

**MEDI-CAL
MAY 2009
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2008-09 and 2009-10**

ASSUMPTIONS

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MEDI-CAL ASSUMPTIONS
May 2009
FISCAL YEARS 2008-09 & 2009-10

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:

USERS	=	f(TND, S.DUM, O.DUM, Eligibles)
CLAIMS/USER	=	f(TND, S.DUM, O.DUM)
\$/CLAIM	=	f(TND, S.DUM, O.DUM)

- 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	(OA-66) (CA-17)	X	X	<p><u>CHIP Reauthorization Act of 2009 - DRA Citizenship Option</u></p> <p>The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Public Law 111-3) includes a provision which gives states the option to use a Social Security Administration (SSA) data match in lieu of obtaining evidence of U.S. citizenship from Medi-Cal applicants and beneficiaries as required by federal law. During the data match process for citizenship verification the applicant or beneficiary will receive full-scope Medi-Cal benefits for up to 90 days. If citizenship is not verified within the 90 days, the Department will have 30 days to terminate full-scope Medi-Cal benefits. States who choose this option could be subject to penalty for cost of services provided to citizens whose status cannot be verified if the percentage of unverified cases exceeds three percent of the cases included in the matching process. County administration workload will decrease because counties would not need to verify citizenship if there is an SSA data match.</p> <p>The electronic daily verification system required to complete the data match process is expected to begin in mid 2009 and be fully implemented by late 2010. Funding will be required for an updated Social Security Number (SSN) verification process and a Feasibility Study Report (FSR) for implementation of a real-time verification system. CHIPRA provides a 90% federal match for development of this system.</p>
E 0.2	(PC-177)	X	X	<p><u>CHIPRA – Elimination of 5-Year Bar on Full-Scope Medi-Cal for Children and Pregnant Women</u></p> <p>The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that immigrants who are designated as “Qualified Aliens” are eligible for full-scope Medi-Cal with federal financial participation (FFP) if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the U.S. for less than five years and pays for nonemergency services with 100% State funds if FFP is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services). CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children or pregnant women even if they have been in the U.S. for less than five years.</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-183) (CA-18)		X	<p><u>Low-Income Subsidy Applications Treated as Medi-Cal Applications</u></p> <p>Beginning January 1, 2010, the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 will require all states to process SSA Low-Income Subsidy (LIS) applications (Part D) as an application for the Medicare Savings Program (MSP). The date the SSA receives a LIS application will also be considered the date of the state Medi-Cal application, thus starting the 45-day clock for determining Medi-Cal eligibility. Since the LIS applications do not contain enough information to determine Medi-Cal eligibility, the counties will have to establish files in MEDS and request additional information from all LIS applicants on the SSA lists. This federal requirement will result in an increase in caseload duties for county eligibility workers and additional benefit costs.</p>
E 0.4	(CA-19)		X	<p><u>County Costs for SSI/SSP Reduction</u></p> <p>SBX3 6 (Chapter 13, Statutes of 2009) reduces SSP to 2008 levels effective May 1, 2009, which will cause some Medi-Cal beneficiaries to lose Supplemental Security Income/State Supplementary Payment (SSI/SSP)-based eligibility. Each of those individuals will require an SB 87 eligibility review as required by <i>Craig v. Bontá</i>.</p> <p>SSI/SSP income levels will be reduced effective July 1, 2009, which will impact additional Medi-Cal beneficiaries. To meet the requirements of ARRA Maintenance of Eligibility (MOE) provisions, a new Medi-Cal category will be created that will allow continued eligibility at the same levels prior to the reduction.</p> <p>It is anticipated that there will be county administrative costs related to the SB 87 eligibility review process and evaluation of eligibility.</p>
E 0.5	(PC-196)		X	<p><u>Reduction in CDSS IHSS Share-of-Cost Buyout Eligibles</u></p> <p>Some Medi-Cal enrollees have a share-of-cost (SOC) for their Medi-Cal benefits, which requires them to pay for a certain amount of their medical costs out of pocket before Medi-Cal pays the rest of the costs. Some beneficiaries enrolled in the In-Home Supportive Services Program (IHSS) have a lower SOC than regular Medi-Cal enrollees. Currently, the California Department of Social Services (CDSS), in a process called buyout, pays the Department of Health Care Services the difference between the IHSS SOC and the Medi-Cal SOC.</p> <p>Effective October 1, 2009, the CDSS will pay the SOC buyout for only the most functionally impaired IHSS beneficiaries, which will result in some IHSS beneficiaries losing Medi-Cal eligibility because they will not meet the Medi-Cal SOC limits.</p>

