p>
HF 7 (PC-80)	X	X	<p><u>Distressed Hospital Fund</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, "distressed hospitals" receive supplemental payments from the Distressed Hospital Fund, Item 4260-601-8033. SB 1100 requires the transfer of 20 percent per year over five years of the balance of the ESSP Fund (SB 1255/VGT), Item 4260-601-0693, to the Distressed Hospital Fund. Contract hospitals that meet the following requirements, as determined by CMAC, are eligible for distressed funds:</p> <ul style="list-style-type: none"> <li>• The hospital serves a substantial volume of Medi-Cal patients.</li> <li>• The hospital is a critical component of the Medi-Cal program's health care delivery system.</li> <li>• The hospital is facing a significant financial hardship.</li> </ul>

## HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 8 (PC-88)	X		<p><u>MIA LTC Program– Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD for the the State-only funded Medically Indigent Adult Long-Term Care program.</p>
HF 9 (PC-86)	X		<p><u>BCCTP – Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD for the State-only funded portion of the Breast and Cervical Cancer Treatment Program.</p>
HF 10 (PC-89)	X	<b>X</b>	<p><u>DPH Rate Reconciliation</u></p> <p>Under the MH/UCD, DPHs no longer receive negotiated per diem rates comprised of GF and FFP. Instead, DPHs receive interim per diem rates comprised of FFP only, based on the CPEs. However, the Department continued to pay the DPHs the negotiated per diem rates until May 2006. In June 2006, the Department reprocessed all paid claims from July 1, 2005 through May 21, 2006. Claims for services on or after May 22, 2006 have been paid at the interim per diem <del>rate</del> <b>rates</b>.</p> <p>For hospitals whose interim per diem rate was higher than the negotiated per diem rate, the Department reimbursed the GF with FFP in June 2006, and the hospitals received the additional FFP payment they were owed due to this increase.</p> <p>For hospitals whose interim per diem rate was lower than the negotiated per diem rate, the Department claimed the correct FFP based on the new interim rate and reimbursed the GF. The remaining GF repayment that is owed by the DPHs has been established as a receivable and will be offset from future payments for physician and non-physician practitioner professional services when SPA <b>05-023</b> is approved in FY 2006-07. It is anticipated that the Department will begin these offsets by <del>June</del> <b>August</b> 2007. In the event that the reimbursement of physician and non-physician practitioner professional services is not sufficient to repay the receivable, the State will withhold the remaining amount from claim payments.</p>

## HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
HF 11 (PC-79)	X	X	<p><u>CCS AND GHPP – Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on SB 1100, the Department may claim federal reimbursement for the CCS Program and Genetically Handicapped Persons Program (GHPP) from the SNCP established by the MH/UCD. The 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 in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.</p>
HF 12 (PC-84)	<b>X</b>	X	<p><u>DPH Interim Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), each designated public hospital's (DPH) 2005-06 interim per diem rate, comprised of 100 percent federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year ending June 30, 2006.</p> <p>This <del>The</del> reconciliation process <b><u>for Demonstration Year 1</u></b> will occur in <del>April each year</del> <b><u>June 2007</u></b> and may result in an overpayment or underpayment to a DPH and will be handled as follows:</p> <ul style="list-style-type: none"> <li>• For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.</li> <li>• For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the two rates multiplied by the number of qualified Medi-Cal days.</li> </ul> <p><b><u>The reconciliation process for Demonstration Years 2-5 will occur in April each year.</u></b></p>

## HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u> <u>B/Y</u>	
HF 13 (PC-85)	X	<p><u>Stabilization Funding to NDPHs, Private Hospitals, and Distressed Hospitals</u></p> <p>Effective for dates of service on or after July 1, 2005, a portion of the total stabilization funding, comprised of FFP and GF, as specified in W&amp;I Code section 14166.20, will be distributed as follows:</p> <ul style="list-style-type: none"> <li>• Non-designated public hospitals (NDPHs) will receive <b><u>an amount equal to the difference between the</u></b> total funds equal to 0.64 percent of the total stabilization funding <b><u>and the aggregate payment increase in FY 2005-06, compared with their aggregate baseline.</u></b></li> <li>• Private hospitals will receive total funds equal to the sum of \$42.5 million and an additional amount based on the formulas specified in W&amp;I Code 14166.20.</li> <li>• Distressed hospitals will receive total funds equal to the lesser of \$23.5 million or 10 percent of the total stabilization funding.</li> </ul> <p>Stabilization funding to NDPHs, private hospitals, and distressed hospitals is comprised of GF made available from the federalizing of four-state only programs, any additional GF needed, and 50% FFP. Stabilization funding is also available to DPHs through the SNCP.</p> <p><b><u>The stabilization amount is calculated following the completion of the interim reconciliations of the interim Medicaid inpatient hospital payment rates, interim DSH payments, and interim SNCP payments. CMAC determines the actual stabilization payments each NDPH, private hospital, and distressed hospital will receive and the Department distributes these payments. Stabilization payments are expected to be distributed in the fiscal year following the interim reconciliation process.</u></b></p>

## HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 14 (PC-83)	X		<p><u>Health Care Coverage Initiative</u></p> <p>Under the MH/UCD, <b>An amount of</b> \$180 million in federal funds is available <b>each year in Demonstration Years 3-5</b> to expand health care coverage to eligible low-income, uninsured persons. SB 1448 (Chapter 76, Statutes of 2006) provides the statutory framework for the Health Care Coverage Initiative and directs the Department to issue a Request for Applications to enable a county, a city and county, a consortium of more than one county, or a health authority to apply for an allocation of this federal funding.</p> <p>Certified public expenditures (CPEs) submitted to the Department must reflect total fund expenditures for <b>health care</b> services provided <b>to eligible low-income, uninsured persons</b>. The Department will then submit the claim for FFP that will be reimbursed to the certifying <b>entity entities</b>. No GF will be expended for this program.</p>
HF 15 (PC-87)	X	X	<p><u>Base Adjustment – DPH Interim Rate</u></p> <p>Effective July 1, 2005, based on SPA 05-021, Designated Public Hospitals (DPHs) no longer received CMAC negotiated per diem rates (50% GF/50% FFP.) DPHs receive an interim per diem <del>rate</del> <b>rates</b> based on estimated costs using the hospitals' Medi-Cal <del>cost</del> <b>costs</b> trended forward. The interim per diem <del>rate</del> <b>rates are</b> funded using the hospitals' CPEs to match federal funds. The expenditures consist of 100% federal funds; however, the Medi-Cal inpatient base estimate assumes costs are 50% GF/50% FFP. Therefore, an adjustment is necessary to shift the funding from 50% GF/50% FFP to 100% FFP.</p>
HF 16 (PC-81)	X	X	<p><u>DPH Interim Rate Growth</u></p> <p>Effective July 1, 2005, based on SPA 05-021, DPHs receive interim per diem rates based on estimated costs using the hospitals' Medi-Cal <del>cost</del> <b>costs</b> trended forward. The trend used is to reflect increased costs and is expected to be different from the former CMAC negotiated rate trend for some DPHs. The interim per diem rate consists of 100% FFP.</p>

**MANAGED CARE: NEW ASSUMPTIONS**

	Applicable F/Y <u>C/Y</u> <u>B/Y</u>	
M 0.1 (PC-145)	X	<p><u>Capitated Rate Methodology Project Rate Increases</u></p> <p>The Department engaged Mercer Government Human Resources Consulting in May 2005 to review the Medi-Cal base data, and to recommend opportunities for improvement to the current capitation rate development process, and reimbursement structure. Mercer has issued a report to the Department that recommends the Department adopt a plan-specific, experience-based rate methodology, in which capitation payments to contracted health plans are matched to their relative risk. The report also identifies some plan "Pay for Performance" opportunities. Managed care rates will be adjusted to reflect the Mercer findings, effective with the 2007-08 rate years.</p>
M 0.2 (PC-147)	X	<p><u>SBRHA Carve-Out of AIDS Drugs</u></p> <p>The remaining drugs associated with the treatment of AIDS will be carved out for the Santa Barbara Regional Health Authority because they are no longer in the plan's contracted scope effective January 1, 2007. The Department is adjusting rates accordingly and the cost for the drugs will be budgeted in fee-for-service.</p> <p>The AIDS drugs to be carved out from the Santa Barbara Regional Health Authority are (listed by generic name):</p> <p>Stavudine, Lamivudine, Saquinavir Mesylate, Ritonavir, Indinavir sulfate, Nelfinavir Mesylate, Nevirapine, Delavirding Mesylate, Zidovudine/Lamivudine, Saquinavir, Efavirenz, Abacavir Sulfate, Amprenavir, Lopinavir/Ritonavir, Abacavir/Zidovudine/Lamivudine, Tenofovir Disoproxil Fumarate, Enfuvirtide, Atazanavir Sulfate, Emtricitabine, and Fosamprenavir Calcium.</p>
M 0.3 (PC-148)	X	<p><u>Managed Care Eligibility Adjustments</u></p> <p>A Bureau of State Audits (BSA) audit found that the Department made managed care capitation payments for deceased plan members. In 2005, CMS notified the Department that repayment is due for the federal portion of these incorrect payments. The Department's legal counsel has recommended that CDHS repay CMS. The counsel contends that any attempt to collect the funds could expose the Department to lawsuits filed by managed care health plans. Payment of \$822,500 will be made to CMS in October 2007.</p>

### MANAGED CARE: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
M 0.4 (PC-153)	X	<u>Coverage for Former Agnews Residents</u>
		<p>The California Department of Developmental Services (CDDS) submitted a plan to the Legislature in January 2005 to close the Agnews Developmental Center. The closure plan was approved and the projected closure date is June 30, 2008. Approximately 250 Agnews clients have moved or will move into communities, primarily in Alameda, San Mateo, and Santa Clara counties.</p> <p>The Department believes that Medi-Cal managed care provides the best assurance that all former Agnews clients will get the services they need, and anticipates that these plans will be identified as the health care providers for these individuals. Due to the significant behavioral, health and personal care needs of these clients, current capitation rates will not provide sufficient funding. The Department intends to establish a mechanism whereby the plans will be paid an enhanced interim capitation rate for these individuals, followed by periodic supplemental payments to fully reimburse the plans for all appropriate costs.</p>

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 1 (PC-49)	X	X	<u>Two-Plan Model</u> <sup>‡</sup>

Under the Two-Plan Model program, the Department contracts with two managed care plans in a county. One plan is a locally developed managed care health plan referred to as the Local Initiative (LI). The other plan is a non-governmentally operated Health Maintenance Organization referred to as the Commercial Plan (CP). (An exception exists in Fresno County where there are currently two Commercial Plans and no Local Initiative.) Currently, twelve counties are fully operational under the Two-Plan Model.

<sup>‡</sup> 2006-07 capitation rates ~~newly~~ include:

- AB1629 and other LTC increases in capitation rates for managed care plans.
- **Restoration of provider payment decreases required by AB 1762, Health Trailer Bill of 2003.**

<sup>‡</sup> ~~Stanislaus County converted back to a fully operational two-plan county in August 2005 (as described in PC-51).~~

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 2 (PC-50) (Reworded)	X	X	<u>County Organized Health Systems</u>
			Five County Organized Health Systems (COHSs) are operational in eight counties. The Partnership Health Plan of California (PHC) includes undocumented alien beneficiaries (aid codes 55, 58, 5F, 5G, 5N).
			COHS rate years for 2006-07 are as follows:
			CalOPTIMA Orange County (rate year will change to July 1 <sup>st</sup> – June 30 <sup>th</sup> starting in FY 2007-08)
			October 1 <sup>st</sup> – September 30 <sup>th</sup>
			Santa Barbara Regional Health Authority (SBRHA) Santa Barbara County
			July 1 <sup>st</sup> – June 30 <sup>th</sup>
			Health Plan of San Mateo (HPSM) San Mateo County
			July 1 <sup>st</sup> – June 30 <sup>th</sup>
			Partnership Health Plan of California (PHC) Solano County Napa County Yolo County
			July 1 <sup>st</sup> – June 30 <sup>th</sup>
			Central Coast Alliance for Health (CCAH) Santa Cruz County Monterey County
			July 1 <sup>st</sup> – June 30 <sup>th</sup>

The Department is revising the rates for Central Coast Alliance for Health and Santa Barbara Regional Health Authority to make adjustments for Part D of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, retroactive to January 1, 2006, and AB 1629 and other long term care increases, retroactive to August 1, 2004.

2006-07 capitation rates include:

- The remainder of rate adjustments for Nurse-to-Patient Staffing Ratio increases (CalOPTIMA only).
- ICF/DD Quality Assurance Fee for all plans (except HPSM) effective with each plan's 2004-05 rate period.
- AB 1629 and other LTC increases in capitation rates for managed care plans (all plans except HPSM).
- Restoration of provider payment decreases required by AB 1762, Health Trailer Bill of 2003.

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 3 (PC-58)	X	X	<u>PHP</u>

Kaiser is the only remaining Prepaid Health Plan (PHP) and has contracts in Marin and Sonoma Counties.

**2006-07 capitation rates include:**

- **AB 1629 and other LTC increases in capitation rates for managed care plans.**
- **Restoration of provider payment decreases required by AB 1762, Health Trailer Bill of 2003.**

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 4 (PC-57)	X	X	<p><u>AIDS Healthcare Foundation Centers (AHF)</u></p> <p>HIV/AIDS Managed Care Organization (MCO): Positive Healthcare Services (aka AIDS Healthcare Foundation or AHF <b>Centers</b>) is located in Los Angeles, with an enrollment of 814 as of June 2006. Enrollment is expected to reach 850 <b>820</b> by June 2007 and 875 <b>830</b> by June 2008.</p> <p><b><u>All drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) will be included in the plan's contracted scope of services effective July 1, 2007, except for new drugs which do not fit into one of the current therapeutic classes and for which the Department does not have sufficient utilization data to determine the financial impact the use of those drugs will have on the managed care plan. Once the Department has collected sufficient data to appropriately determine the financial impact on the managed care plan, the drugs will be carved into the plan's contracted scope of services and be taken into consideration when reevaluating the managed care plan's capitation rates.</u></b> ADHC and drugs currently used to treat AIDS were included in the plan's contracted scope of service except the following:</p> <p>Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) drugs classified as Nucleoside Analogs, Protease Inhibitors, Fusion Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, approved by the federal Food and Drug Administration (FDA) after January 1, 2002.</p> <p>This had no impact on the total budget as costs shifted from fee for service to managed care.</p> <p>Savings Sharing/Incentive Distributions: Prior obligations exist for AHF <b><u>AIDS Healthcare Centers</u></b>. These are obligations that are owed to the contractors for cost savings created when actual costs are less than FFS equivalent costs. The process of making final determinations of the amount of savings sharing can extend beyond a two-year period. Because of the long period of time needed to make the final determinations, prior contracts have expired and/or encumbered funds have reverted before final payments can be made. Funds in FY 2006-07 are needed to provide payments for prior years' savings sharing. Savings sharing is the state's terminology for what the federal government refers to as incentive arrangements. The methodology for calculating savings sharing/incentive distributions is the same.</p> <p>A settlement has been reached with AHF <b><u>AIDS Healthcare Centers</u></b> regarding a pending recovery of funds dispute. The amount of the proposed settlement is \$268,000 GF, and is expected to be paid in FY 2006-07.</p>

**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**2006-07 capitation rates include:**

- **AB 1629 and other LTC increases in capitation rates for managed care plans.**
- **Restoration of provider payment decreases required by AB 1762, Health Trailer Bill of 2003.**

**<sup>1</sup>List of AIDS drugs currently excluded from AIDS Healthcare Centers:**

**Abacavir/Lamivudine, Atazanavir Sulfate, Darunavir ethanolate – Prezista, Emtricitabine, Efavirtide, Fosamprenavir Calcium, Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate-Atripla, Tenofovir Disoproxil-Emtricitabine, and Tipranavir.**

M 5 (PC-51)    X    X

**Geographic Managed Care <sup>4</sup>**

Sacramento: Geographic Managed Care (GMC), as authorized by AB 336 (Chapter 95, Statutes of 1991), was implemented in Sacramento County as of April 1994. Contractors are: Health Net, **Community Solutions, Inc.**, Blue Cross **of California Partnership Plan, Inc.**, Kaiser **KP Cal, LLC**, Western Health Advantage **Community Health Plan**, Molina **Healthcare of California Partner Plan, Inc.**, and Care 1<sup>st</sup> **Partner Plan, LLC**. As of, June **December** 2006, enrollment in GMC reached 164,967 **159,908** members.

San Diego: ~~The plans participating in San Diego GMC~~ **GMC, as authorized by SB 2139 (Chapter 717, Statutes of 1996), was implemented in San Diego County as of August 1998.** Contractors are: Health Net **Community Solutions, Inc.**, Blue Cross **of California Partnership Plan, Inc.**, Community Health Group, Kaiser **KP Cal, LLC**, and Molina **Healthcare of California Partnership Plan, Inc.**, **Care 1<sup>st</sup> Partnership Plan, LLC, and Community Health Group Partnership Plan.** As of June **December** 2006, enrollment in San Diego GMC was 167,846 **164,741**. ~~A new application process was conducted during the first half of FY 2005-06 with other new contracts awarded effective January 1, 2006. A new contractor, Care 1<sup>st</sup>, became operational effective February 1, 2006.~~

**<sup>4</sup> 2006-07 capitation rates ~~newly~~ include:**

- AB1629 and other LTC increases in capitation rates for managed care plans.
- **Restoration of provider payment decreases required by AB 1762, Health Trailer Bill of 2003.**

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
M 6 (PC-53)	X	X

Senior Care Action Network

The Senior Care Action Network (SCAN) is a social health maintenance organization (SHMO) in designated areas of Los Angeles, San Bernardino, and Riverside Counties. This project provides medical, social, and case management services to Medicare beneficiaries ages 65 and over. **SCAN covers only Medicare eligible individuals in the aged, disabled, and long term care aid group categories. All necessary medical services are provided by SCAN except for those specifically excluded by contract. Enrollees who are SNF or ICF certifiable are eligible for additional services. Rates are determined by federal law on an actuarially sound basis. In addition, CA state law requires that rates be no more than the rates determined on a FFS equivalent basis.** Enrollees who are SNF or ICF certifiable are eligible for additional services. DHS contracts with SCAN for services to dually eligible members in the above counties. Dual eligible enrollment is expected to reach 8,400 **7,675** by June 30, 2007, and 9,200 **8,056** by December 31, 2007, **and 9,575 by June 30, 2008.** SCAN is developing an outreach program targeting the dual eligibles in all service areas. Since beneficiaries would have greater benefits under SCAN than they would by enrolling in other health plans, enrollment is expected to increase in all counties and aid categories. CMS has discontinued the SHMO pilot program; ~~so~~ **therefore**, SCAN will no longer be a SHMO effective December 31, 2007. SCAN has applied to CMS for approval as a special needs program. It is anticipated that SCAN will be approved and that after December 31, 2007, SCAN enrollees will be transitioned to a new contract under this authority. **The Department is actively working with CMS to identify the appropriate Medicaid authority that will authorize the State to fund comparable Medi-Cal services to enrollees with little or no disruption of services at the end of the SHMO demonstration.**

FY 2006-07 funding reflects a one-time lump-sum retroactive payment resulting from the inclusion of Orthopaedic Hospital rate increases. The payment covers the additional capitation due for FY 2001-02 through FY 2003-04. The rate adjustment has been fully incorporated into the rates effective October 1, 2004.

**FY 2006-07 funding reflects retroactive adjustments resulting from LTC rate adjustments effective 8/1/04, 8/1/05, and 8/1/06, as well as the 7/1/05 QIF rate increase and the 10/1/04 and 10/01/06 rate increase adjustments. These are adjustments that occur each year as a result of the timing of the rate year for LTC under AB 1629, which is different from the SCAN plan rate year. Funding also reflects the retroactive payment resulting from the five percent provider restoration effective January 1, 2007.**

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 7 (PC-54)	X	X	<u>PACE: Program of All-Inclusive Care for the Elderly</u>

The Department contracts with four PACE organizations for risk-based capitated lifetime care of the frail elderly. PACE programs provide all medical services, home and community-based long-term care (including adult day health care) to Medi-Cal and Medi-Cal/Medicare crossover beneficiaries who are certified by DHS for skilled nursing facility or intermediate care facility level of care.

On Lok Senior Health Services started in November 1983. Projected enrollment of 934 dual eligibles and ~~29~~ **40** Medi-Cal only eligibles is expected to be reached by June 30, 2007; and ~~4,002~~ **1,013** dual eligibles and ~~32~~ **43** Medi-Cal only eligibles by June 30, 2008, in San Francisco. In Alameda, projected enrollment of ~~95~~ **93** dual eligibles and ~~5~~ **3** Medi-Cal only eligibles is expected to be reached by June 30, 2007; and ~~447~~ **132** dual eligibles and ~~6~~ **4** Medi-Cal only eligibles by June 30, 2008.