ELIGIBILITY: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
E 0.6 (PC-197)	X	<p><u>Reduction in CDSS IHSS Share-of-Cost Buyout</u></p> <p>The CDSS and the Department have implemented a process that enables Medi-Cal IHSS recipients who have a Medi-Cal SOC higher than their IHSS SOC to pay the IHSS SOC. Without the payment from CDSS 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. Through the IHSS SOC Buyout program, CDSS pays the difference between the IHSS SOC and the Medi-Cal SOC. Through an interagency agreement, CDSS transfers funds to the Department to repay the federal government for the services that should have been paid by the beneficiary as part of meeting the Medi-Cal SOC.</p> <p>Effective October 1, 2009, as a result of the limit imposed to the IHSS SOC buyout to the most functionally impaired, this change will decrease the amount of repayment to the federal government.</p>
E 0.7 (CA-20)	X	<p><u>CalWORKs Reductions – Medi-Cal Only Enrollees</u></p> <p>Effective October 1, 2009, CDSS will implement CalWORKs reform and cost containment measures, which will result in a reduction of families that qualify for Medi-Cal through enrollment in CalWORKs. It is assumed that those families will remain eligible for Medi-Cal benefits in other Medi-Cal Only aid codes and will require a one-time re-enrollment into those aid codes by county eligibility workers.</p>
E 0.8 (OA-75)	X	<p><u>Eliminate Certified Application Assistance</u></p> <p>The interagency agreement with MRMIB includes the Title XIX federal financial participation (FFP) for Medi-Cal costs for CAA fees for children placed on Medi-Cal accelerated enrollment and for the Medi-Cal related costs of processing the application assistance payments. Effective October 1, 2009, the certified application assistance payments will be eliminated.</p>
E 0.9 (CA-23)	X	<p><u>CalWORKs 4% MAP Reduction</u></p> <p>Effective July 1, 2009, CDSS will implement a 4% reduction in the Maximum Aid Payment (MAP) for the CalWORKs program, which will result in a reduction of families that qualify for Medi-Cal through enrollment in CalWORKs. It is assumed that those families will remain eligible for Medi-Cal benefits in other Medi-Cal Only aid codes, and will require a one-time re-enrollment into those aid codes by county eligibility workers.</p>

ELIGIBILITY: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
E 0.10 (CA-21)	X	<p><u>County Costs for Reduction of SSI/SSP Grants</u></p> <p>As a result of a writ issued in the <i>Craig v. Bontá</i> litigation, counties were instructed that Medi-Cal beneficiaries losing SSI/SSP-based Medi-Cal on or after June 30, 2002, cannot have their Medi-Cal benefits automatically discontinued until an SB 87 eligibility review has been completed. SBX3 6 (Chapter 13, Statutes of 2009) reduces SSP to 2008 levels effective May 1, 1009, which will cause some Medi-Cal beneficiaries to lose SSI/SSP-based eligibility. Each of those individuals will require an SB 87 eligibility review as required by <i>Craig v. Bontá</i>.</p> <p>SSI/SSP income levels will be reduced to the maximum federally allowed levels effective September 1, 2009, which will impact additional Medi-Cal beneficiaries. To meet the requirements of MOE provisions, a new Medi-Cal category will be created that will allow continued eligibility at the same levels prior to the reduction.</p> <p>It is anticipated that there will be county administrative costs related to the SB 87 eligibility review process and evaluation of eligibility under the new category created to comply with ARRA MOE.</p>
E 0.11 (PC-195)	X	<p><u>Limitation of IHSS Services to Highest Level of Need</u></p> <p>The Department of Health Care Services provides the Title XIX FFP to CDSS, via interagency agreements, for the federal share of IHSS personal care services provided to Medi-Cal beneficiaries.</p> <p>Effective October 1, 2009, the CDSS will limit the provision of IHSS domestic and related services to individuals with the highest level of need.</p>
E 0.12 (OA-78)	X	<p><u>Reduction to MCAH Grant</u></p> <p>The California Department of Public Health (CDPH) administers the Maternal, Child, and Adolescent Health (MCAH) programs. Included in those programs is the Adolescent Family Life Program (AFLP), which provides case management for pregnant teens, education, and prevention of subsequent pregnancies. FFP is paid to CDPH through an IA with the Department, which budgets the FFP.</p> <p>Effective October 1, 2009, the MCAH Grant funding for the AFLP will be reduced.</p>

ELIGIBILITY: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
E 0.13 (PC-163)	X	<u>New Qualified Aliens-PRUCOL Rollback</u>
		Beginning July 1, 2009, the Department will eliminate full-scope Medi-Cal for New Qualified Aliens (Qualified Aliens who have been in the country for less than five years who are subject to the five-year bar) for beneficiaries 19 years of age and older, excluding pregnant women, and for the Permanently Residing (in the United States) Under Color of Law (PRUCOL) immigrants and Amnesty Aliens who are not defined as eligible Qualified Aliens under federal law. New Qualified Aliens and PRUCOL immigrants will be eligible for emergency, prenatal, postpartum, nursing facility and tuberculosis care, as well as for the time-limited Breast and Cervical Cancer Treatment Program.

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 1	(OA-46)	X	X	<u>Single Point of Entry</u>
<p>The Department and the Managed Risk Medical Insurance Board (MRMIB) have developed a family application form that can be used for both the Healthy Families Program (HFP) and Medi-Cal that was released in FY 2007-08. This form is sent to a Single Point of Entry (SPE), where it is 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>The Department pays the federal Title XIX share for the Medi-Cal applications through an interagency agreement with MRMIB.</p>				
E 2	(PC-4)	X	X	<u>Bridge to HFP</u>
<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 or are eligible for Medi-Cal with a SOC. 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 capitation payment for each of these member months.</p>				
E 3	(PC-12)	X	X	<u>Resource Disregard – % Program Children</u>
<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 4	(PC-11)	X	X	<u>New Qualified Aliens</u>

PRWORA, as amended, 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. FFP is not available for nonemergency services for Not Qualified Aliens. These aliens are eligible for FFP for emergency services and pregnancy-related 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 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 sponsored 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 5	(PC-5)	X	X	<u>Refugees</u>

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 Fin 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.

Beginning July 1, 2007, the Refugee Resettlement Program (RRP) federal grant began to be administered by the 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 (DHCS) began to invoice CDPH for reimbursement of refugee expenditures.

In 2007, the federal government added up to 6 months of RMA eligibility for Afghan Special Immigrants and up to 8 months of RMA eligibility for Iraqi Special Immigrants. ~~The Department is preparing an ACWDL to implement the benefits for this population.~~ **This new requirement was implemented with the publication of ACWDL 08-53 dated November 25, 2008.**

E 6	(OA-11)	X	X	<u>SSA Costs for Health Coverage Information</u>
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The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for SSI/SSP recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 7	(OA-5)	X	X	<u>Postage & Printing</u>
<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. The reprographics functions for composing, printing, and mailing formerly performed by the Department's Central Issuance Distribution Mass Mailing Unit were performed by the Office of State Publishing beginning in February 2007. Beginning in October 2008, the design, translation, focus testing and printing of certain informing and application forms and their distribution to community based organizations and counties are performed by the Health Care Options vendor.</p> <p><u>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 and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees, and at least every 3 years to existing beneficiaries. Postage and printing costs for the HIPAA NPP are included in this item.</u></p> <p><u>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.</u></p>				
E 8	(CA-7)	X	X	<u>Systematic Alien Verification Entitlement System</u>
<p>The federally mandated Systematic Alien Verification 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 Income and Eligibility Verification System 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 9	(OA-33)	X	X	<p><u>Maternal and Child Health-CDPH</u></p> <p>Federal matching funds are available for county administrative costs relating to the following services for Medi-Cal eligible women, infants, children, and adolescents: (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 10	(OA-47)	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 11	(CA-1) (Reworded)	X	X

Statewide Automated Welfare System (SAWS)

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 will be reduced to three by 2010 when the counties who currently use ISAWS complete their planned migration to C-IV.