The Center for Elders Independence in Oakland started in July 1992. Expansion to an additional site in Berkeley was effective April 2000. Enrollment is expected to reach 506 dual eligibles and 74 Medi-Cal only eligibles by June 30, 2007; and 645 dual eligibles and 95 Medi-Cal only eligibles by June 30, 2008.

Sutter Senior Care in Sacramento started in August 1992. Effective April 2000, one area of Yolo County is served through an existing Sacramento site. Enrollment is expected to reach ~~225~~ **224** dual eligibles and ~~4~~ **5** Medi-Cal only eligibles by June 30, 2007; and 240 dual eligibles and 5 Medicare only eligibles by June 30, 2008.

Alta Med Health Senior Buena Care in East Los Angeles started in January 1996. Enrollment is expected to reach ~~320~~ **341** dual eligibles and ~~85~~ **91** Medi-Cal only eligibles by June 30, 2007; and 356 dual eligibles and 95 Medi-Cal only eligibles by June 30, 2008.

St. Paul's Homes and Services for the Elderly, a non-profit corporation, submitted a PACE application for its subsidiary corporation, Community Elder Care of San Diego (CESD). As of July 2006, this organization's application is under review by the OLTC. If approved, CESD is expected to be operational in FY 2007-08. CESD projects a beginning census of 20 enrollees with a monthly growth of six enrollees per month for the first year of operation.

FY 2006-07 funding reflects a one-time lump-sum retroactive payment resulting from the inclusion of *Orthopaedic Hospital* settlement money. The payment covers the excess capitation due for FY 2001-02 through FY 2003-04. The rate adjustment has been fully incorporated into the rates effective October 1, 2004.

**FY 2006-07 funding also reflects retroactive adjustments resulting from LTC rate increase adjustments effective 8/1/04, 8/1/05, and**

## MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

**8/1/06 as well as the 10/1/04 and 10/01/06 rate increase adjustments. These are adjustments that occur each year as a result of the timing of the rate year for LTC under AB 1629, which is different from the PACE plan rate year. Funding also reflects retroactive payments to establish rates paid to PACE Organizations at no less than 90% of the FFS equivalent effective July 1, 2006 and the five percent provider restoration effective January 1, 2007.**

FY 2006-07 funding reflects a one-time lump-sum retroactive payment resulting from rate adjustments that were paid to the plans beginning on October 1 of each year, but which were retroactively effective in each of those years. The retroactive adjustment reflects the number of months for each year the applicable rates were not paid.

M 8 (PC-59)	X	X	<p><u>Risk Payments for Managed Care Plans</u></p> <p>Medi-Cal managed care plans that have opted for reinsurance protections receive slightly lower capitation rates in return for financial risk limitations. Disbursements for risk/reinsurance expenditures occur when the cost of care in a 12-month period for a single beneficiary exceeds the amount specified in the health plan contract. Currently, Santa Barbara Regional Health Authority is the only managed care plan that has reinsurance protection. Estimated expenditures for risk provisions are \$5,000,000 <b><u>\$4,000,000</u></b> in FY 2006-07, and \$5,500,000 <b><u>\$4,500,000</u></b> in FY 2007-08.</p>
M 9 (PC-60)	X	X	<p><u>Family Mosaic – Capitated Case Management Projects</u></p> <p>Family Mosaic Project (<b>FMP</b>): Located in San Francisco, this program case manages emotionally disturbed children and adolescents at risk for out of home placement. Enrollment began in June 1993 and reached 144 in June 2006; it is expected to reach 165 by June 2007 and 178 by June 2008.</p> <p><b><u>FMP provides, coordinates, and oversees mental health treatment for children and youth with severe emotional and behavioral problems, targeting children who are at high risk for out-of-home placement or incarceration. FMP uses the capitation payments to provide the required services and also purchase and monitor other services from a network of private providers and community-based organizations in order to keep families together.</u></b></p>

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 10 (PC-OA)	X	X	<p><u>San Diego County Administrative Activities</u></p> <p>The County of San Diego provides administrative services for the San Diego Geographic Managed Care program. These administrative activities include health care options presentations, explaining the enrollment and disenrollment process, customer assistance, and problem resolution. Federal funding for these activities was discontinued as of August 1, 2003. The County of San Diego renewed its contract with the State effective July 1, 2005.</p>
M 11 (PC-52)	X	X	<p><u>Managed Care Intergovernmental Transfers</u></p> <p>The County of San Mateo will transfer funds under an IGT to the Department for the purpose of providing capitation rate increases to the Health Plan of San Mateo (HPSM), a COHS. These funds will be used for the nonfederal share of capitation rate increases paid to HPSM. The transfer of funds began in June 2006, effective retroactively to July 2005. The IGT has been extended to 2006-07 and 2007-08.</p> <p>The County of Los Angeles and LACare Health Plan, the Local Initiative, operating under the Two Plan model in Los Angeles County, have jointly submitted an IGT proposal to the Department to increase funds to the Department to be used for the nonfederal share of capitation rate increases. The IGT will be implemented in January 2007 <b><u>effective October 2006. The transfer of funds will begin in May 2007, and continue on an ongoing basis.</u></b></p>
M 12 (PC-64)	X	X	<p><u>FFS Costs for Managed Care Enrollees</u></p> <p>Managed care contracts specify that certain services are carved out of the rates paid for managed care enrollees. These services are provided through the fee-for-service system. The most significant carve-outs for most plans are federally qualified health care centers, rural health clinics, CCS services, and anti-psychotic drugs.</p>

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 13 (PC-OA)	X	X	<u>SPD Education and Outreach</u>

The Budget Act of 2006 includes funds to target barriers to enrollment of seniors and persons with disabilities (SPDs) into managed care, the budget includes funding for the Department to enter into an interagency agreement (IA) for education and outreach activities to increase the voluntary enrollment of Medi-Cal SPDs in all managed care counties. An IA with UC Berkeley has been negotiated for \$1.1 million for both FYs 2006-07 and 2007-08 to initiate **consisting of local assistance and support funds performs** education and outreach activities.

**On a cash basis, the local assistance portion is expected to be expended in the following fiscal years:**

<u>FY 2006-07</u>	<u>\$100,000</u>
<u>FY 2007-08</u>	<u>\$600,000</u>
<u>FY 2008-09</u>	<u>\$500,000</u>
<u>FY 2009-10</u>	<u>\$1,000,000</u>

**OTHER: AUDITS AND LAWSUITS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/YA 1 (PC-117) Lawsuits / Claims\*a. Attorney Fees of \$5,000 or Less

1. <i>Emily Q. v. Shewry</i>	06-55339,06-55489	\$638	\$0	
2. <i>James R. Minor</i>	159031	\$3,561		New
	Total	\$4,199	\$0	
	Fund Balance	\$45,801	\$50,000	

b. Provider Settlements of \$75,000 or Less

1. <i>Daughters of Charity Health Sys.</i>	CGC-05-439035	\$54,383		
2. <i>Catholic Healthcare West, So. Calif.</i>	BC335002	\$27,869		
3. <i>Alta Bates Summit Medical Ctr.</i>	CGC-05-438358	\$35,567		
4. <i>Children's Hosp &amp; Research Ctr.</i>	CGC-05443366	\$66,362		
5. <i>Catholic Healthcare West, So. Calif.</i>	BC331156	\$54,624		
6. <i>Catholic Healthcare West, So. Calif.</i>	BC337443	\$38,265		
7. <i>St. Vincent Medical Center</i>	04CS00601	\$31,875		
8. <i>Daughters of Charity Health Sys.</i>	CGC-05-445764	\$3,975		
9. <i>Catholic Healthcare West et. al.</i>	BC340267	\$2,655		
10. <i>Daughters of Charity Health Sys.</i>	BC341482	\$10,227		New
11. <i>Aurora Behavioral Health</i>	BC326729	\$38,350		New
12. <i>Seton Medical Center</i>	CGC-06-450141	\$1,025		New
13. <i>Children's Hosp &amp; Research Ctr</i>	CGC-06-450469	\$5,800		New
14. <i>Catholic Healthcare West, So. Calif</i>	BC346420	\$60,515		New
15. <i>Catholic Healthcare West, So. Calif</i>	BC334510	\$33,738		New
16. <i>Contra Costa Regional Med Ctr</i>	CGC-06-451803	\$47,500		New
	Total	\$512,730	\$1,600,000	
	Fund Balance	\$1,087,270		

c. Beneficiary Settlements of \$2,000 or Less

1.				
2.				
	Total	\$0	\$0	
	Fund Balance	\$15,000	\$15,000	

d. Small Claims Court Judgments of \$5,000 or Less

1. <i>Arun K. Mittal, MD, Inc.</i>	SBA 06S00934	\$677		
2. <i>David Ling</i>	LAM 06M08730	\$723		New
3. <i>Pacific Infusion Care</i>	RSC 10719	\$2,602		New
	Total	\$4,002	\$0	
	Fund Balance	\$195,998	\$200,000	

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

e.	<u>Other Attorney Fees</u>			
	1. <i>CA Advocates for Nursing Home</i>	315107	\$40,154	
	2. <i>Jonathan Corn</i>	05CS01362	\$1,615	
	3. <i>Health Advocates</i>	BS095298	\$35,678	
	4. <i>Jonathan Corn</i>	05CS01362	\$51,362	
	5. <i>MJ</i>	06CS00225	\$30,000	New
	Total		\$158,809	\$0
f.	<u>Other Provider Settlements / Judgments</u>			
	1. <i>St. Francis Medical Center</i>	C047027	\$61,493	
	2. <i>Sierra Hosp Foundation</i>	05CECG03331	\$135,000	New
	Total		\$196,493	\$0
g.	<u>Other Beneficiary Settlements</u>			
	1. <i>Jonathan Corn</i>	05CS01362	\$14,140	
	2.			
	Total		\$14,140	\$0

\* Amounts may exclude interest payments.

A 2 (PC-123)

Audit Settlements

At this time, there are no audit settlement payments for FY 2006-07.

A 3 (PC-118)

X

X

Notices of Dispute / Administrative Appeals – Settlements

Settlement agreements for disputes between the Department and the Two-Plan model managed care plans are estimated to be \$1,000,000 for possible settlements in FY 2006-07 and \$1,000,000 for FY 2007-08.

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
A 4 (PC-114)	X	X	<u>Minor Consent Settlement</u>
			<p>On June 17, 2002, the Department, Los Angeles County, and the U. S. Department of Justice executed a settlement agreement concerning an audit by the federal Office of the Inspector General relating to the incorrect claiming of FFP for services (especially mental health services) provided to minor consent eligibles from January 1, 1993, to the present. The terms of the settlement include payment of \$73.3 million, plus interest, of which Los Angeles County paid \$6.8 million within 10 days of receipt of the fully executed agreement. The balance of \$66,500,000, plus interest, will be withheld from California's Medicaid payments over ten years, with the first "adjustment" to be made July 1, 2003. Additionally, the Department and Los Angeles County entered into a separate agreement dated June 14, 2002, in which the County agreed to reimburse the Department an additional \$1,559,353. \$59,353 was due on or before August 1, 2003, without interest. The remaining \$1,500,000 was due in five installments of \$300,000 commencing August 1, 2003, plus interest which commenced June 15, 2003. In August 2005, Los Angeles County paid the Department the entire \$945,000 balance owed.</p>
A 5 (PC-130)	X		<u>GlaxoSmithKline Settlement</u>
			<p>In a settlement of a private class action lawsuit, the drug company GlaxoSmithKline has agreed to pay restitution to state Medicaid programs. The lawsuit was associated with drug pricing activities of the company for two injectable drugs. According to the settlement, California's recovery is <del>\$2,477,804.34</del> <b>\$2,492,178.58</b>, of which <del>\$1,238,900.65</del> <b>\$1,246,089.29</b> will go to the Department.</p>

**OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 0.1 (PC-137)	X		<p><u>Dental FI Underwriting Gain</u></p> <p>In November 2006, Delta Dental paid the Department \$131,718,000 (TF) based on the results of a contractually required independent audit. Dental contract provisions require that Delta Dental obtain an annual independent audit to determine any underwriting gain or loss, and specify the gain or loss sharing ratios with the State. The underwriting gain or loss is based on a comparison of the total premiums paid by the Department and actual expenditures incurred by Delta Dental. The November 2006 payment by Delta Dental was for the period August 2003 through April 2005 and covered an extended audit period due to a nine-month extension of the multiyear contract.</p>
R 0.2 (PC-140)	X	X	<p><u>Disputed Drug Rebates</u></p> <p>The Department collects drug rebates as required by federal and state laws. Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Disputed rebates are defined as being 15 days past due. The Department works to resolve these disputes and to receive rebate payments.</p> <p>Monies from resolved disputed rebates from 1991 to the second quarter of 2002 are considered Aged Drug Rebates and are budgeted separately in the Medi-Cal Estimate. Monies from the resolution of disputed rebates from the third quarter of 2002 to the present are considered Disputed Drug Rebates and had previously been budgeted in the Federal Drug Rebate, State Supplemental Rebate, and FPACT rebate policy changes.</p>
R 0.3 (PC-139)	X	X	<p><u>Medical Supply Rebates</u></p> <p>The Department is contracting for medical supply rebates, beginning with diabetic supply products. Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers. Manual invoicing started in December 2006.</p>
R 0.4 (PC-OA)		X	<p><u>FFP for Department of Public Health Support Costs</u></p> <p>SB 162 (Chapter 241, Statutes of 2006) requires the reorganization of the California Department of Health Services into two departments, the California Department of Health Care Services (DHCS) and the California Department of Public Health (CDPH). As part of the reorganization, the Title XIX federal Medicaid funding for Medi-Cal-related CDPH support costs will be moved to the Medi-Cal local assistance Item 4260-101-0890 beginning July 1, 2007. The federal funds will be shown as a reimbursement in the DPH budget.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 1 (PC-OA)	X	X	<p><u>Los Angeles County Medicaid Demonstration Project</u></p> <p>The original Los Angeles County Medicaid Demonstration Project (Project) expired June 30, 2000. An extension proposal was submitted to CMS to extend the project for an additional five years, from July 1, 2000, through June 30, 2005. CMS approved the Special Terms and Conditions for the extension of the waiver on January 17, 2001, and approved the SPA on January 22, 2001. The Special Terms and Conditions require a gradual phase-out of Waiver funding beginning FY 2002-03. In FY 2002-03 the Project FFP was reduced from \$246,600,000 to \$185,000,000. The FFP reduction continued in FY 2003-04 from \$185,000,000 to \$135,500,000 and in FY 2004-05 to \$86,300,000. The waiver extension ended on June 30, 2005. Demonstration project close-out activities, including payment of claims and submission of the final project report, will continue in FY 2006-07 <b><u>and FY 2007-08 for additional costs for audits and evaluations that were required at the end of the project.</u></b></p>
R 2 (PC-NA)	X	X	<p><u>FMAP Changes</u></p> <p>The Federal Medical Assistance Percentage (FMAP), which determines the federal Medicaid sharing ratio for each state, was 50% for the Medi-Cal program effective for the federal fiscal year beginning October 1, 2002. Public Law 108-27, the federal Jobs and Growth Tax Relief Reconciliation Act of 2003, increased the FMAP to 54.35% from April 1, 2003, to September 30, 2003, and to 52.95% from October 1, 2003, to June 30, 2004. The FMAP will be 50.0% from July 1, 2004 to June 30, 2007. Beginning July 1, 2007, the FMAP is assumed to be 50.0%.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
R 3 (PC-104) (PC-143)	X	X

Dental Contract

The dental rates for the period August ~~2004~~ **2005** through July ~~2005~~ **2006** are:

<u>Refugees</u>	<u>All Others</u>
<del>\$51.24</del> <b>\$34.99</b>	<del>\$9.22</del> <b>\$8.52</b>

The dental rates for the period August ~~2005~~ **2006** through July ~~2006~~ **2007** are:

<u>Refugees</u>	<u>All Others</u>
<del>\$34.99</del> <b>\$35.92</b>	<del>\$8.52</del> <b>\$8.51</b>

~~The Budget Act and Health Trailer Bill of 2003 reduced selected provider payments by 5%, effective January 1, 2004. The Department had been temporarily enjoined from implementing this payment reduction for dental providers by federal court order. The Department won the appeal in August 2005. AB 1735 amended the implementation date from January 1, 2004, to January 1, 2006. The 5% payment reduction would have expired December 31, 2006; however, SB 912 (Chapter 8, Statutes of 2006) rescinded the payment reduction effective March 4, 2006. Accordingly, the 5% payment reduction was factored into the new dental rates for the period January 1 through March 3, 2006.~~

~~Full operations for the previous dental FI contract ended April 30, 2005. The new dental FI contract became effective May 2005. The FY 2006-07 rates are currently in the process of negotiation with Delta Dental.~~

Dental rates were reduced for the period August 2005 through July 2006 from \$9.22 to \$8.52 for regular eligibles, and from \$51.24 to \$34.99 for refugees. The retroactive change order to implement this effective August 2005 is will be completed in May 2007.

Dental rates for the period August 2006 through July 2007 decreased from \$8.52 to \$8.51 for regular eligibles, and increased from \$34.99 to \$35.92 for refugees. The retroactive change order to implement this effective August 2006 will be completed in August 2007.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 4 (PC-56)	X	X	<p><u>Dental Geographic Managed Care</u></p> <p>The Geographic Managed Care (GMC) project in Sacramento County covers dental services for eligibles with mandatory aid codes and SSI/SSP on a voluntary basis. Since April 1994, dental managed care services to beneficiaries have been delivered through four contractors. There are approximately 166,000 beneficiaries enrolled in the four dental GMC plans. Contractors are required to reimburse DHS for all administrative and regulatory contract monitoring costs, including equipment, staff salaries and related expenses.</p> <p>The four GMC contracts will expire December 31, 2007. A Request for Application (RFA) process is currently being planned, and beginning January 1, 2008, the GMC plans will continue to operate under a new contract through that RFA process.</p>
R 5 (PC-56)	X	X	<p><u>Dental Managed Care within Medi-Cal Two-Plan Model Counties</u></p> <p>The 1997-98 Budget Act made provision for the Department to enter into contracts with health care plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at risk basis. Additionally, the Budget Act allows the Department to require that dental managed care contractors reimburse the Department for all administrative and regulatory contract monitoring costs, including equipment, staff salaries and related expenses.</p> <p>The Department has contracted with thirteen dental plans that are providing services as voluntary prepaid health plans (PHPs) in Los Angeles County. There are approximately 216,000 beneficiaries enrolled in the thirteen PHP plans. These contracts will expire June 30, 2007. Beginning July 1, 2007, the two-plan contracts will continue to operate under contract extensions.</p>
R 6 (PC-131)	X	X	<p><u>EDS Cost Containment Projects – Program Savings</u></p> <p>The Department has approved implementation of proposals developed by the Fiscal Intermediary (EDS) to contain Medi-Cal costs. The cost containment proposals result in savings to the Medi-Cal program. The Fiscal Intermediary will share in the achieved savings for two years after implementation of each proposal.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 7 (PC-OA)	X	X	<u>MIS/DSS Contract</u>

The Management Information System and Decision Support System (MIS/DSS) gathers data from provider, financial, eligibility and managed care/fee-for-service encounter and claims data into an integrated, knowledge-based system that is used by staff in various DHS units, including the Medi-Cal Managed Care Division in its monitoring of Health Plan performance, and the Audits and Investigations in its anti-fraud efforts.