The LEADER Consortium has been in the maintenance and operation stage since May 1, 2001. As a result of an LA County study and discussions with the State, the County intends to replace the LEADER system. The County is evaluating vendor responses to the replacement system RFP and contract negotiations with the successful bidder are expected to begin in 2009. The contract start date has been delayed six months. While the proposed replacement system is modified and implemented, the County has extended the existing LEADER maintenance and operations contract for an additional four years, through April 2011, with up to four optional one-year extensions beyond that date.

The CalWIN consortium is fully implemented in all 18 counties. CalWIN is currently in the maintenance and operation phase.

Currently, the C-IV system continues to serve only the four original counties and is 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 development and implementation stage. Application development activities began in August 2007. A 22-month planning effort to migrate the 35 ISAWS counties concluded in June 2008. Implementation activities started in October 2008 and will proceed in parallel with the completion of the development effort. ISAWS counties are planned to convert to C-IV by June 2010, with ISAWS Project closure occurring shortly thereafter.

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		
		<u>C/Y</u>	<u>B/Y</u>	
E 12	(CA-2)	X	X	<p><u>CalWORKs Applications</u></p> <p>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.</p>
E 13	(OA-52)	X		<p><u>State Hospital Eligibility Activities</u></p> <p>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. The Budget Act of 2008 eliminated the GF authorized to match Medi-Cal FFP from the CDMH budget. Claims for services provided in FY 2007-08 will be paid in FY 2008-09.</p>
E 14	(PC-3) (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, children receiving a CHDP screen are pre-enrolled in Medi-Cal/Healthy Families for up to two months of full-scope benefits, during which time the family can choose to apply for continuing Medi-Cal/Healthy Families coverage. 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><u>Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment, so claims will no longer be Title XXI funded.</u></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>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 15	(OA-51)	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>
E 16	(PC-13)	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. <u>Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment, so claims will no longer be Title XXI funded.</u></p>
E 17	(CA-8)	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 18	(CA-9) (CA-13)	X	X	<p><u>County Cost of Doing Business</u></p> <p>Based on the Medi-Cal County Administration Cost Control Plan, county welfare department administrative cost increases for Medi-Cal eligibility determinations were limited to a maximum increase of 4.17% for FY 2006-07. The FY 2007-08 increase limit will be 3.70% based on the final Department of Finance California Necessities Index projection for 2007-08. The FY 2008-09 increase is estimated to be 5.26% and the FY 2009-10 increase is estimated to be 4.02%.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 19	(CA-6)	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&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 20	(CA-3)	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>
E 21	(PC-7)	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>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 22	(CA-5)	X	X	<u>Deficit Reduction Act of 2005 – Citizenship/Identity Requirement</u>

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 **or nationals** 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. The All County Letter to implement this requirement was developed with extensive stakeholder input and was issued on June 4, 2007. Final federal regulations on the citizenship requirements of the DRA were issued on July 2, 2007.~~

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 **non-citizen** immigrants, or those who are exempt from the new requirement, including but not limited to, Supplemental Security Income recipients, Medicare beneficiaries, some Social Security Disability beneficiaries, and foster children.

~~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.~~

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 23	(OA-37)	X	X	<p><u>Reimbursement for the Medi-Cal Share of Child Welfare Services/Case Management System (CWS/CMS) - CDSS</u></p> <p>The Department has entered into an Interagency Agreement (IA) with the CDSS to reimburse CDSS the federal portion of all actual costs incurred in the development, implementation, maintenance and operation of the CWS/CMS related to the Medi-Cal program. The CWS/CMS project is expected to reduce eligibility worker time by automating the Medi-Cal program business requirements. The CDSS has budgeted the General Fund portion of the CWS/CMS, so only the federal funding portion is reflected in this agreement. The FY 2006-07 federal share of \$3 million is expected to be paid in FY 2007-08 and FY 2008-09 once federal approval is obtained. <u>A cost allocation methodology has been agreed upon by CDSS and the federal Department of Health and Human Services.</u></p>
E 24	(CA-12)	X	X	<p><u>Reduction of CNI-Based COLA to Counties for FY 2008-09</u></p> <p>Effective July 1, 2008, the Department will eliminate the COLA for county staff who perform tasks as part of the Medi-Cal eligibility process.</p>
E 25	(CA-4)	X	X	<p><u>Medi-Cal Data Privacy and Security Agreements</u></p> <p>The Department is entering into Medi-Cal Privacy and Security Agreements with each county social services department. The purpose of these agreements is to ensure the privacy and security of Medi-Cal Personally Identifiable Information (PII). The Agreements would require counties to perform various activities, including protecting computer systems, employing physical security controls, safeguarding paper documents, and notifying the Department of breaches. The counties must be in substantial compliance with their Agreement no later than July 1, 2010. The Department expects to complete the signing of all 58 Agreements by June 30, 2009.</p>
E 26	(CA-11)		X	<p><u>County Administration Reconciliation</u></p> <p>Within two years following the end of a fiscal year, county administrative expenditures are reconciled to the county administration allocation for the applicable fiscal year. In FY 2008-09, the Department will reconcile FY 2006-07 and FY 2007-08.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 27	(OA-53)	X	X	<u>Health-e App</u>
<p>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 and is available to enrollment entities in all California counties. The California Health Care Foundation that owns the system plans to make system changes to enable the general public to use Health-e App.</p> <p>The Department pays for the federal Title XIX share of this cost through an interagency agreement with MRMIB. MRMIB budgets the federal Title XXI share of the cost. The California Health Care Foundation (CHCF) grants the matching funds for the federal Title XIX and Title XXI funding.</p> <p>Private foundations are funded funded a study to define the technical requirements needed for expansion to public use. The MRMIB released the final report on the public access assessment is being developed by MRMIB in October 2008.</p>				
E 28	(PC-9) (CA-16)	X	X	<u>Craig v. Bontá Lawsuit Procedures</u>
<p>As a result of a writ issued in the <i>Craig v. Bontá</i> lawsuit litigation, counties were instructed that Medi-Cal beneficiaries losing SSI/SSP-based Medi-Cal on or after June 30, 2002, cannot have their Medi-Cal benefits automatically discontinued until an SB 87 eligibility review has been completed. The only exceptions to the court ruling were those individuals who lose SSI/SSP-based Medi-Cal due to death or incarceration. The Department has determined some beneficiaries are being were discontinued in error and will issue additional instructions to clarify <i>Craig</i> procedures. Efforts are underway to identify affected individuals. To the extent that <i>Craig</i> beneficiaries are were discontinued in error, the Department will incur costs to restore eligibility and benefits. <u>It is anticipated there will be county administrative costs due to increased county expenditures related to the SB 87 eligibility review process for Craig claimants.</u></p>				

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 29	(PC-168) (OA-67)		X	<p><u>Program Integrity and Eligibility Verification</u></p> <p>In FY 2009-10, the Department is implementing three activities to increase program integrity and ensure appropriate enrollment into the Medi-Cal Program. The three areas are the Public Assistance Reporting Information System (PARIS), Asset and Eligibility Verification and In-Home Supportive Services (IHSS) Investigations.</p> <p>The PARIS matches allow states to compare beneficiary information with the U.S. Department of Defense, the U.S. Office of Personnel Management and other states to identify federal pension income or health benefits as well as changes in residence and public assistance benefits in other states.</p> <p>Under the Asset and Eligibility Verification program, the Department will procure a direct service contractor beginning in FY 2009-10 to provide counties with electronic data on aged, blind and disabled (ABD) applicants and beneficiaries from financial institutions that could indicate assets and property not reported by the applicant or beneficiary.</p> <p>Also, investigators will conduct investigations of IHSS beneficiaries and providers who are suspected of fraud and abuse and who have been referred to the Department by the counties, through the Medi-Cal Fraud Hotline, and other sources.</p> <p>These activities are expected to achieve savings/cost avoidance through improved verification and identification capabilities, increases in the accuracy of eligibility determinations for the ABD population and actions taken against providers and/or beneficiaries who have committed fraud or abuse of the program.</p>
E 30	(CA-15)		X	<p><u>Reduction of CNI-Based COLA to Counties for FY 2009-10</u></p> <p>Effective July 1, 2009, the Department will eliminate the Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 31	(PC-30)	X	X	<u>CDSS IHSS Share-of-Cost Buyout</u>