A 9-month, non-competitive bid (NCB) extension was approved for the ~~current~~ MIS/DSS maintenance and operations contract with Medstat. This contract ~~expires~~ **expired** January 17, 2007. The Department of General Services (DGS) conducted a competitive procurement, on behalf of CDHS, to award a new MIS/DSS contract. The contract award was protested and ~~the protest is currently pending at the Victims Compensation and Government Claims Board (the Board)~~ **has ruled in the Department's favor.**

**A new contract for development of the Next Generation MIS/DSS was executed with Bull Services, Inc. in February 2007. Bull Services, Inc. has elected not to receive progress payments. As a result, no FY 2006-07 payments are scheduled for this contract. FY 2007-08 expenditures represent one-time and ongoing costs associated with system design, development, and implementation. On December 19, 2006, CMS approved the Next Generation MIS/DSS Implementation Advanced Planning Document (IAPD), including the enhanced funding for this project at 90% FFP for new development and 75% FFP for all other system costs.**

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
R 8 (PC-OA)	X	X	<p><u>MIS/DSS Oversight Contract Procurement</u></p> <p>The Department of General Services (DGS), on behalf of the Department, conducted a competitive procurement for a new contract to enhance, operate and maintain the MIS/DSS.</p> <p>The request for proposal was released in September 2005 and a Notice of Intent to Award the MIS/DSS contract was issued on April 28, 2006. A protest of this intended award was received on May 5, 2006. <del>It is expected that the new MIS/DSS contract will be executed in January 2007.</del> As <b><u>The Victims Compensation and Government Claims Board has ruled in the Department's favor. The new Next Generation MIS/DSS contract was executed with Bull Services, Inc. in February 2007. The contract execution closes out the procurement effort: however, as</u></b> required by the Department of Finance's Project Oversight Framework <b><u>for this high criticality project</u></b>, the Department engaged an Independent Procurement Oversight Consultant (IPOC) in January 2006, and an <del>the</del> Independent Verification &amp; Validation (IV&amp;V) Contractor in August 2006, <b><u>will remain throughout the project implementation phases</u></b> to provide oversight of the project management and implementation processes.</p> <p><b><u>On December 19, 2006,</u></b> CMS has approved the <b><u>Next Generation MIS/DSS Implementation Advanced Planning Document (IAPD), including</u></b> Planning Advanced Planning Document with enhanced funding for this project at <del>75%</del> <b><u>90% FFP for the IV&amp;V and 75% FFP for the IPOC,</u></b> with a commitment to consider 90% FFP for project components and planning activities that qualify for enhanced 90% FFP. This determination will be based on details of the new system included in the IAPD. The IAPD will be sent to CMS in September 2006, and the <b><u>On January 10, 2007 DOF approved the Next Generation MIS/DSS IAPD</u></b> in lieu of Special Project Report (SPR) <del>will be sent to DOF.</del></p>
R 9 (PC-124)	X	X	<p><u>Indian Health Services</u></p> <p>Effective April 21, 1998, Medi-Cal implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and CMS. The agreement provided that California can be reimbursed 100% federal medical assistance percentage for payments made by the State for services rendered to Native Americans through IHS tribal facilities. Forty-four clinics in California have elected to participate under the IHS/MOA. Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 10 (PC-OA)	X	X	<u>Baby Welcome Kits</u>
			Beginning in November 2001, Title XIX FFP has been claimed for the "Welcome Kits" distributed by the California Children and Families Commission (Proposition 10) to parents of Medi-Cal eligible newborns.
R 11 (PC-97)	X		<u>DSH Payments</u>
			SBs 855 and 146 (Chapters 279 and 1046, Statutes of 1991) established the Medi-Cal Inpatient Payment Adjustment (MIPA) Fund, which provides for supplemental payments to disproportionate share hospitals (DSH). There have been numerous changes in federal law and regulations that affect the DSH allotment available to California. House Resolution (HR) 5661 established that, beyond SFY 2002-03, the maximum federal allotment is determined by the prior year actual allotment amount adjusted by the change in the annual CPI.
			HR1, the Medicare Prescription Drug Act, increased the DSH allotment by 16 percent in SFY 2003-04. This one-time increase fixed the federal DSH allotment at \$1,032,579,800 until the annual allotment computed by the HR 5661 methodology (adjusting the prior year funding level by the CPI) exceeds \$1,032,579,800. At that time, the HR 5661 methodology will apply.
			The remaining <del>FY 2003-04</del> and FY 2004-05 payments were paid in FY 2005-06 with the exception of <del>\$3,500,000</del> <b>\$2,209,000</b> for redistribution of FY 2004-05 DSH overpayments collected in FY <del>2006-07</del> <b>2005-06</b> . In accordance with SPA 05-22, the computation of the DSH payments to DPHs, NDPHs, and private hospitals has been changed. For additional information, please see the Hospital Financing section of the assumptions.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 12 (PC-90)	X	X	<p><u>Capital Project Debt Reimbursement</u></p> <p>SB 2665 (Chapter 1310, Statutes of 1990), and SB 1732 (Chapter 1635, Statutes of 1988) authorize Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. To qualify, a hospital must be a disproportionate share hospital, must have either a SPCP or County Organized Health Systems contract with the State of California, and must meet other specific hospital and project conditions specified in Section 14085.5 of the Welfare and Institutions Code.</p> <p>SB 1128 (Chapter 757, Statutes of 1999) authorizes a distinct part (DP) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP must meet other specific hospital and project conditions specified in section 14105.26 of the W&amp;I Code. The two DPs that qualify for this reimbursement have commenced their capital construction projects.</p>
R 13 (PC-105)	X	X	<p><u>Developmental Centers/State Operated Small Facilities</u></p> <p>The Medi-Cal budget includes the estimated federal fund cost of the California Department of Developmental Services' (CDDS) Developmental Centers (DCs) and two State-operated small facilities.</p>
R 14 (PC-OA)	X	X	<p><u>CDDS Administrative Costs</u></p> <p>The Medi-Cal budget includes FFP for CDDS Medi-Cal-related administrative costs. Beginning in FY 2001-02, CDDS began budgeting the General Fund in its own departmental budget.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 15 (PC-102) (PC-OA)	X	X	<p><u>Mental Health Services – CDMH</u></p> <p>The Medi-Cal budget includes the estimated cost of specialty mental health services provided to Medi-Cal beneficiaries through the Medi-Cal Specialty Mental Health Services waiver program administered by CDMH.</p> <p>On April 26, 2005, CMS approved the renewal of the Specialty Mental Health Waiver for the term April 1, 2005 through March 31, 2007. This approval included merging the Medi-Cal Mental Health Care Field Test (San Mateo County) and Solano County Mental Health programs into the Specialty Mental Health Waiver program, effective July 1, 2005.</p> <p>Beginning in FY 2006-07, the GF cost of EPSDT mental health services and the San Mateo Pharmacy/Lab contract will be included in the CDMH budget rather than in the CDHS budget.</p> <p><del>In</del> <b><u>On December 28, 2006, the Department submitted an application to renew the Medi-Cal Specialty Mental Health Services waiver for the period April 1, 2007 through March 31, 2009. On March 27, 2007, CMS approved a 90-day extension of the waiver through June 30, 2007. The Department expects CMS final waiver approval within this added timeframe.</u></b></p>
R 16 (PC-110)	X	X	<p><u>Healthy Families – CDMH</u></p> <p>Title XXI FFP will be claimed for the cost of providing additional mental health services to Severely Emotionally Disturbed children who have exhausted Healthy Families mental health benefits.</p>
R 17 (PC-113)	X	X	<p><u>State Hospitals – CDMH</u></p> <p>Beginning with the November 2002 Estimate for FY 2002-03, the CDMH began budgeting for its own Medi-Cal related state hospital reimbursements. Previously, these reimbursements had been budgeted by the California Department of Developmental Services on behalf of CDMH.</p>
R 18 (PC-107) (PC-OA)	X	X	<p><u>Mental Health Drug Medi-Cal – CDADP</u></p> <p>Title XIX FFP will be claimed for Drug Medi-Cal services administered by the California Department of Alcohol and Drug Programs (CDADP).</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 19 (PC-OA)	X	X	<p><u>Perinatal HIV Testing Project</u></p> <p>The Perinatal HIV Testing Project, administered by the Office of AIDS, develops and disseminates HIV educational material for prenatal women, and provides prenatal HIV testing information to perinatal care providers and organizations. Technical assistance and training is offered to those prenatal providers who currently treat Medicaid patients. Beginning in 1998, CMS approved an expansion into outreach to individuals in addition to providers.</p>
R 20 (PC-119) (PC-OA)	X	X	<p><u>CLPP Case Management Services</u></p> <p>The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments, which provide case management services. To the extent that local governments provide case management to Medi-Cal eligibles, federal matching funds can be claimed.</p>
R 21 (PC-122)	X	X	<p><u>Cigarette and Tobacco Products Surtax Funds</u></p> <p>Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the <i>Orthopaedic Hospital</i> settlement via the Hospital Services Account and the Unallocated Account. The amounts available to Medi-Cal vary from year to year.</p>
R 22 (PC-94)	X	X	<p><u>Certification Payments for DP-NFs</u></p> <p>In the Budget Act of 2001, the Legislature took action to allow Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals to claim FFP on the difference between their projected costs and the maximum DP-NF rate Medi-Cal currently pays. The acute care hospitals must be owned and operated by a public entity, such as a city, county, or health care district.</p>
R 23 (PC-BA)	X	X	<p><u>Alternative Birthing Centers</u></p> <p>Pursuant to W &amp; I Code Section 14148.8, the Department is required to provide Medi-Cal reimbursement to alternative birthing centers (ABCs) for facility-related costs at a statewide all-inclusive rate per delivery. This reimbursement must not exceed 80% of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts. The reimbursement rates must be updated annually and must be based on an average hospital length of stay of 1.7 days. The ABC rates will increase each year by the same percentage as the CMAC average acute care hospital contract rate.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 24 (PC-OA)	X	X	<p><u>Health and Human Services Agency HIPAA Funding</u></p> <p>In order to meet the requirements of HIPAA and ensure that its provisions are applied uniformly in the impacted programs, a HIPAA office has been established at the Health and Human Services Agency. Title XIX federal financial participation is available for HIPAA activities related to Medi-Cal.</p>
R 25 (PC-70)	X	X	<p><u>Hospice Rate Increases</u></p> <p>Pursuant to state regulations, Medicaid hospice rates are established in accordance with 1902(a)(13), (42 USC 1396a(a)(13)) of the federal Social Security Act. This act requires annual increases in payment rates for hospice care services based on corresponding Medicare rates. New hospice rates are effective October 1<sup>st</sup> of each year.</p> <p>Effective February 1, 2003, hospice room and board providers are reimbursed at 95% of the Medi-Cal per-diem rate paid to the facility with which the hospice is affiliated. This change in reimbursement methodology was made to reflect the CMS allowable rate, in accordance with 42 USC 1396a(a)(13)(B) and 1902(9a)(13)(B) of the federal Social Security Act.</p>
R 26 (PC-67)	X	X	<p><u>Annual MEI Increase for FQHCs and RHCs</u></p> <p>The Department implemented the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) included in the 2000 Benefits Improvement and Protection Act on January 1, 2001. Clinics have been given the choice of a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate, or (2) their 2000 cost-based rate. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate adjustment is the percentage increase in the Medicare Economic Index (MEI) and is effective October 1<sup>st</sup> of each year.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 27 (PC-111)	X	X	<p><u>Nurse-to-Patient Ratios for General Acute Care Hospitals</u></p> <p>AB 394 (Chapter 945, Statutes of 1999) requires the Department to adopt regulations establishing minimum, specific and numerical licensed nurse-to-patient ratios by licensed nurse classification and hospital unit for general acute care and psychiatric hospitals. The regulations specify the number of patients that may be assigned per licensed nurse in the following hospital units: critical care, burn unit, labor and delivery, surgical service, perinatal service, pediatric service, postanesthesia recovery unit, emergency service, step-down/intermediate care unit, telemetry unit, medical/surgical care unit, specialty care unit, and psychiatric unit. The regulations were implemented January 1, 2004. On January 1, 2005, the nurse-to-patient ratio for medical, surgical, and combined medical/surgical units, and mixed units further changed from 1:6 to 1:5.</p>
R 28 (PC-91)	X	X	<p><u>Hospital Outpatient Supplemental Payments</u></p> <p>AB 915 (Chapter 747, Statutes of 2002) creates a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. The supplemental amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match used to draw down FFP will be paid exclusively with funds from the participating facilities and will not involve General Fund dollars. <del>Retroactive claiming will be allowed to July 1, 2002.</del> Payments are expected to be made in June 2006 for FY 2004-05, and in June 2007 for FY 2005-06.</p>
R 29 (PC-93)	X	X	<p><u>FFP For Local Trauma Centers</u></p> <p>The Budget Act of 2003 provided funding for Los Angeles County and Alameda County to transfer funds to the Medi-Cal program to be matched with federal funds. The combined funds will be used to offset costs of care at local trauma care centers throughout the counties.</p>
R 30 (PC-48)	X	X	<p><u>Federal Drug Rebate Program</u></p> <p>Federal law requires drug manufacturers to provide rebates to the federal government and the states as a condition of FFP in the states' coverage of manufacturers' drug products. The manufacturers have 30 days to make payment after being billed. <del>In 2005, AIDS Healthcare Foundation and the Health Plan of San Mateo were found to meet the criteria of a Managed Care Organization and can no longer participate in the federal Medicaid drug rebate program.</del></p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 31 (PC-47)	X	X	<p><u>State Supplemental Drug Rebates</u></p> <p>The Department negotiates state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels. As with the federal drug rebates, the Department estimates the state supplemental rebate amounts by using actual fee-for-service trend data for drug expenditures and applying a historical percentage of actual amounts collected to the trend projection.</p>
R 32 (PC-40)	X	X	<p><u>Non FFP Drugs</u></p> <p>Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid Programs if the manufacturer of the drug has not signed a rebate contract with CMS. The Department is establishing claiming procedures to ensure that FFP is claimed correctly. Effective <del>January</del> <b>March</b> 2007, an automated <b>quarterly</b> report will be available to determine the costs of drugs for which there is no FFP. This report will be used to reduce the FFP appropriately. The Department will also retroactively adjust FFP for drugs purchased in <del>the</del> prior <del>three</del> years.</p>
R 33 (PC-43)	X	X	<p><u>Enteral Nutrition Contracts</u></p> <p>Medi-Cal currently covers nutritional products for individuals who are unable to eat regular food to sustain their health. Many of the products are expensive and the Department is seeking ways to reduce the overall cost of providing the enteral nutrition products. In accordance with the Health Trailer Bill of 2002, the Department implemented a provider rate reduction and began the process of contracting with nutritional product manufacturers for lower costs or rebates. The process began in 2002 and was delayed due to legal issues regarding the contract content. With these issues resolved, the Department's first contracts were in place on January 1, 2006, with provider payment reductions effective March 1, 2006. <del>December 2007</del> <b><u>Due to the difficulty in reaching a consensus of categorizing product types with manufacturers, June 2008</u></b> is the target date to have all products under contract.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 34 (PC-42)	X	X	<p><u>Medical Supply Contracting &amp; Maximum Allowable Product Cost (MAPC) for Medical Supplies</u></p> <p>The Health Trailer Bill of 2002 allows contracting with medical supply manufacturers and changes the reimbursement methodology for establishing the <b>Maximum Allowable Product Cost (MAPC)</b> for medical supplies from AWP to WSP. <b><u>Savings is achieved through lower reimbursement rates and had been delayed due to contract language negotiations. Conflicting workload issues, resulting from the concurrent implementation process for the UPN Waiver, have further slowed the contracting process.</u></b></p> <p><b><u>Medical Supply Contracting was formerly a component of the Medical Supply Reduction assumption and incorporates both Medical Supply Contracting and MAPC for Medical Supplies.</u></b></p>
R 35 (PC-44)	X	X	<p><u>New Therapeutic Category Reviews</u></p> <p>The Department has added additional staff positions to perform new annual drug therapeutic category reviews (TCRs). Drugs are organized into therapeutic categories, such as antibiotics, or drug that treat hypertension, acid reflux, etc. There are many as 114 of these therapeutic categories. The Department regularly conducts TCRs on these drugs to determine safety, efficacy, essential need, potential of misuse, and cost, prior to including drugs in the List of Contract Drugs. Drugs on the List do not require prior authorization prior to dispensing. The <u>TCRs to date are:</u></p> <ul style="list-style-type: none"> <li>• Statin drugs for hypercholesterolemia (Implementation Date 7/2004)</li> <li>• Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARB) (cardiac drugs) (Impl. Date 7/2004)</li> <li>• Non-sedating antihistamines (Impl. Date 8/2004)</li> <li>• Antidepressants, oral (Impl. Date 7/2004)</li> <li>• Proton pump inhibitors (Impl. Date 1/2005)</li> <li>• Papain/urea and papain/urea/cholorhyllin debriding products (Impl. Date 9/2005)</li> <li>• Short Acting Beta 2 Agonist Inhalers (Impl. Date 6/2006)</li> <li>• <b><u>Statin drugs for hypercholesterolemia (Impl. Date 7/2007)</u></b></li> <li>• <b><u>ACE inhibitors and ARBs (Impl. Date 10/2007)</u></b></li> <li>• <b><u>Antibiotics (Impl. Date 1/2008)</u></b></li> </ul> <p>The Department <b>had</b> delayed additional TCRs until the impact of Medicare Part D was assessed. <b><u>Statin drugs for hypercholesterolemia and ACE inhibitors/ARBs have had new generic drugs introduced since their first TCR, necessitating a new TCR.</u></b></p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 36 (PC-OA)	X	X	<p><u>EPSDT Case Management</u></p> <p>Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. As more children shift from CHDP to the CHDP Gateway, costs for county administration shift from the state funded CHDP Program to the Medi-Cal and Healthy Families programs.</p>
R 37 (PC-OA)	X	X	<p><u>CCS Case Management Costs</u></p> <p>Medi-Cal provides funding for the county administration of the California Children's Services (CCS) Program for those children that receive CCS services that are Medi-Cal eligible.</p>
R 38 (PC-127)	X	X	<p><u>State Only IMD Ancillary Services – CDMH</u></p> <p>Effective July 1, 1999, the cost of ancillary services for Medi-Cal eligibles who have not attained 65 years of age and who are residents of CDMH Institutions for Mental Diseases (IMDs) is entirely state-funded.</p>
R 39 (PC-45)	X	X	<p><u>Aged Drug Rebate Resolution</u></p> <p>The Budget Act of 2003 includes funding for staff to resolve aged drug rebate payment disputes. Between 1991 and 2002 the Medi-Cal program accumulated large rebate disputes with participating drug companies. An <b>Based on an</b> Office of Inspector General (OIG) audit identified, <b>the Department estimated</b> \$29.5 million as being <b>potentially recoverable from the</b> aged drug rebate payment disputes. An approved Budget Change Proposal (BCP) added four permanent staff in FY 2002-03 to recover additional rebate amounts from these aged disputes.</p> <p>An approved BCP added 11 temporary staff in FY 2003-04 to allow the Department to resolve all aged disputes. The staff will continue working through FY <del>2006-07</del> <b>2007-08, assuming approval of a BCP.</b> <b><u>Approximately \$55 million is expected to be recovered by the end of FY 2007-08.</u></b></p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 40 (PC-OA)	X	X	<p><u>Postage and Printing – Third Party Liability</u></p> <p>The Third Party Liability Branch uses direct mail and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and insure that Medi-Cal is the payor of last resort. The number of forms/questionnaires printed and mailed and report information received correlates to the Medi-Cal caseload.</p>
R 41 (PC-OA)	X	X	<p><u>Continuous Nursing Care Pilot Project</u></p> <p>AB 359 (Chapter 845, Statutes of 1999) required the Department to establish a Section 1915(b) waiver pilot program to provide continuous 24-hour nursing care to developmentally disabled individuals in the least restrictive setting. CMS has approved renewal of the waiver effective October 1, 2005 through September 30, 2007. The Department has budgeted \$250,000 in FY 2006-07 for a final independent assessment to determine the feasibility and cost effectiveness of establishing the Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing (ICF/DD-CN) as a permanent new provider type and adding this service to the State Plan.</p> <p>The ICF/DD-CN daily rates are based on the ICF/DD-N daily rates, including the Pediatric Sub-Acute Ventilator rates. The Department has discovered that the ICF/DD-CN daily rates have not been adjusted for the annual ICF/DD-N rate changes. The Department will recalculate the daily rates to include these adjustments that were inadvertently omitted for FY 2005-06.</p>
R 42 (PC-OA)	X	X	<p><u>TAR Postage</u></p> <p>Postage costs related to mailing treatment authorization request-related documents to providers and beneficiaries are budgeted in local assistance.</p>
R 43 (PC-115)	X	X	<p><u>HIPP Premium Payouts</u></p> <p>The Department pays the premium cost of private health insurance for high-risk beneficiaries under the Health Insurance Premium Payment (HIPP) program when payment of such premiums is cost effective.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 44 (PC-100)	X	X	<p><u>Medicare Part A and Part B Buy-In</u></p> <p>The Department pays CMS for Medicare Part A (inpatient services) and Part B (medical services) premiums for those Medi-Cal beneficiaries who are also eligible for Medicare.</p> <p>These premiums allow Medi-Cal beneficiaries to be covered by Medicare for their cost of services, thus saving Medi-Cal these expenditures. The premium amounts are set by CMS effective January 1st of each year. Beginning January 1, 2005 <del>2006</del>, premiums are <del>\$375</del> <b>were \$393</b> for Part A and <del>\$78.20</del> <b>\$88.50</b> for Part B. Beginning January 1, 2006 <del>2007</del>, premiums are \$410 and <del>\$88.50</del> <b>\$93.50</b>, respectively. Premiums are estimated to be \$448 <b>\$428</b> and <del>\$100.20</del> <b>\$98.80</b>, respectively, beginning January 1, 2007 <del>2008</del>.</p>
R 45 (PC-68)	X	X	<p><u>Non-Contract Hospital 10% Interim Rate Reduction</u></p> <p>The Trailer Bill of 2004 reduced non-contract hospital interim payments for acute inpatient services provided during FY 2004-05 by 10% effective September 1, 2004. The 10% reduction <del>will be</del> <b>was</b> applied to the interim rate on file and in effect on July 1, 2004. The interim payment provides payment for services provided through the non-contract hospital's fiscal year.</p> <p>Subsequent to the receipt of a non-contract hospital's Medi-Cal cost report for <b><u>a hospital fiscal year that includes any portion of state</u></b> FY 2004-05, a cost settlement is performed by the Department. This cost settlement includes an audit to determine allowable and reimbursable costs related to the care provided to Medi-Cal patients. The cost settlement also includes a reconciliation of amounts paid (interim payments) versus amounts payable. Normally, if audited costs are lower than those reported in the cost report, the hospitals reimburse the difference to Medi-Cal. If audited costs are higher, Medi-Cal reimburses the difference to the hospitals. <b><u>However, another provision of the Health Trailer Bill of 2004 limits</u></b> the final reimbursable costs computed for FY 2004-05 <del>will be limited</del> to the lesser of the FY 2004-05 audited Medi-Cal reimbursable costs or the as-audited reimbursable costs computed using the average cost per day for the hospitals' FY End in 2003 and the number of Medi-Cal days for FY 2004-05. The <b><u>Department began issuing the</u></b> final cost determinations <del>will be made</del> beginning in FY 2006-07 <b><u>2005-06</u></b>.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 46 (PC-39)	X	X	<p><u>HIV/AIDS Pharmacy Pilot Program</u></p> <p>AB 1367 (Chapter 850, Statutes of 2004) required the Department to establish the HIV/AIDS Pharmacy Pilot Program to evaluate the effectiveness of pharmacist care in improving health outcomes. Ten pharmacies are participating and will receive an increase of an additional \$9.50 in their dispensing fee for claims with a date of service on or after September 1, 2004. CMS has denied the SPA regarding this program because it is a pilot that requires a waiver for FFP. State law implementing the pilot was not contingent on federal approval. Therefore, the funding for this program is 100% GF. The Department will reimburse the FFP for drugs that have been claimed for this program. The program will sunset January 1, 2008.</p>
R 47 (PC-65)	X	X	<p><u>NF-B Rate Changes and Quality Assurance Fee</u></p> <p>AB 1629 (Chapter 875, Statutes of 2004) lifted the rate freeze for freestanding skilled nursing facilities (freestanding NF-Bs and freestanding subacute services), as well as provided for a cost-of-living adjustment, a change in the rate methodology, and a quality assurance (QA) fee. Rate increases are capped at 8% for FY 2005-06, 5% for FY 2006-07, and 5.5% for each fiscal year thereafter. <b><u>Additionally, the minimum wage increase (AB 1835, Chapter 230, Statutes of 2006) will impact reimbursement rates as of January 1, 2007. This increase will result in an add-on to the reimbursement rates effective August 1, 2007.</u></b></p> <p>The QA fee is capped at 6% for each fiscal year <b><u>thru December 31, 2008. Effective January 1, 2008, under 42 U.S.C. 1396b(w)(4)(C) as revised pursuant to PL 109-432, the QA fee will be capped at 5.5% of the total gross revenue. Due to the midyear change in the allowable percentage to be collected, the impact on the reimbursement rates and the QA fee collection will be annualized in order to reduce the confusion to providers. In addition, any changes in the facilities' licensing fees will also impact the August 1, 2007 reimbursement rates and the allowable QA fee amount to be collected.</u></b> The rate methodology and QA fee provisions sunset on July 31, 2008.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 48 (PC-66)	X	X	<u>LTC Rate Adjustments</u>

Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of the annual rate study. For the rate year 2005-06, new LTC rates will be effective August 1, 2005. Funds will be included for Managed Care, PACE, SCAN, and On LOK. Facilities affected by AB 1629 (freestanding NF-Bs and freestanding subacute services) will undergo a rate methodology change. Any changes to these freestanding NF-Bs and freestanding subacute services will be included in the SNF QA Fee and Rate Change policy change. It is assumed that new LTC rates for rate years 2006-07 and 2007-08 will be effective August 1, 2006 and August 1, 2007, respectively. The rates for 2007-08 are estimated based on increases from the prior rate year. **Additionally, the minimum wage increase (AB 1835, Chapter 230, Statutes of 2006) will impact reimbursement rates as of January 1, 2007. This increase will result in an add-on to the reimbursement rates effective August 1, 2007.**

**Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) are required to pay a QA fee. The QA fee collection is capped at 6% thru December 31, 2007. Effective January 1, 2008, under 42 U.S.C. 1396b(w)(4)(C) as revised pursuant PL 109-432, the QA fee will be capped at 5.5% of the total gross revenue. Due to the midyear change in the allowable percentage to be collected, the impact on the reimbursement rates and the QA fee collection will be annualized in order to reduce the confusion to providers. In addition, any changes in the facilities' licensing fees will also impact the August 1, 2007 reimbursement rates and the allowable QA fee amount to be collected.**

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 49 (PC-121)	X		<p><u>FFP Repayment – Specialty Mental Health Waiver</u></p> <p>The Department has agreed to repay CMS for an overpayment within the Specialty Mental Health Services Waiver administered by CDMH through an Interagency Agreement with CDHS. In its oversight role, CDMH identified overpayments to Tri-Cities, a subcontractor of the Los Angeles County Mental Health Plan, of approximately \$6.3 million in FFP for Fiscal Years 1996-97, 1998-99, 2001-02, 2002-03, and 2003-04. On February 13, 2004, Tri-Cities, a Joint Powers Authority composed of the cities of Claremont, La Verne, and Pomona, filed Chapter 9 bankruptcy. As part of the bankruptcy proceedings, Tri-Cities identified the total overpayment amount as \$9.1 million in FFP. The Department repaid \$6.3 million to CMS in FY 2004-05. The audits have been completed, and the total overpayment amount has been determined to be \$8.2 million. The remaining \$1.9 million due to CMS is expected to be paid in FY 2006-07.</p>
R 50 (PC-96)	X	X	<p><u>Medi-Cal Reimbursement for Outpatient Small and Rural Hospitals</u></p> <p>Health and Safety Code section 124870 requires CDHS to increase reimbursement rates for outpatient services rendered to Medi-Cal beneficiaries by small and rural hospitals (SRH). The Budget Act of 2000 increased the funding for this program to \$4,000,000, or \$8,000,000 when matched with federal funds. Eligible SRH providers are reimbursed on a quarterly basis through a Payment Action Notice (PAN) to the FI. The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
R 51 (PC-95)	X	X	<p><u>Medi-Cal Reimbursement for Outpatient DSH</u></p> <p>SB 2563 appropriated \$5,000,000 General Fund to be allocated to hospitals providing a disproportionate share of outpatient services. The total appropriation each year is \$10,000,000 when combined with federal matching funds. Eligible DSH providers are reimbursed on a quarterly basis through a PAN to the FI. The payment represents one quarter of the total annual amount due to each eligible hospital.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 52 (PC-OA)	X	X	<p><u>Immunization Registry</u></p> <p>Immunization services are required for Medi-Cal eligibles based on the Title XIX Early and Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. California Health and Safety Code Section 120440 governs the operation of immunization registries, secure databases of childhood vaccination records that allow medical providers to identify and vaccinate all under-immunized children, including those assisted by Medi-Cal and CHDP. California is covered by nine regional registries that are based in local health departments. The Department currently allocates Local Assistance General Funds in Item 4260-111 for the operation of the regional immunization registries. CMS has determined that funds to operate immunization registries similar to those in California are eligible for 50% match for Medi-Cal related activities under Section 1903(a)(7) of Title XIX. Beginning in FY 2005-06, the Department <del>will</del> <b>claim <u>claimed</u></b> Title XIX FFP for the Medi-Cal beneficiary related costs of the immunization registry system. The registry cost for non-Medi-Cal children will continue to be funded through current General Funds.</p>
R 53 (PC-OA)	X	X	<p><u>PIA Eyewear Courier Service</u></p> <p>The Prison Industries Authority (PIA) fabricates the eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an interagency agreement with PIA to reimburse them for one-half of the costs of the courier service that delivers orders between the optical providers and PIA. The current PIA courier contract <del>expired</del> <b><u>which was due to expire in January 2007, and will go out for bid at that time for a new courier has been extended to April 2007 to allow the new courier time to phase-in to the different areas of the State for a smooth transition.</u></b></p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
R 54 (PC-126)	X	X	<p><u>Reimbursement of FFP for Non-Institutional Provider Overpayments</u></p> <p>The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 required that the federal government be reimbursed its share of all provider overpayments in the quarter in which the 60<sup>th</sup> day after discovery of an overpayment falls. Although the Department has done so for institutional overpayments, an internal auditor found that FFP was not being reported correctly for non-institutional provider overpayments. Changes in the Department's COBRA System were made to rectify the non-institutional reporting and the system changes became operational in July 2006. The system began reporting non-institutional FFP for debts established after July 1, 2006. The repayment of FFP <del>will be made beginning</del> <b><u>for overpayments identified after July 1, 2006 began</u></b> in FY 2006-07. <b><u>The repayment of \$92 million FFP owed for overpayments identified prior to July 1, 2006 will be made in FY 2006-07. If any of these debts are subsequently discovered to be uncollectible, the Department will initiate the necessary documentation to obtain reimbursement from CMS.</u></b></p>
R 55 (PC-OA)	X	X	<p><u>COHS Rebates Reconciliation</u></p> <p>To increase drug rebate collections for the seven COHS counties (excludes Health Plan of San Mateo), the Department will reconcile the counties' Paid Claims files with drug records obtained from the Pharmacy Benefits Manager (PBM) contractors who adjudicate the drug claims for COHSs to improve their drug data in order to improve drug rebate collections for these claims. The Department will enter into contracts to analyze edit reports, research cause and correction for critical data errors, establish error feed-back loops to the sources of the errors, develop corrective action plans, track error rates, and monitor improvement efforts. These ITSD efforts qualify for 75% FFP. Increased rebates are expected to begin in FY 2007-08 and will be incorporated into the Federal Drug Rebate Program and the State Supplemental Drug Rebates policy changes.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 56 (PC-69)	X	X	<u>Durable Medical Equipment Reimbursement</u>
			<p>Durable Medical Equipment documentation policy for “By Report” pricing required the provider to submit the manufacturer’s suggested retail price (MSRP) published from a catalog dated prior to August 1, 2003. The Health Trailer Bill of 2006 changed the catalog date from “prior to August 1, 2003” to “prior to June 1, 2006”. The Department will implement this change for dates of service on or after September 1, 2006.</p> <p>“By Report” reimbursement policy for wheelchairs and wheelchair accessories is 80%, 85%, or 90% of MSRP based on a total aggregate tier. The Health Budget Trailer Bill of 2006 changed the reimbursement methodology to eliminate the total aggregate tier, three levels of MSRP reduction, and utilize a pricing methodology of 80% of MSRP or 85% of MSRP if the provider employs or contracts with a qualified rehabilitation professional. The Department will implement this change for dates of service on or after September 1, 2006.</p> <p>Coverage and reimbursement policies for oxygen delivery systems and oxygen contents allow the provider to be reimbursed for the rental of equipment and separately reimbursed for the oxygen contents. The Health Budget Trailer Bill of 2006 changed the coverage and reimbursement policies and requires the Department to align with Medicare’s policies that include oxygen contents with the rental of an oxygen delivery system using an all-inclusive reimbursement rate. Reimbursement rates will be adjusted to not exceed 80% of Medicare’s rate for the same or similar service. The Department <del>will implement</del> <b><u>implemented</u></b> this change effective for dates of service on or after January 1, 2007.</p> <p><b><u>Medicare’s oxygen policy allows beneficiaries to bill once a month for oxygen delivery systems and contents. However,, because the Medi-Cal population includes more active individuals who have greater oxygen usage, beginning July 1, 2007, and retroactive to January 1, 2007, the Department will revise its oxygen policy to allow beneficiaries to bill for additional oxygen each month.</u></b></p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
R 57 (PC-OA)	X	<p><u>MIS/DSS Interim Operations</u></p> <p>The <del>current</del> MIS/DSS contract <del>expires</del> <b><u>with Medstat expired on</u></b> January 17, 2007, <del>prior to the implementation of the new MIS/DSS solution (the</del> <b><u>The</u></b> new contractor, <b><u>Bull Services, Inc.,</u></b> will have six months from contract award <b><u>in February 2007</u></b> to design, develop and install a new system). To ensure the availability of the critical data in the MIS/DSS database <b><u>in the interim</u></b>, the Department <del>will hire a contractor to initiate interim operations</del> <b><u>hired California Multiple Award Schedule (CMAS) contractors</u></b> to provide limited access to MIS/DSS data and reports. The temporary updating of the existing database will be completed by CMAS contractors until the new MIS/DSS database is available. This interim operation will only provide status quo operations, and will not implement any of the improvements identified in the DOF-required Independent Assessment of the MIS/DSS (August 2004); nor will this interim operation provide training, user support, or analytical consulting functions.</p> <p><b><u>While the Victims Compensation and Government Claims Board has ruled in the Department's favor, it is still unknown whether Medstat will file an appeal in Superior Court. If an appeal is filed the Department would have to extend the interim contract.</u></b></p>
R 58 (PC-OA)	X	<p><u>Medi-Cal vs. Medicare Rate Study – Report to Legislature</u></p> <p>The Health Trailer Bill of 2006 requires the Department to report to the Legislative fiscal committees the following:</p> <ul style="list-style-type: none"> <li>• A percentage comparison of Medi-Cal rates to those of Medicare. Dental, pharmacy, federally qualified health centers, rural health clinics and health facilities services are excluded from this comparison.</li> <li>• Estimated cost to raise Medi-Cal rates to at least 50% of Medicare rates. Estimate to include cost to keep managed care costs comparable.</li> <li>• For those procedures/services covered only by Medi-Cal, a priority list of procedures/services that may merit adjustment. Estimate to include cost to keep managed care rates comparable.</li> </ul> <p>The Department has hired a contractor to perform this one-time study. This report is due to the Legislature by March 15, 2007.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
R 59 (PC-98)		X	<p><u>Freestanding Outpatient Clinics and State Veterans' Homes Supplemental Payments</u></p> <p>AB 959 (Chapter 162, Statutes of 2006) adds eligible freestanding outpatient clinics and state veterans' homes to the current Medi-Cal outpatient supplemental program. Under this program, clinics that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments.</p> <p>State veterans' homes that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, or health care district are also eligible to receive supplemental payments.</p> <p>The non-federal match is paid from public funds of the participating facilities.</p> <p>Supplemental payments to state veterans' homes will be effective retroactively beginning with the rate year starting August 1, 2006, pending an approved State Plan Amendment. Supplemental payments to freestanding outpatient clinics will be effective retroactively beginning July 1, 2006 pending an approved State Plan Amendment. Payments to both types of facilities are expected to be made in FY 2007-08.</p>
R 60 (PC-92)	X	X	<p><u>IGTs for Non-SB 1100 Hospitals</u></p> <p>W&amp;I Code, Section 14164, provides general authority for the Department to accept IGTs from any governmental entity in the state in support of the Medi-Cal program. The Department has entered into an Interagency Agreement with Contra Costa County to accept an IGT to be matched with federal funds and distributed to <del>West Contra Costa Healthcare District, who owns</del> Doctors Medical Center San Pablo/<u>Pinole</u>. This funding is to prevent Doctors Medical Center San Pablo/<u>Pinole</u> from closing.</p>
R 61 (PC-OA)	X	X	<p><u>Epocrates</u></p> <p>The Department will enter into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) in the Epocrates system. Epocrates RX™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country. Epocrates provides the Department with an opportunity to reach a large network of health professionals via a point-of-care clinical reference for physicians and other health professionals. <b><u>Epocrates' formulary is free to health professional users.</u></b></p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 62 (PC-OA)	X	X	<p><u>SB 437 – Self-Certification Evaluation</u></p> <p>SB 437 (Chapter 328, Statutes of 2006) requires the Department to implement a process that allows applicants and beneficiaries to self-certify the amount and nature of assets and income without the need to submit income and asset documentation. The self-certification process must be implemented on July 1, 2007 in two phases. The first phase is a two-year pilot in two counties. Following this first phase, the Department must provide the Legislature with an evaluation of the self-certification process and its impact on the Medi-Cal program. Following submission to the Legislature, the Director, in consultation with the DOF, shall determine whether to implement the self-certification process on a statewide basis, based on the outcome of the evaluation, contingent on an appropriation of funds in the Budget Act or subsequent legislation.</p> <p>The Department will enter into a contract for the evaluation of the self-certification process. To ensure that the evaluation contractor is prepared with an evaluation plan by July 2007, this contractor must be selected by February 2007.</p>
R 63 (PC-73)		X	<p><u>NF-B 2007-08 Rate Cap Adjustment</u></p> <p>The Department is proposing legislation to reduce the cap in allowable rate increases for freestanding skilled nursing facilities and freestanding adult subacute facilities. The growth cap percentage was specified in AB 1629 (Chapter 875, Statutes of 2004) as 5.5% for FY 2007-08. Proposed legislation would reduce the cap increase percentage to 4.5% for FY 2007-08. AB 1629 sunsets July 4 <b>31</b>, 2008.</p>
R 64 (PC-41) (Reworded)		X	<p><u>Drug Reimbursement Reduction</u></p> <p>The Deficit Reduction Act of 2005 requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit on generic drugs. In addition, the settlement of a lawsuit between First Data Bank (Medi-Cal's source for drug pricing information) and the federal government will result in an approximate 5% reduction in the Average Wholesale Price (AWP) for many drugs. Both of these changes will result in reduced reimbursement to pharmacy providers. Additionally, the Department's proposed change to a reimbursement rate of AMP plus a percentage can create additional savings. The Department is conducting a pharmacy rate study to determine if a change in the dispensing fee is necessary. An increase in the dispensing fee would offset some of the savings obtained through the drug cost reductions.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
R 65 (PC-OA)	X	<p><u>CA-MMIS Replacement – CDPH Staff</u></p> <p>The current Fiscal Intermediary (FI) contract with Electronic Data Systems expires June 30, 2010. The next contract will run from July 1, 2010 to July 1, 2015. The California Department of Health Care Services (DHCS) has requested 24 3-year limited term positions beginning July 1, 2007. These positions are to comprise the core team to perform the preliminary work necessary to reproduce the Medi-Cal FI contract, which will include the replacement of the California Medicaid Management Information System (CA-MMIS). Two of the positions were for the Maternal Child Adolescent Health/Office of Family Planning.</p> <p>Title XIX Medicaid matching funds are available for the two Maternal Child Adolescent Health/Office of Family Planning positions, as well as for the others. Because the Maternal Child Adolescent Health/Office of Family Planning program will be in a different department (California Department of Public Health (CDPH)) from the Medi-Cal program (DHCS) beginning in July 2007, an interagency agreement between the departments will be required to allow for the provision of federal funds as a reimbursement. The matching GF will be budgeted in the Maternal Child Adolescent Health/Office of Family Planning program in the CDPH.</p>
R 66 (PC-OA)	X	<p><u>Community Living Support Benefit (AB 2968) - CDPH Staff</u></p> <p>The DHCS has requested four limited term (18-month) full-time positions to perform and support the new workload associated with the implementation of AB 2968 (Chapter 830, Statutes of 2006). AB 2968 requires the DHCS to develop and implement a program to provide a community-living support benefit to Medi-Cal beneficiaries residing in the City and County of San Francisco who would otherwise be homeless, living in shelters or institutionalized. One of the positions is needed for the CDPH, Licensing and Certification.</p> <p>Title XIX federal Medicaid matching funds are available for this one position, as well as for the other three. However, this program will be in a separate state department (CDPH) from the Medi-Cal program (DHCS) beginning in July 2007. An interagency agreement between the two departments will be required to allow for the provision of federal funds as a reimbursement. The matching special fund will be budgeted in the Licensing and Certification program in the CDPH.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
R 67 (PC-OA)	X	<p><u>ICF/DD Continuous Nursing Pilot - CDPH Staff</u></p> <p>The DHCS has requested the extension of the terms of four limited term positions for an additional two-years beginning January 1, 2008, with one of the positions needed for the CDPH, Licensing and Certification.</p> <p>Title XIX federal Medicaid matching funds are available for this one position, as well as for the other three. However, this program will be in a separate state department (CDPH) from the Medi-Cal program (DHCS). An interagency agreement between the two departments will be required to allow for the provision of federal funds as a reimbursement. The matching special fund will be budgeted in the Licensing and Certification program in the CDPH.</p>
R 68 (PC-OA)	X	<p><u>ADHC Program Restructuring (SB 1755) – CDPH Staff</u></p> <p>The DHCS has requested the staffing resources (47 positions) and funding to implement SB 1755 (Chapter 691, Statutes of 2006) and to provide follow-up to the Medi-Cal Payment Error Study (MPES). SB 1755 authorizes DHCS to make significant reforms to the ADHC program under Medi-Cal. One of these positions is needed for the CDPH, Licensing and Certification.</p> <p>Title XIX federal Medicaid matching funds are available for this one position, as well as for the others. However, this program will be in a separate state department (CDPH) from the Medi-Cal program (DHCS) beginning in July 2007. An interagency agreement between the two departments will be required to allow for the provision of federal funds as a reimbursement. The matching special fund will be budgeted in the Licensing and Certification program in the CDPH.</p>

**OTHER: RECOVERIES: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

RC 0.1 (PC-136) X

Reclamation of FFP Paid Through COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 required that the federal government be reimbursed its share of all provider overpayments in the quarter in which the 60<sup>th</sup> day after discovery of an overpayment falls. After changes in the Department's COBRA System became operational in July 2006, the Department discovered that FFP had been incorrectly reported on (1) some monies that had been refunded to providers and (2) for certain provider overpayments associated with the County Medical Services Program (CMSP). In both instances, no FFP should have been reported. The Department will reclaim about \$20.87 million in incorrectly reported FFP in FY 2006-07. The claim covers the period of October 1, 1985 to present. This reporting error was the result of the change in federal law and therefore did not occur prior to October 1, 1985.