The CDSS and the Department have implemented a process that enables Medi-Cal IHSS recipients who have a Medi-Cal SOC higher than their IHSS SOC to ~~be eligible for Medi-Cal at the beginning of each month~~ **pay the IHSS SOC**. ~~Each~~ **Without the payment from CDSS 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.

~~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's, 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.

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 **Medi-Cal** 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.

Effective July 1, 2009, SBX3 6 (Chapter 13, Statutes of 2009) requires CDSS to limit the IHSS SOC buyout program to current recipients. Individuals who become eligible for the IHSS program on or after July 1, 2009, will not be eligible to receive the SOC payment difference. Additionally, IHSS recipients who leave the programs or lose eligibility and subsequently become eligible will no longer be eligible to receive the SOC difference.

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 33	(PC-160)	X	X	<u>Additional Caseload Increase</u>

The original Medi-Cal base caseload estimate for the ~~November 2008~~ **May 2009** Estimate included data through ~~August 2008~~ **February 2009** and was based on **data and** economic and unemployment forecasts available at that time. ~~Most forecasts were predicting increasing unemployment through the end of calendar year 2008, with unemployment leveling off in 2009.~~

Later economic **actual** data showed the economy worsening and forecasts of increasing unemployment through at least the end of the budget year. As a result, **through April 2009 shows** the Medi-Cal caseload was revised **increasing at a steeper level than expected** for those aid categories which are most directly affected by unemployment and which had shown an increase since the original base caseload estimate was completed.

BENEFITS: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 0.1 (PC-187)		X	<u>Reduce ADHC Program</u>
			On August 1, 2009, the Department will implement a reduction in Adult Day Health Care (ADHC) benefits by limiting visits to three days per week per beneficiary.

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
B 1	(OA-35)	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 DHCS, via an interagency agreement with CDSS.</p> <p><u>On October 7, 2008, P.L. 110-352, the Fostering Connections to Success and Increasing Adoptions Act of 2008, was signed into law. P.L. 110-351 is an amendment to the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, and improve incentives for adoption. Beginning January 1, 2010, the Department, through CDSS, will implement the new requirements and provide for Health Oversight and Coordination.</u></p>
B 2	(PC-17)	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. LEAs claim FFP for specific services as authorized in W&I Code Section 14132.06.</p> <p>The Centers for Medicare and Medicaid Services have released the “Payments for Costs of School Administrative and Transportation Services” rule (CMS 2287-F) which would eliminate School Based Medi-Cal Administrative Activities (SMAA) and Home to School Transportation. Elimination of Home to School Transportation will reduce the amount of federal funding to the LEA program. However, elimination of the SMAA program may expand the LEA program because some SMAA will qualify under LEA for reimbursement. A moratorium is in effect which postpones the effective date until April 2009. <u>As a result of the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5), this regulation is under moratorium until June 30, 2009.</u> If additional moratoriums are put in place, they would extend the effective date of this rulemaking, postponing the elimination of the program.</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 3	(PC-122)	X		X <u>Medi-Cal TCM Program</u>

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&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.

CMS published an Interim Final Rule (CMS 2237-IFC) to clarify the situations in which Medicaid will pay for case management activities and when it is not available. This new rule will eliminate two of the six target groups, specifically Public Guardian and Adult Probation. The new rules cite an implementation date of March 3, 2008, which will include a phase in. ~~A moratorium is in effect, which has postponed CMS's enforcement of the regulation until April 2009.~~ **As a result of ARRA, this regulation is under moratorium until July 2009.**

SB 308 (Chapter 253, Statutes of 2003) redefines Local Governmental Agencies to include Native American Indian tribes and tribal organizations as well as subgroups of these entities. 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. 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.~~