RC 0.2 (PC-138)

X

Enhanced Recoveries Generated by DRA of 2005

The DRA clarified the definition of a legally liable health insurer that is responsible for payment of health care items or services to include pharmacy benefit managers (PBMs). The Department has proposed trailer bill language that will avoid conflict with federal law and compel PBMs to comply with the Department's attempts to collect monies owed to the Medi-Cal program. Additional recoveries are expected to begin within three months after the State budget is passed.

**OTHER: RECOVERIES: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
RC 1 (PC-125) (PC-128) (PC-134)	X	X	<p><u>Anti-Fraud Expansion</u></p> <p>Based on additional funding provided in the Budget Acts of 2000 and 2003, the Department significantly expanded its provider anti-fraud activities. Specific areas of review and savings include enrollment reviews, laboratory enrollment reviews, field audits (including pre-checkwrite audits, lab audits), reissuance of BICs, and providers who have ceased billing due to withholds, special claims review activities, prior authorizations, and collections. The Department has started the re-enrollment process of providers beginning with selected provider types. The anti-fraud policy changes reflect activities/savings according to the fiscal years in which they began. These policy changes will be incorporated into the base once their impact is reflected in the base trend data.</p>
RC 2 (PC-135)	X	X	<p><u>Base Recoveries</u></p> <p>Budget Act Language allows all recoveries to be credited to the Health Care Deposit Fund and to be used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, lawsuit settlements, providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances. Gross Third Party Liability collections are based on trends in actual collections.</p>
RC 3 (PC-OA)	X	X	<p><u>Veterans Benefits</u></p> <p>AB 1807 (Chapter 1424, Statutes of 1987) permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the Department of Veterans Affairs.</p>

**OTHER: RECOVERIES: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
RC 4 (PC-132)	X	X	<u>New Recovery Activities</u>

The Budget Act of 2005 increased staffing within the Department's Health Insurance and Recovery programs. Staffing augmentation and replacement of the Recovery Program's Automated Collection Management System (ACMS) are proposed to increase collections in the Estate Recovery (ER) and Personal Injury (PI) Units. In addition, proposed staffing augmentations for Health Insurance programs and contracting for other health coverage (OHC) identification will increase private health insurance carrier billings and enrollment in the Health Insurance Premium Payment Program (HIPP), and allow timelier identification of OHC.

## Recovery Section

The savings areas and their implementation dates are:

1. Increased recoveries of PI expenses due to an expansion of First Inquiry Letters being automatically generated to managed care beneficiaries from trauma code edits at managed care plans; savings started March 1, 2006.
2. Enhance Estate Recovery & Personal Injury Collections; savings start December 2008.

## Health Insurance Section

3.
  - a. Other Coverage Unit Augmentation; savings due to deflected payments started November 1, 2005.
  - b. Other Coverage Unit Augmentation; savings due to increased recoveries start March 1, 2006.
4. Increase Recoveries from Private Health Insurance Carrier Billings due to creation of the Health Insurance Recovery Group; savings started December 1, 2005.
5.
  - a. Other Health Coverage Identification from Electronic Data Matches; savings due to deflected payments start April 1, 2006.
  - b. Other Health Coverage Identification from Electronic Data Matches; savings due to increased recoveries start April 1, 2006.
  - c. Increase cost savings resulting from improvements to the Medicare Buy-In System; savings start in two steps, beginning August 1, 2005 and February 1, 2006.

**OTHER: RECOVERIES: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
RC 5 (PC-129)	✕	X	<u>Medical Support Enhancements</u>
			The Budget Act of 2003 included savings for a Medical Support Enhancement program. The program is designed to extend the IV-D Children program statewide. The IV-D Children program requires (through court orders) absent parents who have private health insurance, or who can afford cost-effective county-acquired insurance, to pay for the health insurance needs of their children. The California Child Support Automation System (CCSAS), which will allow for automated reporting of other health coverage, will be implemented in <del>October 2006</del> <b><u>June 2007</u></b> . <b><u>Savings will begin in July 2007.</u></b>
RC 6 (PC-120)	X	X	<u>Estate Recovery Regulations/Exemption</u>
			Pursuant to a settlement agreement in the case of <i>California Advocates for Nursing Home Reform et al. v. Diana M. Bontá et al.</i> , the Department promulgated the Medi-Cal estate recovery regulations which made a number of clarifying changes with potential fiscal impacts. These include: definition of an estate to include retirement accounts and life insurance policies that revert to the State; addition of authority to collect from estates for the cost of institutional care provided to persons under age 55; exclusion of payments made for personal care services under In-Home Supportive Services; and addition of an exemption from estate recovery for undue hardship when the person seeking the waiver provided care to the decedent for two or more years while living in the home with the decedent that delayed or prevented the decedent's admission to a medical or long-term care institution. The regulations became effective in May 2006.

**FISCAL INTERMEDIARY: EDS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

FI 0.1 (PC-OA)

X

MEDS Replacement Contractor

MEDS is the eligibility system used for tracking and maintaining eligibility for the various programs within Medi-Cal. This system has changed considerably over the past 30 years to incorporate new business and legislative requirements and, as a result, MEDS is extremely complex, difficult to maintain, and nearing the end of its useful life cycle. MEDS is a mission critical system that must assure timely and accurate eligibility information for Medi-Cal beneficiaries. Given the business critical nature of MEDS, a detailed assessment was completed by a specialty vendor that recommends modernization of MEDS begin immediately. In preparation for moving forward with an RFP for the modernization of MEDS, the Department will contract with a vendor to help analyze the existing functionality of the system and help develop detailed business requirements to provide necessary information for RFP and FSR development.

**FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FI 1 (PC-FI)	X	X	<p><u>California Children's Services Claims/Enhancement</u></p> <p>The CMS Net/E47 Project, which provides linkage between the CCS automated case management system and the CA-MMIS and the California Dental Medicaid Management Information System (CD-MMIS), was implemented on July 1, 2004. CMS Net is an automated case management system that is being used by 55 CCS counties, three State CCS regional offices, and GHPP. The Legislature has directed the CCS program to assist county CCS programs not yet participating in CMS Net to make the transition to the system. The three remaining counties, Los Angeles, Orange, and Sacramento include a significant portion of the CCS provider population and over 40 percent of the State's CCS clients.</p> <p>The prospective transition of the three remaining counties to CMS Net requires a specialized education and outreach effort to be conducted by the fiscal intermediary contractor's provider relations staff. This will ensure that providers are sufficiently proficient in the use of the new systems to avoid reduction or delays in services to CCS clients. The systems costs are shared between the Medi-Cal, CCS State-Only and CCS Healthy Families programs.</p>
FI 2 (PC-FI)	X	X	<p><u>Insurance Identification Contracts</u></p> <p>The Department contracts with vendors to identify recipients with other health coverage. Since Medi-Cal is the payer of last resort, other health plans must first be billed before the Medi-Cal program. The Department contracts provide: 1) data matches between the Department's Medi-Cal Recipient Eligibility file and the contractor's policy holder/subscriber file; 2) identification and recovery of Medi-Cal expenditures in workers' compensation actions; 3) identification of private/group health coverage and the recovery of Medi-Cal expenditures when the private/group health coverage is the primary payer; 4) online access to research database services for public records of Medi-Cal recipients; and 5) cost avoidance activities.</p>

**FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FI 3 (PC-FI) (PC-131)	X	X	<p><u>EDS Cost Containment Proposals – Savings Sharing</u></p> <p>The Department continues to review and approve EDS-initiated cost containment proposals, implementing as appropriate to contain Medi-Cal costs. Savings are achieved, with EDS continuing to receive a share of the savings.</p> <p>Additionally, the Contractor continues the process of identifying fraudulent claims activity in two areas – outpatient (physician, DME, lab, pharmacy, etc.) and prepayment review. As other areas are identified, they will be further developed. The savings methodology is linked to actual cost avoidance and/or realized recovery of fraudulent payments to providers. The Contractor has developed a program to formalize the identification of fraudulent claims activity, facilitate appropriate intervention with various audit organizations, recommend system or policy modifications, if appropriate, and support regulation development, if necessary, to support efforts by the Department to expeditiously stop illegal and inappropriate payment activity. The staffing is provided by the Contractor.</p>
FI 4 (PC-FI)	X	X	<p><u>HIPAA – Provider Relations</u></p> <p>Provider relations is an essential component of the activities relating to HIPAA. Additional EDS staffing will be necessary to obtain appropriate provider feedback on proposed HIPAA changes and to provide technical assistance specific to the many CA-MMIS and claims processing changes resulting from these projects. Clear and accurate communication is vital and will be supplemented by provider bulletins, seminars and interactive workshops, and other notices via mail and the Internet. This activity is in addition to those provider relations activities already funded in the FI fixed price contract. The costs associated with this additional activity were authorized through the change order process.</p> <p>EDS staff will be utilized to accommodate increased suspense rates and provider appeals with each code conversion, claim transaction and unique identifier implementation while providers become accustomed to the changes.</p> <p>Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation was in September 2003. The remaining transactions and code conversions will continue to be phased-in. EDS also continues work on implementing the National Provider Identifier.</p>

**FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FI 5 (PC-FI)	X	X	<u>BIC Production and Postage</u>  Costs for production and mailing of Medi-Cal Benefits Identification Cards are paid through the Fiscal Intermediary.
FI 6 (PC-FI)	X	X	<u>Expansion of Drug Rebate Program</u>  As part of the FY 2002-03 Medi-Cal expenditure reduction proposals, per the Health Trailer Bill of 2002 (AB 442, Chapter 1161, Statutes of 2002), up to four contract Pharmaceutical Consultant positions are authorized to perform the same duties as State-employed Pharmaceutical Consultants.

## FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FI 7 (PC-FI)	X	X	<u>HIPAA – CA-MMIS</u>

HIPAA requires uniform national health data standards, unique identifiers and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the CA-MMIS and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDU's) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, Security, and high-level work on other rules. APDUs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- Privacy (April 14, 2003 compliance deadline)
- Transactions and Codes (October 16, 2003 compliance deadline)
- Unique Employer Identifier (July 30, 2004, compliance deadline)
- Security (April 21, 2005, compliance deadline)\*
- National Provider Identifier (May 23, 2007 compliance deadline)\*
- Electronic Signature (Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM)
- Enforcement (March 16, 2006 effective date)
- National Health Plan Identifier (NPRM pending)
- Claims Attachments (Final Rule pending)
- First Report of Injury (NPRM pending)
- Transactions and Code Sets Clarification (NPRM pending)

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation was **began** in October 2003 and the second phase of implementation was in October 2004. The third and fourth phases of implementation were in October 2005 and October 2006, and the remaining transactions and code conversions will continue to be phased-in and implemented **after** October 2006. Full completion is projected in **through** June 2010.

## FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
FI 8 (PC-FI)	X	X	<p><u>HIPAA UPN Exception Request</u></p> <p>The Department has received from CMS approval of a waiver request for an exception to the HIPAA mandate requiring the exclusive use of the HCPCS codes for medical supplies. CMS has approved, an APD for enhanced FFP funding from 75 percent to 90 percent for the medical supply UPN project. The FI <del>Contractor</del> <b>contractor</b> has been working in conjunction with the Department to procure a vendor <del>that will be the data clearing</del> <b>to function as the data clearing</b> house for all manufacturers to supply their product and UPN information <b>through 2010</b>. <del>The claims system changes for this project are planned for a January 2008 implementation.</del> <b>The vendor contract was signed in January 2007. The first phase of the UPN project includes modifications to the internal CA-MMIS Claims Activity Record to include UPN required data elements in coordination with the National Provider Identifier (NPI) implementation. The second phase of the UPN project is scheduled for the third quarter of 2008. This phase includes the conversion of medical supply local codes to UPN and HCPCS coding standards, batch and real-time claims processing, and manufacturer rebate invoicing for contracted medical supplies.</b></p>
FI 9 (PC-FI)	X	X	<p><u>AB 3029 Medi-Cal Billing Requirements - Benefit Identification Cards</u></p> <p>AB 3029 (Chapter 584, Statutes of 2004) requires providers to use the new 14-digit ID for billing Medi-Cal, but excludes certain providers and services from this billing requirement. Excluded providers will be allowed to continue to use the Social Security Number (SSN) for billing. Providers have been instructed to use the new 14-digit ID; however, compliance is currently voluntary. The system changes required to deny claims submitted with a SSN are expected to be implemented in <del>March</del> 2007.</p>
FI 10 (PC-FI)	X		<p><u>AEVS/PTN/CMC Operating System Upgrade</u></p> <p>As a result of Microsoft no longer supporting the Windows NT Operating system, an operating system upgrade <del>will be</del> <b>was</b> needed for the continued operation of the Medi-Cal FI interactive voice response systems which include the Automated Eligibility Verification System (AEVS), Provider Telecommunications Network (PTN), and the Computer Media Claims (CMC) all of which use Windows NT. Microsoft has notified its customers that Microsoft support ended on December 30, 2004. <del>Work is scheduled to be</del> <b>was</b> completed <del>by the third quarter of FY 2005-06</del> <b>in December 2006</b>.</p>

## FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u> <u>B/Y</u>	
FI 11 (PC-FI)	X	<p><u>Elimination of Contractor Staff Utilized for the Enhancement of CMS Net</u></p> <p>The Children's Medical Services Network (CMS Net) is the automated eligibility, medical case management, and client tracking system for the California Children's Services (CCS) Program. Four contractor staff were assigned to assist in a multi-year effort to enhance CMS Net through the provision of electronic linkages to the Medi-Cal Eligibility Data System (MEDS), the CA-MMIS, Dental CA-MMIS and the Health Insurance System (HIS) third party liability recovery system. As CMS Net transitions from development to an ongoing maintenance and operations phase with completion of the electronic interface of the CMS Net and CA-MMIS, this work has been transferred to State staff.</p>
FI 12 (PC-NA)	X	<p><u>Extension of the EDS Contract</u></p> <p>The Department currently holds a contract with EDS for the operation of CA-MMIS. Operations under the base contract continue through June 30, 2007. Through the provisions of the contract, the Department expects to exercise all three one-year bid extensions, which will extend the contract until June 30, 2010.</p>
FI 13 (PC-OA)	X	<p><u>Medicaid Information Technology Architecture (MITA) Assessment</u></p> <p>The CMS is requiring the Department to create frameworks and technical specifications for the Medicaid Management Information Systems (MMIS) of the future. CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through MITA the Department will develop the ability to streamline the process to access information from various systems. CMS will not approve APDs or provide federal funding to the Department without adherence to MITA.</p> <p>The Department is required to complete the MITA State Self-Assessment (SS-A) of business processes to determine the current and long-term business requirements. The Department will hire a Contractor who will use the MITA Maturity Model to document current business process, workflow, operational procedures, cross-functional integration, performance measurement, and extract document business rules from the Department's current legacy systems.</p> <p>The SS-A is the first of a three phased transition plan that CMS expects states to use to guide their MITA implementation.</p>

**FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FI 14 (PC-FI)	X	X	<u>CA-MMIS Replacement Contractor</u>

CA-MMIS is the claims processing system used for Medi-Cal. This system has changed considerably over the past 30 years to incorporate technological advances as well as address new business and legislative requirements and, as a result, CA-MMIS is extremely complex, difficult to maintain, and nearing the end of its useful lifecycle. CA-MMIS is a mission critical system that must assure timely and accurate claims processing for Medi-Cal providers. Given the business critical nature of CA-MMIS, a detailed assessment was recently completed by a specialty vendor and it recommends modernization of CA-MMIS begin immediately. Therefore, the Department will contract with a vendor to develop detailed business requirements and provide assistance with the next Request for Proposal (RFP) for CA-MMIS maintenance and operations. The Department would contract for the CA-MMIS replacement business requirements and RFP development using the CMAS contractor list.

Note: Additional EDS Fiscal Intermediary Costs are included in the following Assumptions:

- Medicare Modernization Act Part D Drug Prescription Program
- *Conlan v. Bontá; Conlan v. Shewry*

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

## FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 1 (PC-FI)	X	X	<p><u>Turnover of Existing Health Care Options Contract</u></p> <p>The Turnover period is to ensure an orderly transfer of the Health Care Options contract from the current contractor to the State or successor contractor at the end of the contract (Period of extended operations ends March 31, 2008). Turnover activities <del>will begin</del> <b>began</b> January 1, 2007, fifteen months prior to the end of the contract.</p>
HO 2 (PC-FI)	X	X	<p><u>HIPAA National Provider ID Health Care Options Remediation</u></p> <p>The HIPAA Administrative Simplification provisions require CMS to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. They also address the security and privacy of health data. Adopting these standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of standardized electronic data interchange in health care.</p> <p><del>The Health Care Options (HCO) Contractor uses provider IDs to view the Provider Master File through EDSnet to check whether a provider is enrolled in the Medi-Cal Program. The current HCO system was assessed to determine the changes that will be necessary to accommodate the National Provider ID. The assessment consisted of a gap analysis to define the difference between current system operations and post-provider ID operations. With the assessment complete, remediation will be undertaken to bring the system into full operational compliance with the National Provider ID.</del></p> <p><b><u>In order for the HCO Contractor to be in full operational compliance with the NPI various system and material changes to the current HCO operations are necessary. The system changes include: screens, displays, reports, data extracts, and database table fields. Access to the Medi-Cal Provider Master File for the exemption process via NPI is dependent upon EDS modification to their EDSnet application. The HCO Optical Character Reader and the enrollment form will also be modified to comply with the NPI mandate.</u></b></p>

## FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
HO 3 (PC-FI)		X	<p><u>Period of Extended Operations</u></p> <p>The Department has notified MAXIMUS of its intention to exercise the Period of Extended Operations for a period no shorter than six months, but up to one year. An amendment will extend the contract from September 30, 2007 to September 30, 2008. <del>Costs will be higher for the extension period. There are no bid rates; therefore, HCO will use the bid rates for the last three years of the contract (Extension Year 3) and adjust them by the California Consumer Price Index.</del> <b><u>The bid rates for Extension Phase 3 will be used during this period.</u></b></p>
HO 4 (PC-FI)		X	<p><u>Managed Care Expansion</u></p> <p>The Budget Act of 2005 included geographic expansion of managed care in 13 additional counties. This action included approval to mandatorily enroll seniors and persons with disabilities (SPDs) in any of the expansion counties with County Organized Health Systems. Health Care Options costs will begin in FY 2007-08.</p>
<u>HO 5 (PC-FI)</u>		<u>X</u>	<p><b><u>Personalized Provider Directories</u></b></p> <p><b><u>HCO currently prints and mails health plan Provider Directories that provide information for every Medi-Cal managed care provider in the beneficiary's county of residence. The Department has proposed Trailer Bill Language to implement a Personalized Provider Directory as a pilot project in one Two-Plan Model county and one GMC county. The content and format of the Personalized Provider Directories will be determined in consultation with health plans and stakeholders. At the end of the pilot project period the Department, in consultation with health plans and stakeholders, will perform an assessment to determine if Personalized Provider Directories provide more accurate, up-to-date provider information to Medi-Cal managed care beneficiaries, in a smaller, standardized, and user-friendly format that results in a reduction of default assignments, cost savings to the State, and if they should be implemented statewide in all managed care counties.</u></b></p>

**FISCAL INTERMEDIARY: DELTA DENTAL: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

## FISCAL INTERMEDIARY: DELTA DENTAL: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
DD 1 (PC-FI)	X	X	<u>HIPAA – CD-MMIS</u>

HIPAA of 1996 requires uniform national health data standards, unique identifiers, and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the California Dental Medicaid Management Information System (CD-MMIS) and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). An Advance Planning Document Update (APDU) was submitted on April 29, 2004 to CMS and approved for enhanced funding of Transactions and Code Sets. **An IAPD was submitted in October 2006 to CMS requesting enhanced funding for implementing the NPI rule.** APDs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- Privacy (April 14, 2003 compliance deadline)
- Transaction and Code Sets (October 16, 2003 compliance deadline)
- Unique Employer Identifier (July 30, 2004 compliance deadline)
- Security (April 21, 2005 compliance deadline)
- National Provider Identifier (NPI) (May 23, 2007 compliance date)  
(This may require a separate change order.)
- Electronic Signature (Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM)
- Enforcement (March 16, 2006 effective date)
- National Health Plan Identifier Standard (NPRM pending)
- Claims Attachments (Final rule pending)
- First Report of Injury (NPRM pending)
- Transactions and Code Sets Clarification (NPRM pending)

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department was not fully compliant with HIPAA by the October 2003 federally mandated implementation date for transactions and code sets. The Department is phasing in transactions, implementing the most critical ones first (in terms of provider impact). Dental procedure codes are 100 percent local codes that will be converted to the national CDT-4 codes. This complex effort is underway and will extend ~~into~~ **to November** 2007. This project is being delayed from 2006 to 2007 in an effort to coincide with the related regulations package effective date.

A high-level assessment on Denti-Cal operations and CD-MMIS was completed regarding the adoption and implementation of the NPI. **The Department and the FI are currently executing efforts to be able to accept the NPI from providers by the May 23, 2007 NPI compliance**

**FISCAL INTERMEDIARY: DELTA DENTAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

date. Providers have been instructed via provider bulletins and the Internet to begin registering their NPI with the Department. System modifications and enhancements to the CD-MMIS began in April 2006 with the most critical work packages to implement first, without interrupting payments to providers or services to beneficiaries. The Department has obtained IV&V services beginning December 2006 which are expected to be completed in FY 2007-08.

The rules of NPI do not mandate that a provider obtain a separate NPI number for each of their office locations. We anticipate that this policy will impact current business practices and may delay payments to the providers. There will be a significant impact to the current FI's workload to minimize the operational impact of the new policy changes and to respond to an increase of volume of inquiries from providers. The FI has submitted a Notification of Claim (NOC) and the Department is currently in the process of evaluating this NOC.

DD 2 (PC-FI)    X

Dental Contract Takeover Costs

Takeover activities for the new dental contract commenced December 2004. Payments for Takeover started in January 2005. As a result of the incumbent also being the successor contractor, certain Takeover tasks were deleted per Amendment 01 of Contract 04-35745. There was a commensurate price reduction to the original bid price for Takeover. Takeover was delayed pending resolution of a contract issue regarding the leveraging of State assets from one contract to another. While this delay will not result in the need for any new dollars, it will result in shifting some takeover payments which were originally anticipated to be paid in FY 2004-05 and FY 2005-06, to FY 2006-07.

## FISCAL INTERMEDIARY: DELTA DENTAL: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
DD 3 (PC-FI) (Reworded)	X	X	<u>System Replacement for California Dental Management Information System (CD-MMIS)</u>

In an effort to reduce future bid prices for the Denti-Cal fee-for-service dental program, the Department will seek to increase the competition for the next contract procurement by bringing the antiquated CD-MMIS legacy system architecture into more widely supported current technology standards. Additionally, it is envisioned that this new system will automate claims adjudication processes that are currently performed manually. The system will meet all Medicaid Information Technology Architecture (MITA) requirements and will be eligible for federal certification. The federal government has approved this proposal in concept and is awaiting the advanced planning document (APD) for review. Once approved, the federal participation is expected to be 90% FFP/10% GF for design, development and implementation of this system.

In May 2004, Delta, the current contractor, selected Electronic Data Systems (EDS) as the subcontractor to replace the CD-MMIS system. The proposal included a fixed-price additional contract service (ACS) bid for a replacement CD-MMIS. The original ACS bid price was \$26.7 million. Due to a delay in the start of the project, the recently submitted final ACS cost proposal was \$40.3 million, 51% above the original bid. As a result of the significant cost increases from the original fixed price ACS bid the Department decided to not go forward with the ACS. In March 2007, the Department gave Delta the option of going out for a competitive bid for the system replacement. Delta has accepted and plans on developing a Request for Proposal (RFP) for a replacement system by June 2007. Delta will be soliciting 5 MMIS systems integrators. Delta anticipates awarding the contract by September 2007, work is expected to begin in January 2008 and implementation of the system replacement is expected in FY 2009-10.

Note: Additional Delta Dental Fiscal Intermediary Costs are included in the following Assumptions:

- *Conlan v. Bontá; Conlan v. Shewry*

**INFORMATION ONLY:****GENERAL FUND REVENUES**

The State General Fund is expected to receive the following revenues from quality assurance fees (accrual basis):

FY 2004-05:	\$ 25,155,000	ICF-DD Quality Assurance Fee
	<del>\$115,634,000</del> <b><u>\$115,600,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	<del>\$140,789,000</del> <b><u>\$140,755,000</u></b>	Total
FY 2005-06:	\$ 27,582,000	ICF-DD Quality Assurance Fee
	<del>\$216,852,000</del> <b><u>\$235,951,000</u></b>	Managed Care Quality Improvement Assessment Fee
	<del>\$234,506,000</del> <b><u>\$231,893,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	<del>\$478,940,000</del> <b><u>\$495,426,000</u></b>	Total
FY 2006-07:	<del>\$ 27,750,000</del> <b><u>\$ 27,136,000</u></b>	ICF-DD Quality Assurance Fee
	<del>\$236,549,988</del> <b><u>\$241,648,000</u></b>	Managed Care Quality Improvement Assessment Fee
	<del>\$247,605,000</del> <b><u>\$277,514,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	<del>\$496,005,000</del> <b><u>\$546,298,000</u></b>	Total
<b><u>FY 2007-08:</u></b>	<b><u>\$ 27,086,000</u></b>	<b><u>ICF-DD Quality Assurance Fee</u></b>
	<b><u>\$241,934,000</u></b>	<b><u>Managed Care Quality Improvement Assessment Fee</u></b>
	<b><u>\$271,124,000</u></b>	<b><u>Skilled Nursing Facility Quality Assurance Fee (AB 1629)</u></b>
	<b><u>\$540,144,000</u></b>	<b><u>Total</u></b>

**ELIGIBILITY**1. Cash Assistance Program for ABD Legal Immigrants

Based on the provisions of PRWORA, certain aliens would have had their SSI/SSP benefits terminated and lost their categorical linkage to Medi-Cal effective October 1, 1998. These beneficiaries were grandfathered by federal legislation. AB 2779, a trailer bill to the 1998 Budget Act, establishes a state-only cash assistance program for aged, blind and disabled legal immigrants who meet the SSI/SSP immigration status requirements that were in place in August 1996 and all other current SSI/SSP requirements. There is no automatic linkage to Medi-Cal for persons eligible under this cash grant program. They must meet current Medi-Cal eligibility requirements. MEDS changes were made so that persons who are eligible for Medi-Cal and a cash grant under this program can be easily identified.

**INFORMATION ONLY:****2. Impact of SB 708 on Long-Term Care for Aliens**

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-2000 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to new applicants. Because the current state-only long-term care program is available to eligible new applicants and does not include the expenditure limit, the Department is taking steps to bring the current program into conformance with SB 708. This will require the Department to rescind outdated regulations, and implement new regulations to define the spending limit and to clarify other implementation requirements. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-2000 base year, no fiscal impact is expected in FY 2005-06 and FY 2006-07 due to the spending limit.

**3. Additional Disabled Recipients Off SSI/SSP**

The SSA continues to increase the number of continuing disability reviews on disabled persons. As a result, many more SSI/SSP recipients are being found no longer disabled. This has resulted in the termination of approximately 800 SSI/SSP recipients each month. Under federal regulation, Medi-Cal eligibility must be continued for these individuals while their SSI/SSP appeal is pending. This appeal process can take from 12 months to 3½ years. The State must track the SSI/SSP appeal process so that once the appeal process is exhausted, the counties can make a determination of Medi-Cal eligibility under another Medi-Cal category. The cases will be under aid code 6N while the appeal on the disability cessation is pending. Effective April 2003, the No Longer Disabled population that has exhausted the appeal process with SSA can be identified and tracked through MEDS. This population will remain in aid code 6N through the appeal process and be assigned a Pickle type indicator of "D". If the appeal is lost or exhausted, MEDS will place the beneficiary in aid code 6E, so they can be tracked on an exceptions eligible report, developed as a result of the *Craig v. Bontá* lawsuit.

**4. Communications Between Managed Care Plans and County Welfare Departments**

SB 87 (Chapter 1088, Statutes of 2000) establishes that the Department, in consultation with the counties, consumer advocates, managed care plans and Medi-Cal providers, conduct a feasibility study on adopting a mechanism that allows counties to notify a managed care plan whenever a beneficiary enrolled in their plan is to have their annual Medi-Cal eligibility redetermination.

Counties are to undertake outreach efforts in maintaining contact with Medi-Cal beneficiaries to ensure home addresses and telephone numbers are current so that eligibility forms to be completed by the beneficiary are forwarded correctly and submitted timely. Managed care plans will be encouraged to report updated beneficiary contact information with county staff. The updated contact information is to be limited to a beneficiary's change of address, change of name, and telephone number. The Department is required to develop a consent form used by counties to record the beneficiary's consent permitting the county to use updated contact information received from the managed care plan to update their case file. The Department finalized the consent form and released it to the health plans in January 2003 and to the counties in March 2003. The Department is providing the annual redetermination information to managed care plans on the monthly eligibility tapes that plans receive each month for their enrollees.

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**INFORMATION ONLY:**5. Accelerated Enrollment for Foster Care

AB 430 (Chapter 171, Statutes of 2001), the budget trailer bill (BTB), added Section 14007.45 to the W&I Code to require the Department to submit for federal approval, a SPA to implement accelerated eligibility for children just entering the foster care system. The federal law does not authorize limiting presumptive eligibility (PE) to one eligibility group such as foster care children; thus, it is unlikely that the federal government would approve such an amendment. The statute specifies that if federal participation is not available for the accelerated eligibility, the Department is to instruct counties to establish procedures to expedite eligibility determinations for children entering the foster care system. The Department distributed ACWDL Number 01-41 in July 2001 which directs the CWDs to expedite Medi-Cal eligibility as soon as a detention order has been issued by a court. The SPA is under development and will be submitted to CMS.

6. Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. ~~The President's Budget proposes extending the program through September 30, 2006.~~ **HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The President's Budget has extended the QI-1 program each year, but only for an additional year.**

7. Extension of the Sunset Date of the 250% Working Disabled Program

Effective April 1, 2000, AB 155 (Chapter 820, Statutes of 1999), established the 250% Working Disabled Program, a Medi-Cal program for disabled persons who are employed and have family income below 250% of the federal poverty level (FPL). To be eligible, persons must meet SSI/SSP eligibility criteria except for income from earnings and pay a monthly premium: \$20 to \$250 for individuals and for couples, \$30 to \$375. The program was due to sunset effective April 1, 2005. The Health Trailer Bill of 2004 extended the sunset date to September 1, 2008.

8. Curtailing Asset Shelters

SB 620 (Chapter 547, Statutes of 2003) placed restrictions on the marketing of annuities to persons age 65 or older if the purpose is to affect Medi-Cal eligibility. Proposed regulations will place additional restraints on the transfer of assets to qualify for Medi-Cal, the sheltering of assets of otherwise resource-ineligible individuals, and the sale of annuities to individuals who are receiving services under a Section 1915(c) waiver, nursing facility level of care in a medical institution or nursing facility care.

**INFORMATION ONLY:**9. Domestic Partners on Medi-Cal

Assembly Bill 205 (Chapter 421, Statutes of 2003) requires that registered domestic partners shall have the same rights, protections, and benefits, and shall be subject to the same responsibilities, obligations, and duties under law, whether they derive from statutes, administrative regulations, court rules, government policies, common law, or any other provisions or sources of law, as are granted to and imposed upon spouses. AB 205 also provides that it does not amend or modify federal laws or the benefits, protections and responsibilities provided by these laws.

Because domestic partner relationships are not recognized in federal laws and regulations, there is no federal reimbursement for any expenditure based on domestic partner relationships. Since California is establishing Medi-Cal benefits based on domestic partnership, it will only apply to the existing State-only Medi-Cal program and costs solely existing due to domestic partnerships will be State-only funded. The costs are expected to be insignificant.

10. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. Its current sunset date is ~~September 30, 2006~~ **June 30, 2007**.

11. Newborn Hospital Gateway

SB 24 (Chapter 895, Statutes of 2003) requires DHS to adopt an electronic Newborn Hospital Gateway process for families to enroll a "deemed eligible for Medi-Cal" newborn into Medi-Cal from hospitals that have elected to participate in the process, to the extent that up to three staff and funding from non-state entities is made available to DHS for this purpose. The Medi-Cal Fiscal Intermediary will develop and maintain this electronic enrollment process. Additionally, for enrollment of a child under the age of one year deemed to have applied and be eligible for Medi-Cal benefits, the enrollment procedures of the Newborn Hospital Gateway shall specifically include procedures for confirming the eligibility of, and issuing a BIC to, that child. Since this activity requires special funding in the form of a grant, it will begin when the staffing and funding become available. The Department is exploring funding options. SB 29 (Chapter 148, Statutes of 2004) allows DHS twelve months from the time staffing and funding are available to implement.

12. Prenatal Gateway

SB 24 (Chapter 895, Statutes of 2003) requires DHS to adopt an electronic Prenatal Gateway process which allows qualified providers to grant immediate, temporary Medi-Cal coverage to low-income, pregnant patients pending their formal Medi-Cal application and eligibility determination, to the extent that up to three staff and funding from non-state entities is made available to DHS for this purpose. In order to complete these changes to the current paper process, additional funds are required in order to hire contracting staff to make the necessary changes to the MEDS, which resides at the Health and Human Services Data Center. Since this activity requires special funding in the form of a grant, it will begin when the staffing and funding become available. The Department is exploring funding options. SB 29 (Chapter 148, Statutes of 2004) allows DHS twelve months from the time staffing and funding are available to implement.

**INFORMATION ONLY:****13. ISAWS Migration to C-IV County Administrative Costs**

The Health and Welfare Data Center has proposed migrating the thirty-five counties using the ISAWS eligibility system to the C-IV eligibility system. **The thirty-five counties using the ISAWS system to determine eligibility have made the decision to migrate to the C-IV system.** This system is newer and has many features not available in ISAWS. Proposals have been discussed with the counties and various state agencies, including the Department of Finance. Although all the General Fund migration costs are budgeted through the Data Center and the State Department of Social Services, there are some additional county administrative expense costs which need to be accounted for in the Department of Health services budget. **The system costs associated with this migration are budgeted through the State Department of Technology Services and the State Department of Social Services. Only the federal funding for the Medi-Cal related share of the system costs is included in the CDHS budget. The ISAWS migration planning costs are currently identified in the SAWS policy change in the County Administration Section.**

These costs have been estimated to be \$30 million per fiscal year. The actual cost per year will be less than that amount since the migration will have a staggered start. The first county for ISAWS migration is not scheduled at this time. The migration is expected to begin sometime in the latter part of FY 2007-08.

**There will also be increased county administrative costs (General Fund and federal funds) for the migration resulting from the difference in productivity standards between the two consortia. The productivity in the ISAWS counties is greater than that in the C-IV counties. It is assumed that the migration to the C-IV system will result in the counties requesting additional staff, which will reduce productivity, at least initially, and increase costs. This funding will be added to the Medi-Cal budget once the roll-out schedule for the migration has been determined.**

**14. 250 Percent Working Disabled Program**

It is anticipated that the Department will investigate an interface between the Third Party Liability Branch's Automated Collection Management System and MEDS to communicate and update eligibility of individuals obligated to pay premiums under the 250% Working Disabled program. The targeted start date for implementing this project is December 2008. To date, no costs or savings projections are available for this project.

**INFORMATION ONLY:****15. Deficit Reduction Act of 2005 – Transfer of Assets Provisions**

The Deficit Reduction Act of 2005 (DRA), enacted February 8, 2006, makes changes regarding the resource eligibility criteria for purposes of establishing eligibility for payment of services received in a nursing facility, nursing facility level of care in a medical institution, and home and community-based waiver services under Section 1915(c) or (d) of the Social Security Act. These provisions apply to all Medi-Cal applicants and recipients, including any individuals who may be SSI/SSP program recipients and those who may also be CalWORKs recipients. As a result of these changes, individuals may be made ineligible only for payment of nursing level services and may remain eligible for all Medi-Cal benefits to which they would otherwise be entitled. This creates the need for an asset eligibility determination for individuals requesting nursing facility level of care in a medical institution or home and community-based waiver services that must be conducted by a Medi-Cal eligibility worker. A system to identify these individuals will have to be developed (e.g., through treatment authorization requests for nursing facility level of care in a medical institution services/applications to participate in the home and community-based waiver), to refer cases to county staff for determinations, systems changes designed and developed, new notices of action designed and the involvement of the Social Security Administration and CDSS secured.

Sections 6011 and 6016, pertaining to transfers of assets for less than fair market value:

- Extend the period of time during which transfers of assets can be scrutinized to determine whether they are disqualifying to 60 months.
- Change the start date for periods of ineligibility for payment of nursing facility level of care in a medical institution and home and community-based waiver services from the date of transfer to the most recent date of application as an institutionalized individual or date of institutionalization for someone who is already a Medi-Cal beneficiary.
- Require that partial month periods of ineligibility for payment of nursing facility level of care in a medical institution and home and community-based waiver services be imposed when small transfers of assets occur.
- Provide that states may combine multiple transfers made in more than one month.
- CMS developed minimum criteria for considering whether undue hardship exists when individuals have been found to have made disqualifying transfers of assets under OBRA '93. If the imposition of a period of ineligibility for payment of LTC and Waiver services would result in undue hardship, then the state cannot impose the period. Under the DRA, Congress and CMS's current undue hardship criteria are incorporated into the Social Security Act.

**INFORMATION ONLY:**

16. Deficit Reduction Act of 2005 – Treatment of Annuities

The Department will propose legislation for statutory and regulatory changes necessary to implement Section 6012 of the DRA, pertaining to treatment of annuities:

- Requires the institutionalized individual or spouse to disclose any interest in an annuity.
- Requires the institutionalized individual to name the State as a remainder beneficiary on his/her annuity.
- Clarifies that the purchase price of annuities is to be used when considering whether amounts have been transferred for less than fair market value and are disqualifying.
- Requires that any transaction that changes the financial return to or interest of the beneficiary or spouse in an annuity could be considered a disqualifying transfer resulting in a period of ineligibility for nursing facility level of care in a medical institution and home and community-based waiver services.

17. Deficit Reduction Act of 2005 – Limitation on Home Equity

The Department will propose legislation for statutory and regulatory changes necessary to implement Sections 6014 of the DRA, pertaining to disqualification for long-term care coverage for individuals with substantial home equity:

- Prohibits payment for nursing facility level of care in a medical institution or home and community-based waiver services whenever an individual requesting those services has home equity over \$500,000.
- Permits states to increase that amount up to \$750,000.
- Individuals remain eligible for all other Medi-Cal covered services to which they would otherwise be entitled.

**INFORMATION ONLY:****18. Deficit Reduction Act of 2005 – Entrance Fees Paid to Continuing Care Retirement Communities and Life Care Communities**

The Department will propose legislation for statutory and regulatory changes necessary to implement Section 6015 of the DRA, pertaining to the entrance fees of continuing care retirement communities (CCRC) or life care communities:

- Requires a change in valuing entrance fees that would affect all applicants/beneficiaries and could result in excess property and total ineligibility for Medi-Cal.
- Requires states to count as an available resource any entrance fee paid by an applicant or beneficiary to a continuing care retirement community as long as it (1) doesn't confer an ownership interest, (2) may be used to pay for care at the facility should other income or resources be unavailable, and (3) is refundable if the person moves out of the facility or upon death.