~~AB 2950 (Chapter 131, Statutes of 2006) amends W&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.~~

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 4	(PC-118)	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>
B 5	(OA-26)	X	X	<p><u>Disease Management Program</u></p> <p>W & 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 has contracted with McKesson Health Solutions, LLC (DM1) to cover the following conditions: advanced atherosclerotic disease syndrome, asthma, coronary artery disease, congestive heart failure, diabetes and chronic obstructive pulmonary disease (DM1). A contract with the AIDS Health Care Foundation (DM2) will focus on HIV/AIDS. The provision of DM1 services began August 1, 2007. Services for DM2 will begin <u>began</u> in February 2009. UCLA has been contracted to conduct program evaluations for both contracts.</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 6	(OA-1)	X	X	<p><u>Medi-Cal Administrative Activities</u></p> <p>AB 2377 (Chapter 147, Statutes of 1994) authorized the State to implement the Medi-Cal Administrative Claiming process. The Medi-Cal program submits 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>Both LGAs and local educational “consortiums” (LECs) contract with the Department for reimbursement and 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 pending determination of LGA status, are made available as the certified public expenditure.</p> <p>SB 308 (Chapter 253, Statutes of 2003) redefines LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. 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. <u>CMS approved the California Tribal MAA Implementation Plan on January 9, 2009, which allows Tribal Entities and Tribal Organizations to participate in the MAA program by contracting with the State to receive reimbursement.</u></p> <p>CMS has released the “Payments for Costs of School Administrative and Transportation Services” rule (CMS 2287-F) which would eliminate School Based Medi-Cal Administrative Activities (SMAA) and Home to School Transportation. Elimination of SMAA will reduce the amount of federal funding to the MAA program. A moratorium is in effect which has postponed the effective date until April 2009. <u>As a result of ARRA, this regulation is under moratorium until July 2009.</u> If additional moratoria are put in place, they would extend the effective date of this rulemaking, postponing the elimination of the program.</p>
B 7	(PC-29)	X	X	<p><u>SCHIP Funding for Prenatal Care</u></p> <p>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.</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 8	(PC-21) (PC-FI)	X	X	

Conlan v. Bontá; Conlan v. Shewry

In *Conlan v. Bontá* and *Conlan v. Shewry*, the petitioners sought an administrative process for directly reimbursing Medi-Cal beneficiaries who incurred out-of-pocket medical expenses. After two appellate court decisions, *Conlan v. Bontá* (2002) 102 Cal.App.4th 745; *Conlan v. Shewry* (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 out-of-pocket medical expenses for Medi-Cal covered services.

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.

~~In December 2006, a SPA was submitted to CMS requesting federal funding to provide reimbursement directly to beneficiaries for Medi-Cal covered benefits under the conditions mandated by the court. The SPA was approved on October 9, 2007 for the retroactive and evaluation periods of time and denied for the post approval period of time. The Department was invited to resubmit a separate SPA for portions of the post approval period of time. This separate SPA was approved January 16, 2008.~~

CMS has approved two SPAs that confirm FFP eligibility for direct reimbursements arising in the retroactive period and evaluation period, as well as two narrow types of claims arising in the post-approval period. CMS has denied a SPA that would have confirmed FFP eligibility for most direct reimbursements during the post-approval period.

The Department has appealed the decision regarding the denied SPA and has submitted a brief to support the Department’s position in the federal administrative appeal process. **The If a settlement cannot be reached between CMS and the Department then** the formal decision is expected to be issued later this year **(2009)**.

~~Additionally, the Department filed a motion to stay that portion of the Beneficiary Reimbursement Process to which CMS has denied FFP availability. At the hearing held on July 25, 2008, the court indicated it would rule in favor of the Department and order the requested stay. Petitioners have objected to the Department’s proposed stay order. The parties are presently engaged in attempting to find mutually agreeable language for the proposed order to file with the court.~~

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Additionally, on November 3, 2008, the trial court granted the Department’s motion and issued an order staying direct reimbursement by the Department of most post-approval expenses. The Department took this step in order to protect the Medi-Cal program from expenditures for which FFP would not be available due to the SPA denial by CMS. The stay will remain in effect until the dispute regarding the availability of FFP with CMS is resolved.