**19. SB 437 Healthy Families Presumptive Eligibility Program**

SB 437 (Chapter 328, Statutes of 2006) created the Healthy Families (HF) Presumptive Eligibility Program, which provides presumptive Medi-Cal eligibility until HFP eligibility is determined for children who have become ineligible for Medi-Cal or begin to have a share of cost. This program will replace the one-month Bridge to Healthy Families Program after **completion of an internal FSR, approval and needed system development changes, and issuance of instructions to the counties. Implementation is expected to occur in early 2008.**

**20. SB 437 Medi-Cal to Healthy Families Presumptive Eligibility Program**

SB 437 (Chapter 328, Statutes of 2006) created the Medi-Cal to Healthy Families (HF) Presumptive Eligibility program, which provides presumptive coverage for children who meet certain criteria. Counties ~~would~~ **will** perform an initial screen when an application for Medi-Cal or HF eligibility is filed, and provide presumptive coverage to children whose income is not within the levels for no-cost Medi-Cal eligibility, ~~—The child's income must be~~ **but is** within HF levels. This program will ~~replace the Medi-Cal to HFP Accelerated Enrollment Program after~~ **begin after completion of an internal FSR, approval and needed system development changes, and issuance of instructions to the counties. Implementation is expected in early 2008.**

**21. SB 437 Women, Infants and Children (WIC) Gateway**

SB 437 (Chapter 328, Statutes of 2006) created the WIC Gateway, which allows children applying to the WIC program to submit a simple electronic application to simultaneously obtain presumptive eligibility for Medi-Cal and Healthy Families (HF) and apply for enrollment into Medi-Cal or the HF Program with the consent of their parent or guardian. This program is expected to be implemented after FSR approval and system development.

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**INFORMATION ONLY:****22. KinGAP**

Assembly Bill 1808 (Chapter 75, Statutes of 2006), established a program to enhance benefits in the existing KinGAP Program. The enhancements include additional benefits such as a Specialized Care Increment for those children that qualify, and an annual clothing allowance for all children. This new KinGAP Enhanced Program was to be implemented October 1, 2006.

Three issues regarding Medi-Cal eligibility were identified when discussing the implementation of the new KinGAP Enhanced program. One issue was that the Medi-Cal eligibility determination function must be transferred to either a CalWORKs or Medi-Cal eligibility worker as federal law requires. This will cause a shift of workload in the counties and could affect county administrative costs for this caseload. The other issues are whether the payments for KinGAP are exempt as income to the child in these cases and whether the Foster Care resource limit of \$10,000 can be used in determining Medi-Cal eligibility for this population. A State Plan Amendment (SPA) has been submitted to the Centers for Medicare and Medicaid Services (CMS) to exempt KinGAP payments as income and up to \$10,000 in resources. If the SPA is denied, Medi-Cal benefits for some KinGAP children will be discontinued unless legislation is adopted to provide state-only benefits. Such legislation is being drafted that would provide state-only Medi-Cal to KinGAP children who are not eligible for no cost full scope federally funded Medi-Cal.

**23. CalWORKS Budget Reduction**

The Governor's 2007-08 proposed budget includes an implementation of full family sanctions under CalWORKs. If enacted, this may result in a loss of CalWORKs eligibility for some persons. Loss of CalWORKs eligibility does not necessarily mean loss of Medi-Cal eligibility. County costs will shift from CalWORKs to Medi-Cal for those who become Medi-Cal only cases.

**24. CalWORKs Caseload Reduction**

As a result of California's increase in the minimum wage, families in the CalWORKs program with earned income will have an increase in income. This increase will result in some families having too much income to remain CalWORKs eligible. Although these families will also lose their CalWORKs-based Medi-Cal, some may be eligible for the Section 1931(b) program. If not eligible for the Section 1931(b) program, they will receive up to one year of no cost Medi-Cal under the Transitional Medi-Cal program. At the end of the year, they will be evaluated for the Medically Needy program, and if they can establish linkage such as unemployment, they may be eligible with a share of cost.

**25. Hospital Distribution of Applications (AB 774)**

Hospitals are increasing their distribution of Medi-Cal and Healthy Families applications as part of the implementation of AB 774 (Chapter 755, Statutes of 2006). The new law requires hospitals to provide uninsured patients with applications for the Medi-Cal and Healthy Families programs. To comply with the law, hospitals are obtaining bulk supplies of the standard Medi-Cal application (MC 210) and the Healthy Families/Medi-Cal application (MC 321) from the Department. As a result, the implementation of AB 774 may increase the number of Medi-Cal eligibility determinations performed by counties and the number of publications printed and distributed by the Department.

**INFORMATION ONLY:****26. State-Funded Services For Victims of Trafficking and Other Serious Crimes:**

**SB 1569 (Chapter 672, Statutes of 2006) creates a state-only program of social services and benefits for non-citizen victims of human trafficking, domestic violence, and other serious crimes. The bill amends W&I Code Section 14005.2 to allow these victims to be eligible for services and benefits to the same extent that these services are provided to refugees, and provides that if these services are unavailable through federal funding, these services shall be paid for with state funds. The costs are not expected to be significant.**

**27. Determining Medi-Cal Eligibility for County Wards**

**SB 1469 (Chapter 657, Statutes of 2006) requires county juvenile halls, camps, or ranches to apply for Medi-Cal benefits for all wards who may be eligible so that they can receive these benefits immediately upon their release. The requirements of this bill must be implemented on January 1, 2008, but procedures and protocols must be established by June 1, 2007. The legislation is not expected to result in significant costs to the Medi-Cal program.**

**28. Health-e App**

Health-e App is an electronic, web-based alternative to the traditional paper Medi-Cal/Healthy Families joint application, intended to reduce application processing time so that children can obtain needed health insurance as quickly as possible. Health-e App is available to enrollment entities in all California counties. The Managed Risk Medical Insurance Board (MRMIB), plans to make system changes to enable the general public to use Health-e App. ~~The cost for system changes will be a one-time development cost in the current year. CDHS will pay the federal Title XIX share of this cost via an interagency agreement with MRMIB.~~ **Private foundations are funding a study to define technical requirements. The foundations will present the findings to MRMIB and the Department in August 2007.**

**BENEFITS****1. Civil Rights of Institutionalized Persons Act**

Subsequent to the *Davis* lawsuit, which was recently settled between the Department and advocates for community long-term care, the United State Department of Justice (USDOJ) forwarded a letter to Governor Schwarzenegger on August 3, 2004. This letter outlined the USDOJ's concerns regarding inappropriate institutionalization of people at Laguna Honda Hospital (a large 1200 bed nursing facility in San Francisco). This inquiry falls under the USDOJ's probe under the Civil Rights of Institutionalized Persons Act (CRIPA). The USDOJ is requesting that state departments reply to the allegations and commit to significant changes in the way in which people are authorized for, discharged, and diverted from nursing facilities.

The Department's Office of Legal Services is lead on this response and interactions with the USDOJ. The Department anticipates that significant changes may be required in the manner in which Medi-Cal authorizes NF TARs, as well as in the process of licensing and certification of nursing facilities in California. While this inquiry is restricted to Laguna Honda at this point, the concepts of state-wideness and comparability under the federal Medicaid Program will eventually require that any changes made at Laguna Honda will be required for all nursing facilities statewide. These changes will result in significant costs to the Medi-Cal program.

**INFORMATION ONLY:**2. Assisted Living Waiver Pilot Project

AB 499 (Chapter 557, Statutes of 2000) required the Department to submit an HCBS waiver to CMS to test the efficacy of providing Assisted Living as a Medi-Cal benefit for elderly and disabled persons in two settings, Residential Care Facilities for the Elderly (RCFEs), and Publicly Subsidized Housing (PSH). In June 2005, CMS approved the Department's Assisted Living Waiver Pilot Project (ALWPP) application, effective January 1, 2006. The ALWPP began providing services to beneficiaries in April 2006. It is anticipated that the ALWPP will serve up to 1,000 persons over its three-year term in the three pilot counties—Los Angeles, Sacramento, and San Joaquin. At this time, there is not enough information available to calculate the budget impact. **The Department will submit to CMS the ALWPP CMS-372 Report, its initial annual cost report for the first year of the waiver, by June 30, 2007.**

3. Pediatric Palliative Care

AB 1745 (Chapter 330, Statutes of 2006) requires the Department to develop, implement, and evaluate a pilot project waiver to provide a pediatric palliative care benefit, which would include those services that are available through the Medi-Cal hospice benefit, as well as certain other services to be determined. The benefit will be implemented through a federal Home and Community-Based Services Waiver. Eligibility will be restricted to those beneficiaries 21 years of age or younger. Authorized providers will include licensed hospice agencies and home health agencies licensed to provide hospice care, subject to criteria developed by the Department for provider participation. During the 12 months following the effective date of the legislation, the CCS program will work together with the Medi-Cal program in coordination with the various agencies and stakeholders to identify services, delivery systems, providers, and method of payment. Until the services and providers/rates are identified the Department is unable to estimate the fiscal impact.

4. Rotavirus Vaccines for Children Program

Rotavirus vaccine has been approved for inclusion in the Vaccines for Children Program. The vaccine, Rotateq, used to prevent a leading cause of severe acute gastroenteritis in children under five years of age, is administered orally beginning at 6 to 12 weeks of age and can be given concomitantly with other vaccines. The Advisory Committee on Immunization Practices recommends a dosing schedule of 2, 4 and 6 months.

**INFORMATION ONLY:**5. AB 2968--SF Community-Living Support Waiver Pilot Project

AB 2968 (Chapter 830, Statutes of 2006) requires the Department to develop and implement a program to provide a community-living support benefit to Medi-Cal beneficiaries residing in the City and County of San Francisco who would otherwise be homeless, living in shelters or institutionalized. The intent of this statute is to increase access to needed health-related and psychosocial services that may reduce the use of acute psychiatric and medical services or institutionalized long term care services for eligible Medi-Cal beneficiaries **residing in the City or County of San Francisco**, and to provide community-based alternatives to Medi-Cal beneficiaries at risk of institutionalization and residents of Laguna Honda Hospital. This statute requires the Department to submit any waiver application, modification of any existing waiver, or amendment to the Medicaid state plan necessary to provide this benefit, and to implement this benefit only to the extent that FFP is available, and the City and County of San Francisco provides county funds for State administration, and to match federal funds for services provided under the waiver. A Medicaid 1915(c), Home and Community Based Services waiver will be required to implement this pilot project. The Department anticipates submission and approval of a waiver to CMS between July 2008 and December 2008, and implementation by January 2009.

6. Telemedicine Services – Increasing Access

**Medi-Cal coverage of telemedicine services will be expanded. Expansion of Medi-Cal coverage of telemedicine services is expected to improve beneficiary access to specialty care and home health services, particularly in rural areas where there is a shortage of health professionals.**

**Expansion includes two changes:**

1. **The national HCPCS billing code associated with payment for telehealth transmission, based on time units, will be activated. Rates will be developed based on three modes of transmission: Telephone line, Dedicated Line, or Wireless/Satellite.**
2. **Providers operating as the “hub” site, the site at which the patient is located, will be paid for each encounter to reimburse for the tasks specific to the provision of telemedicine services.**

**These changes will remove the monetary disincentive that currently exists as a barrier to providers offering telemedicine services. Once this barrier is removed, Medi-Cal can take advantage of the telehealth networks and capabilities that have been developed throughout the state over the last 10 years, and which are continuing to be developed through public/private partnerships. These changes will become effective in FY 2007-08.**

**INFORMATION ONLY:**

**7. Money Follows the Person Demonstration**

**CMS awarded the Department \$130 million for a five-year demonstration under the federal Deficit Reduction Act of 2005--Money Follows the Person (MFP) Rebalancing Demonstration. These funds are for development and implementation of the demonstration in up to ten regions throughout the State, with the bulk of the funding going to the payment for direct services needed to transition 2,000 Medi-Cal eligible residents from health care institutions to federally allowed home and community settings.**

**The MFP Demonstration enables the State to earn enhanced FFP for certain direct services to eligible individuals enrolled in the demonstration. This enhanced FFP (75% for some demonstration services) acts as an incentive for states to re-balance long-term care spending in favor of home and community-based alternatives to institutional care.**

**The demonstration's twelve-month pre-implementation and planning period concludes January 2008. Transition of the first residents from facilities to the community is projected to commence March 2008. Local assistance costs for direct services will be paid beginning in FY 2008-09.**

**FAMILY PACT**

**BREAST AND CERVICAL CANCER TREATMENT**

**MEDICARE MODERNIZATION ACT OF 2003**

**HOSPITAL FINANCING**

**MANAGED CARE**

**1. Expansion of Managed Care to Dual Eligibles**

Dual eligibles who are enrolled in a Medicare HMO will be allowed to enroll in Two-Plan Model or GMC Managed Care plans effective July 2007, **as long as they are accessing the same plans for both Medi-Cal and Medicare services.** ~~The expected increase in dual eligibles may have an effect on capitation rates.~~ **Through aggressive marketing by the health plans, the Department may see an increase in dual eligible enrollment.**

**A new Special Needs Plan (SNP) dual eligible rate is being developed based on each SNP's benefit package. Preliminary information indicates this rate will be slightly lower than the current dual eligible rate.**

**INFORMATION ONLY:**2. Managed Care Expansion (Reworded)

The Budget Act of 2005 included geographic expansion of managed care in 13 additional counties. Three existing County Organized Health Systems are expected to extend their service areas and continue mandatory enrollment of all eligible Medi-Cal beneficiaries, including seniors and persons with disabilities (SPDs). The Department is planning to also implement the Two-Plan and Geographic Managed Care (GMC) models in the expansion counties. The Department continues to work with the stakeholders in all 13 expansion counties.

Below is the proposed list of expansion counties:

<u>County</u>	<u>Plan Type</u>
Marin	COHS
Placer	GMC
San Luis Obispo	COHS
Sonoma	COHS
Lake	COHS
Mendocino	COHS
Kings	Two Plan
Madera	Two Plan
Merced	COHS
San Benito	COHS
Ventura	COHS
El Dorado	GMC
Imperial	GMC

**OTHER: AUDITS AND LAWSUITS**1. Clark vs. Belshé – Ongoing Rate Increase

The Court ordered the Medi-Cal program to increase fees paid to dentists from 55 percent (Phase I) to 80 percent of billed effective November 1, 1992, based on June 1992 cost data. On September 30, 1996, the Court dissolved all aspects of the injunction except for an access plan for sixteen underserved counties. In September of 1998, the final report regarding access for those counties was submitted. The Department decided against requesting that the judge lift his injunction. Accordingly, the injunction remains in effect. The judge has taken the report and a motion to dissolve the case under submission, and indicated he would provide a written ruling. To date, no final decision has been made by the judge. In November 2003, DOF reduced funding by 50 percent in fiscal year 2002-03 and eliminated all funding thereafter, for the change order to the dental fiscal intermediary contract for implementing an outreach program in the underserved counties.

**INFORMATION ONLY:**2. California Association of Health Facilities v. Department of Health Services

The California Association of Health Facilities (CAHF) has filed two lawsuits challenging the validity of Medi-Cal rates for LTC services for rate years 2001-02 and 2002-03. The first lawsuit was filed in State court on January 17, 2003, challenging rates for rate year 2001-02. The Department subsequently removed the case to federal court. Plaintiff contended the rates paid during the 2001-02 rate year violate federal Medicaid laws, including 42 United States Code section 1396a(a)(30)(A), and that the Department failed to comply with the California Administrative Procedure Act (APA) with respect to the adoption of regulations to implement rates. Plaintiff seeks a court order requiring the Department to establish higher LTC rates for the 2001-02 rate year and make retroactive payments to LTC facilities at those higher rates. On July 15, 2003, the Federal District Court for the Northern District of California ruled that the plaintiff had no judicially enforceable right to challenge the rates based on federal law. In August 2003, the federal court remanded the case back to state court for litigation on the plaintiff's contentions that the Department failed to comply with state law in establishing the 2001-02 rates.

The plaintiff filed a second amended complaint in the first lawsuit after it was remanded to state court. In its amended complaint, the plaintiff contends that the Medi-Cal rates paid in 2001-02 were established in violation of the federally approved state plan and a state regulation that requires the program to be administered in accordance with the state plan. The plaintiff filed a second lawsuit raising similar issues for the 2002-03 rate year (August 1, 2002 through July 31, 2003). The plaintiff seeks a court order that would require the Department to recalculate higher rates for the 2001-02 and 2002-03 rate years and pay the long term care facilities the additional amount owed at the higher rates. On June 15, 2004, the court entered judgment for the Department in both cases. The plaintiff filed an appeal with the State Court of Appeal. The parties have completed the process of preparing and filing appellate briefs. The Court of Appeals has not yet set a hearing date.

**On December 26, 2006, the appellate court issued a decision remanding the case to the trial court. The trial court is to decide whether the Department properly exercised its discretionary authority in establishing the rates for 2001-02 and 2002-03.**

3. California Association for Health Services At Home, et al., v. Sandra Shewry

This lawsuit was filed on April 27, 2004 for reimbursement, injunctive, and declaratory relief premised upon the Department's alleged violation of the Medicaid Act's "reasonable promptness" requirement, the Medicaid Act's "access" requirement (including efficiency, economy, and quality of care, federal regulation (42 C.F.R. § 447.204)), and the State Plan. The suit alleges the Department has failed (at least since 2000) to conduct an annual review/studies for home health care services and to adjust the rates accordingly. The Court held that providers failed to demonstrate they are entitled to an award of retrospective monetary relief designed to compensate them for the difference between the rates actually paid and the rates that the providers contended should have been paid. However, the Court did hold that the State Plan requires the Department to conduct a rate review this year and annually thereafter. The Department submitted a SPA removing the requirement to conduct a rate review and received CMS approval effective December 31, 2005. The providers appealed the judgment and the Department cross-appealed. The briefing is nearly complete and the date for oral argument has not been scheduled. **On January 16, 2007, a hearing was held before the State Court of Appeal. The parties are now waiting for a decision.**

**INFORMATION ONLY:****4. California Hospital Association v. Shewry**

The California Hospital Association is a trade association that represents nursing facilities that are a distinct part of a hospital (DP/NF). The plaintiff filed a lawsuit in San Francisco Superior Court challenging the validity of Medi-Cal reimbursement policy for DP/NFs for rate years 2001-02 to the present. The lawsuit was served on the Department on June 8, 2006. The plaintiff contends that the rates paid to DP/NFs violate Title 42, United States Code section 1396a(a)(30)(A). The plaintiff seeks a court order that would require the Department to recalculate rates paid to DP/NFs for rate year 2001-02 through the present and then pay DP/NFs the additional amount owed based on the recalculated rates. No court hearing has been set and the parties are currently conducting discovery.

**5. San Antonio Community Hospital et al. v. Shewry  
Kaiser Foundation Hospitals et al. v. Shewry**

The plaintiffs in the San Antonio Community Hospital and Kaiser Foundation Hospital lawsuits are over 100 non-contract hospitals that challenge the validity of Medi-Cal reimbursement for hospital inpatient services provided during the FY 2004-05 in accordance with Section 32(b) of Senate Bill 1103 (Health Trailer Bill of 2004). The statute limits the final reimbursement to a non-contract hospital for services provided during that state fiscal year to a hospital's audited allowable costs for its fiscal period ending during calendar year 2003. Plaintiffs contend that this has reduced the reimbursement they would have otherwise been entitled to by over \$50 million. The two lawsuits were consolidated and on December 19, 2006, the Sacramento Superior Court issued a judgment in favor of the Department on all issues, with one exception. The court ruled in the plaintiffs' favor on their claim that applying section 32(b) to services provided from July 1, 2004 through August 15, 2004 (prior to August 16, 2004 when the statute was enacted) violated the contract clause of the Constitution. On January 29, 2007, all but 5 of the over 100 plaintiffs filed an appeal. The Department will probably appeal the one issue it lost on.

**OTHER: REIMBURSEMENTS****1. New CMS State Plan Amendment Requirements**

CMS issued a letter effective January 1, 2001, stating that if the State does not respond to requests for information on SPAs within 90 days, CMS will initiate disapproval action on the amendment. Also, for plan amendments submitted January 1, 2001, and thereafter, CMS will not provide FFP for any SPA until it is approved.

**2. Federal Upper Payment Limit**

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of ~~facility~~ **facilities** to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

The UPL only applies to private hospitals and non-designated public hospitals that are part of the category of "non-state government-owned hospitals". The UPL for designated public hospitals consists of audited costs.

**INFORMATION ONLY:**

3. Selective Provider Contracting Program Waiver Renewal

The 1915(b) waiver that authorized the Selective Provider Contracting Program (SPCP) allowed California to negotiate contracts with hospitals for inpatient services on a competitive basis expired on August 31, 2005. However, the Department was allowed to continue the ~~current~~ **SPCP** under the Medi-Cal Hospital/Uninsured Care Demonstration.

4. Delay Checkwrite from June to July

Beginning with FY 2004-05, the last checkwrite of the year will be delayed until the start of the next fiscal year. During June of each fiscal year, one checkwrite for all Medi-Cal program providers whose claims are processed by the fiscal intermediary will be delayed and paid during the next fiscal year. This delay resulted in a decrease in expenditures in FY 2004-05 only.

5. L.A. Waiver Reimbursement for Public Private Partnerships

The L.A. Waiver allowed Public Private Partnership (PPP) community clinics to be paid on a cost-based reimbursement basis. The L.A. Waiver ended June 30, 2005. Nine PPPs did not obtain Federally Qualified Health Center (FQHC) status, which allows reimbursement by indexed growth rates applied to a base year cost. These nine community clinics have reverted back to Medi-Cal's FFS reimbursement rates. The FFS impact of this change on the Medi-Cal budget is expected to be very small. However, there may be savings in the cost-based settlements. Currently, the Department is working on 2003 settlements. Savings from no longer having cost-base reimbursement settlements will not be seen until 2008 or 2009.

**INFORMATION ONLY:**6. CalMEND

The California Mental Health Disease Management Program (CalMEND) was begun by Medi-Cal staff in FY 2004-05 to improve the cost-effectiveness of services provided to persons with severe mental disorders who are being served by state agencies or departments. CalMEND intends to reduce unnecessary provider practice variability, including inappropriate prescribing of antipsychotic medications, through initiation of statewide mental health disorder treatment guidelines to help guide clinical treatment decisions. These guidelines are to be imbedded in a care management structure which emphasizes client and family shared treatment decision-making with health care providers, supported by a state-of-the-art health technology information system, which allows sharing of critical data between client and provider and between the various participating state agencies and departments.

In October 2005, the program was expanded using Mental Health Services Act (MHSA) funds so that specialized consultation could be provided to develop treatment guidelines and begin the implementation of the CalMEND program into selected pilot sites in the various participating organizations. Currently, baseline studies of various treatment parameters are being conducted in the pilot sites, prior to the implementation of initial ~~schizophrenia~~ **clinical practice** treatment and shared decision-making modules, to measure the program's effectiveness. Subcommittees on clinical practice, **data**, health information technology, and client and family issues are fully staffed and operational, as is a policy oversight committee. The policy oversight committee is composed of members appointed by various state agencies/departments, to ensure that the program implementation into the participating organizations is facilitated. A program management team, consisting of state staff and specialty consultants, guides and coordinates the overall program development and implementation activities.

Initial program planning and implementation activities began in October 2005 and are to be accomplished over a 3 1/2 year time period.

7. Katie A. v. Diana Bontá

~~By July 12, 2006, the Specialty Mental Health Services Waiver program must begin implementation of~~  
**On March 14, 2006, the United States' Central District Court of California Preliminary Injunction issued a preliminary injunction in the case of Katie A. v. Diana Bontá, CV02-5662 AHM (SHx) dated March 14, 2006. Katie A. requires requiring the provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program "wraparound" and "therapeutic foster care" (TFC) mental health services under the Specialty Mental Health Services waiver to children in foster care or "at risk" of foster care placement. Katie A. will likely result in a significant change and/or expansion of Medi-Cal mental health services provided under the Specialty Mental Health Services waiver. On April 12, 2006, the Department and the CDSS filed an appeal with the Ninth Circuit Court of Appeals. On March 23, 2007, the Ninth Circuit Court ruled in favor of the State Defendants and reversed the District Court's granting of the preliminary injunction. The Court of Appeals remanded the case with instructions requiring the District Court to review each component service of wraparound and TFC services individually to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program effectively provides each mandated component service.**

**INFORMATION ONLY:**8. Non-Contract Hospital Nurse Staffing Ratio Increase

Effective January 1, 2008, licensed general acute care hospital nurse-to-patient ratios will be further revised in Step-Down and Step-Down/Telemetry Units, Specialty Care (Oncology) Units, and Telemetry Units. The following additional nurse-to-patient ratio changes are effective January 1, 2008:

- Step-Down and Step-Down/Telemetry Units: Change from 1:4 to 1:3.
- Specialty Care (Oncology) Units: Change from 1:5 to 1:4.
- Telemetry Units: Change from 1:5 to 1:4.

Non-contract hospital costs for the nurse-staffing ratio changes are paid during the cost settlement process, approximately two years after implementation. Contract hospital costs are part of the California Medical Assistance Commission negotiation process.

Managed care plan rates for FY 2007-08 will include the managed care cost of the January 1, 2008 ratio changes.

9. Minimum Wage Increase

AB1835 (Chapter 230, Statutes of 2006) increases the California minimum wage from \$6.75 to \$7.50 on January 1, 2007, and to \$8.00 on January 1, 2008. Pursuant to State Plan Amendment 4.19-C, Medi-Cal rates for long term care (LTC) facilities are required to be adjusted for the minimum wage increase using a computed "add-on". The adjustment for the minimum wage add-on will continue until such time as those costs are included in the cost reports used to set rates. **The cost of the minimum wage increases is included in the LTC Rate Adjustment and NF-B Rate Changes and Quality Assurance Fee policy changes.**

10. Nurse Practitioner Direct Payment (AB 1591)

**Currently under the Medi-Cal Program, Certified Nurse Midwives and Nurse Practitioners (family and pediatric specialties) can enroll as free-standing individual providers and provider groups or a Non-physician Medical Practitioner and receive direct reimbursement.**

**AB 1591 (Chapter 719, Statutes of 2006) requires the Department to make payment directly to a certified nurse practitioner for his or her services. The language is not limited to specific specialties. AB 1591 defines "certified" as nationally board certified in a recognized specialty. The Medi-Cal provider rate for certified nurse practitioners remains unchanged. Therefore, the Department does not anticipate a cost increase for this provider type.**

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**INFORMATION ONLY:****OTHER: RECOVERIES**1. Retroactive Medicare Premium Payment for SSI/SSP Administrative Error Cases

The Social Security Administration has determined that approximately 20,000 SSI/SSP recipients may have been qualified to receive Medicare benefits and will establish an application process for them to apply for Medicare benefits. CMS is requiring states that have 1634 agreements to pay retroactive premiums for these recipients that are found eligible in those instances where the states also have a buy-in agreement. California currently has a buy-in agreement for Medicare Part B premiums. California may be able to obtain Medicare reimbursement for services provided to these beneficiaries.

2. Arkansas DHHS v. Ahlborn

A recent United States Supreme Court decision, *Arkansas Department of Health and Human Services v. Ahlborn (2006)*, permitted a drastic reduction to the recoverable amount of a lien for Medicaid services. The ramifications of *Ahlborn* will have a significant effect on the third party liability recovery efforts of all states, and are already having a widespread impact within the legal and insurance communities. The Department has already received many challenges on its liens and expects a significant but indeterminate decrease in recoveries for FY 2006-07 and beyond as a result of this lawsuit. The Department is currently analyzing its options to rectify the impact *Ahlborn* is having on its recovery rights and has proposed trailer bill language that, if passed, will avoid conflict with federal law, protect Medi-Cal liens from settlement manipulation, and enable the Department to maintain its recoveries.

**FISCAL INTERMEDIARY: EDS**1. BIC ID Number Requirement on Medi-Cal Claims

Assembly Bill 3029 (Chapter 584, Statutes of 2004) prohibits the use of the SSN when billing Medi-Cal and requires providers to use the identification number from the Medi-Cal beneficiary's state-issued BIC. AB 3029 exempts hospitals, primary care clinics, LTC facilities, and emergency medical transportation services from the billing requirement. The new billing requirements are expected to produce some initial delays in payment to non-exempted providers. Beneficiaries who do not bring their BICs with them when seeking nonemergency health care may also be turned away by non-exempted providers, who will need the BIC information in order to be reimbursed by Medi-Cal.

The new billing requirements may cause an initial temporary reduction in costs, on a cash basis, as non-exempted providers may have to go back to beneficiaries to get their cards, followed by an increase in costs as the delayed claims are paid.

**INFORMATION ONLY:**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

1. Takeover of New Health Care Options Contract

Takeover activities for the new Health Care Options enrollment broker contract ~~will begin November~~ **are projected to begin in September** 2007. Costs are unknown until the costs are bid by the prospective bidders.

2. HIPAA Privacy and Security MAXSTAR Remediation

The current Medi-Cal Eligibility Data System (MEDS) subsystem of CA-MMIS must be assessed on a yearly basis to determine the changes that will be necessary to accommodate the HIPAA Privacy and Security Rules. This assessment will test for vulnerabilities of the MEDS subsystem and perform a gap analysis to identify any system changes necessary to secure the Medi-Cal beneficiary data.

Following the gap analysis, if vulnerabilities are found that impact the Health Care Options MAXSTAR system, remediation will be undertaken to bring the MAXSTAR system into full operational compliance with the HIPAA Privacy and Security Rules. Remediation costs, if any, that cannot be absorbed within the current contract will be included in future budget estimates.

**FISCAL INTERMEDIARY: DENTAL**

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated Into Base Data/Ongoing

#### ELIGIBILITY

#### BENEFITS

1. Fluoride Varnish

The Department implemented a Medi-Cal program policy change in May 2006 to enable the earlier prevention of tooth decay by adding coverage for fluoride varnish provided by physicians. Fluoride varnish is better tolerated by infants and toddlers than other topical fluorides, with less toxicity and risk of adverse reaction because less of the product is used and application is easier and faster. Because dentists do not routinely see mothers and children under the age of six, medical providers, who do routinely see pregnant women and young children, can intervene earlier to prevent childhood tooth decay.

2. Dental Restoration Documentation Requirement

SB 1403 (Chapter 61, Statutes of 2006) amends W&I Code section 14132.88 to specify that the requirement for providers to submit pre-treatment radiographs (x-rays) for Medi-Cal patients who received four or more dental restorations in a 12-month period will not apply to beneficiaries who are under age four or, regardless of age, are developmentally disabled. Radiographs or photographs of decay on any surface of a tooth will be sufficient documentation to establish medical necessity for the treatment provided.

The Dental FI will be required to modify the California Dental Medicaid Management Information System (CD-MMIS) and create a database to identify developmentally disabled beneficiaries. System changes necessary to make these changes will be absorbed in the current SG budget. At this time, it is not anticipated that there should be any resulting administrative operations cost. In addition, the implementation of this policy will result in an increase of claims paid for dental benefits provided for this population.

3. Dental Health for Children

The Administration is proposing that school-aged children be required to have dental check-ups.

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated Into Base Data/Ongoing

#### 4. \$1,800 Dental Cap for Adults

As part of Medi-Cal Redesign, the Budget Act of 2005 includes efforts to align the Medi-Cal dental benefit with that of employer-based dental services. This redesign limits or caps dental services to all adults up to \$1,800 per calendar year, excluding:

- Emergency dental services;
- Federally mandated services, including pregnancy-related services;
- Dentures
- Maxillofacial and complex oral surgery; and
- Maxillofacial services, including dental implants and implant-retained prostheses.
- Long-term care beneficiaries that have long term care aid codes (13, 23, 53 or 63) or reside in either a skilled nursing facility or an intermediate care facility.

The Department implemented an interim process to control and monitor the cap. The Department and the Dental FI contractor are negotiating a change order to implement a permanent solution which includes augmenting staff and modifying the CD-MMIS to accommodate this policy and process change. The cap will result in savings that will be reflected in the FY 2006-07 capitation rate.

#### **FAMILY PACT**

#### **BREAST AND CERVICAL CANCER**

#### **MEDICARE MODERNIZATION ACT OF 2003**

#### **HOSPITAL FINANCING**

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated Into Base Data/Ongoing

#### MANAGED CARE

##### 1. Capitation Rate Increases

The Department recently conducted a financial review of all Medi-Cal managed care plans to determine if any additional rate adjustments were needed to ensure that all plans would have sufficient resources to provide quality care to Medi-Cal beneficiaries. This review determined that rate increases for six plans will be needed to minimize the risk of insolvency and maintain compliance with required financial standards.

The additional funding for each plan will begin at the start of each plan's rate period, as follows:

<u>Plan</u>	<u>Rate Increase Begins</u>
Central Coast Alliance for Health	July 1, 2006
Health Plan of San Mateo	July 1, 2006
Partnership Health Plan	July 1, 2006
Santa Barbara Health Authority	July 1, 2006
Contra Costa Health Plan	October 1, 2006
Community Health Group	July 1, 2006

##### 2. PACE Rates at 90% of UPL

The Health Trailer Bill of 2006 (AB 1807, Chapter 74, Statutes of 2006), amended section 14592 of the W&I Code to require the Department to establish capitation rates paid to each PACE organization at no less than 90% of the fee-for-service (FFS) equivalent cost, including the Department's cost of administration, that the Department estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries under the FFS Medi-Cal program. The 90% FFS equivalent will be applied effective July 1, 2006 to all PACE Organizations whose capitation rates, for both dual and Medi-Cal only eligibles, are below 90% of FFS.

##### 3. Restoration of Provider Payment Decrease

Due to the significant budget deficit projected for the FY 2003-04 fiscal year, Assembly Bill 1762, the Health Trailer Bill of 2003, required the Department to reduce provider payments, thereby requiring payments made to managed care health plans to be reduced by the actuarial equivalent amount of five percent on specific provider types. This resulted in approximately a two percent reduction to the capitation rates. The provider payment reduction will remain in effect until December 31, 2006. The payment restoration for all plans will be implemented on January 1, 2007.

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated Into Base Data/Ongoing

#### 4. Quality Improvement Fee

The Budget Act and Health Trailer Bill of 2004 require managed care organizations with a contract under Section 1903(m) of the Social Security Act to pay a Quality Improvement Fee. The plans will pay 6% of their total operating revenue to the General Fund. The increased cost for Medi-Cal eligibles will be covered by a 9.57% Medi-Cal rate increase, resulting in a 3% net revenue increase to the plans. The rate increase for the Quality Improvement Fee was implemented for the Two-Plan Model in October 2005 effective July 2005. The rate increases associated with the quality improvement fee were implemented February 2006, retroactively effective to July 2005, for the other plans.

#### **OTHER: AUDITS AND LAWSUITS**

#### **OTHER: REIMBURSEMENTS**

##### 1. Anti-Fraud BIC Card Claims Reprocessing

In an attempt to address Medi-Cal abuse, DHS began issuing new Medi-Cal Benefits Identification Cards (BICs) with new ID numbers to beneficiaries identified as receiving excessive or abnormal health care services in Los Angeles County, effective February 4, 2002. Providers were then required to use the new identification numbers and correct issue dates to have their claims adjudicated. Hospitals, long term care facilities, and certain clinics were excluded from the new billing requirement. Physicians and other providers associated with the excluded entities have encountered difficulties obtaining the BIC ID information from their patients or the excluded entities and subsequently their claims were denied.

To alleviate this problem, new policy was established on February 11, 2005, allowing for exceptions to the billing requirement based on the place of service. The new policy was made effective retroactively for claims with dates of service from February 4, 2002, through February 10, 2005. Starting July 2005, claims from February 2002 through February 2005 will be reprocessed and paid, with the oldest claims being reprocessed first. The reprocessing of claims should be completed by July 2007.

#### **OTHER: RECOVERIES**

##### 1. Anti-Fraud Expansion FY 2005-06

Based on additional funding provided in the Budget Acts of 2000 and 2003, the Department significantly expanded its provider anti-fraud activities. Specific areas of review and savings include enrollment reviews, laboratory enrollment reviews, field audits (including pre-checkwrite audits, lab audits), reissuance of BICs, and providers who have ceased billing due to withholds, special claims review activities, prior authorizations, and collections. The Department has started the re-enrollment process of providers beginning with selected provider types. The anti-fraud policy changes reflect activities/savings according to the fiscal years in which they began.

**DISCONTINUED ASSUMPTIONS**

**Fully Incorporated Into Base Data/Ongoing**

**FISCAL INTERMEDIARY: EDS**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**

1. AB 3029 Medi-Cal Billing Requirements - Benefit Identification Cards

AB 3029 (Chapter 584, Statutes of 2004) requires providers to use the new 14-digit beneficiary ID for billing Medi-Cal, but excludes certain providers and services from this billing requirement. Excluded providers will be allowed to continue to use the SSN for billing. Providers have been instructed to use the new 14-digit ID; however, compliance is currently voluntary. The system changes required to deny claims submitted with an SSN are expected to be implemented in March 2007.

**DISCONTINUED ASSUMPTIONS**

**Time Limited/No Longer Applicable**

**ELIGIBILITY**

**BENEFITS**

**FAMILY PACT**

**BREAST AND CERVICAL CANCER**

**MEDICARE MODERNIZATION ACT OF 2003**

**HOSPITAL FINANCING**

**MANAGED CARE**

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**

**FISCAL INTERMEDIARY: EDS**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DELTA DENTAL**

## DISCONTINUED ASSUMPTIONS

### Withdrawn

#### ELIGIBILITY

##### 1. Medi-Cal to Healthy Families (HF) Accelerated Enrollment

The Budget Act and Health Trailer Bill of 2005 require the State to administer the Medi-Cal to HF Accelerated Enrollment program. This program is to be effective on the first day of the third month following the month of federal approval of the State Plan Amendment (SPA) in accordance with Title XIX and Title XXI. Implementation is contingent upon availability of FFP under Title XXI. Accelerated enrollment to HF is only available for children under the age of 19 with Medi-Cal applications received by the county. The county must determine that: 1) the child is eligible for full-scope Medi-Cal with a share-of-cost; 2) the child's income is within the limits established by HF; and 3) the child, parent(s), or guardian has given permission for the application information to be shared. To the extent possible, the county shall forward sufficient information to the HF program using an electronic process developed for use in the Medi-Cal to HF Bridge Benefits program. The eligibility period for the accelerated enrollment program will begin the first day of the month that the county finds the child meets the HFP eligibility criteria and ends the last day of the month the child is either enrolled in or found ineligible for the HFP. The Department will not require a feasibility study to implement the MEDS changes and provide the necessary information electronically to the MRMIB. This program ~~may be replaced by the~~ **will not be implemented because it will be superseded by the** SB 437 Medi-Cal to Healthy Families Presumptive Eligibility Program, ~~after FSR approval and system development.~~

#### BENEFITS

#### FAMILY PACT

#### BREAST AND CERVICAL CANCER

#### MEDICARE MODERNIZATION ACT OF 2003

#### HOSPITAL FINANCING

#### MANAGED CARE

#### OTHER: AUDITS AND LAWSUITS

## DISCONTINUED ASSUMPTIONS

### Withdrawn

#### OTHER: REIMBURSEMENTS

1. HIPAA Privacy and Security MEDS Assessment

The current MEDS subsystem of CA-MMIS must be assessed to determine the changes that will be necessary to accommodate the HIPAA Privacy and Security Rules. This assessment will test for vulnerabilities of the MEDS subsystem and perform a gap analysis to identify any system changes necessary to secure the Medi-Cal beneficiary data. Following the gap analysis, remediation will be undertaken to bring the system into full operational compliance with the HIPAA Privacy and Security Rules. The assessment will require the use of a contractor because the expertise does not exist within State service and the project will be of short duration.

#### OTHER: RECOVERIES

#### FISCAL INTERMEDIARY: EDS

1. System Replacement for Automated Collection Management System

The Automated Collection Management System is a legacy system used for Medi-Cal recovery case management. The Department seeks to replace the antiquated legacy system architecture with more widely supported current technology standards. Additionally, it is envisioned that this new system will automate many recovery processes that are currently performed manually and increase recovery of Medi-Cal funds. The system will meet all Medicaid Information Technology Architecture (MITA) requirements and will be eligible for federal certification.

A business case justification was submitted in August 2006 to the Office of Technology Review, Oversight and Security (OTROS). The Department will seek to gain CMS approval by developing an Advanced Planning Document (APD). The work on the APD will begin in late 2006. This APD will provide a gap analysis between the proposed solution and the existing system capabilities and processes. Once approved, federal participation will be 90% FFP/10% GF for design, development, and implementation of this system. The FI will secure a sub-contract to perform IV&V. The FI will be reimbursed for the subcontract under the Cost Reimbursement provisions of the EDS contract.

**Note: The ACMS replacement is now being addressed in assumption R 0.4, IRIS Contractor.**

#### FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

## DISCONTINUED ASSUMPTIONS

### Withdrawn

#### FISCAL INTERMEDIARY: DELTA DENTAL

1. Telephone Service Center Minutes (TSC)

The Department issued a change order to establish new billing rates for the TSC. The Department will be negotiating a new price for these new ranges. Until such time as the new billing ranges are negotiated, all current excess minutes will be paid at the current maximum range rate. Upon approval of the new change order, a retroactive invoice will be processed to reconcile the billed rates with the new range and rate.