B 9 (OA-10) ✕ X

Coordinated Care Management Pilot

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:

- CCMP-SPD (CCM 1): Seniors and persons with disabilities (SPDs) who have chronic conditions, or who may be seriously ill and near the end of life; and
- CCMP-SMI (CCM 2): Persons with chronic health condition(s) and serious mental illnesses.

The Department released a Request for Proposal (RFP) for CCM 1 on May 1, 2008 and for CCM 2 on July 10, 2008 to establish two contracts to be effective in ~~December 2008~~ **March 2009** and ~~January~~ **July** 2009, respectively. A ~~four~~ **six** month implementation phase will be needed for both contracts. Payments for CCM 1 will begin in ~~May~~ **October** 2009 and, for CCM 2, in ~~June~~ **January** 2010.

B 10 (PC-123) X X

CLPP Funding for EPSDT Lead Screens

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.

B 11 (PC-164) ✕ X

Discontinue Adult Optional Benefits

Effective ~~May~~ **July** 1, 2009, the Department will no longer provide specified services for adults 21 years of age or older who are not in nursing facilities and excluding pregnant women.

**HOME & COMMUNITY BASED SERVICES:
NEW ASSUMPTIONS**

Applicable F/Y
C/Y B/Y

H 0.1 (PC-189)
(PC-200)

X IHSS and WPCS Hourly Rate Reduction

Waiver Personal Care Services (WPCS) are non-medical long-term care services that assist an individual with activities of daily living.

Beginning October 1, 2009, the Department will reduce the state participation for IHSS workers to the state minimum wage of \$8.00 per hour, plus \$0.60 per hour for health benefits for WPCS. This reduction impacts Medi-Cal Waiver Personal Care Services (WPCS), which pays the same hourly rate.

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

Applicable F/Y
C/Y B/Y

H 1

Home and Community-Based Services

Home and Community-Based Services (HCBS) are services designed to keep persons needing long-term care supported and safe in their homes or other community settings, in lieu of placing them in long-term care facilities like nursing homes, subacute or acute care hospitals, intermediate care facilities for persons with developmental disabilities, or State Developmental Centers. HCBS also provides support for residents in long-term care facilities to return to their homes or communities.

HCBS encompass State Plan services, including Personal Care Services provided through CDSS' In-Home Supportive Services program and Adult Day Health Care; full risk managed care services through Programs of All-inclusive Care for the Elderly (PACE) and Senior Care Action Network (SCAN); a four-year federal demonstration to transition LTC facility residents back to their homes and communities; and several different waiver programs providing a range of services like private duty nursing, personal care, case management, habilitation, emergency response systems, respite, and home modifications for accessibility and safety.

(PC-115) X

X

A. Home and Community Based Services – CDDS

This waiver serves persons with developmental disabilities who are regional center clients and reside in community settings instead of intermediate care facilities for the developmentally disabled. Services include home health aide services, habilitation, transportation, communication aides, family training, homemaker/chore services, nutritional consultation, specialized medical equipment/supplies, respite care, personal emergency response system, crisis intervention, supported employment and living services, and minor home modifications.

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 75,000, and the cap will increase to 95,000 by the fifth year.

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
(PC-18) (OA-40)	X	X		<p>B. <u>Multipurpose Senior Services Program – CDA</u></p> <p>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. This waiver can be renewed for five years. Under the waiver, CDA contracts with 41 local government or nonprofit agencies to provide 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 services include health care and personal care assistance, respite care, housing assistance, meal services, transportation, protective services, emergency response systems, and chore services.</p> <p>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. <u>The GF is budgeted in the CDA budget and at the beginning of each fiscal year the reimbursement is transferred to the Department to pay the MSSP claims.</u></p>
H 2	(PC-NA)	X	X	<p><u>In-Home Operations Waiver</u></p> <p>CMS has approved a new waiver, the IHO Waiver, for a three-year period effective January 1, 2007 through December 31, 2009. The IHO Waiver “grandfathered in” Medi-Cal beneficiaries who have continuously been enrolled in a DHCS-administered HCBS waiver since prior to January 1, 2002, have received and continue to receive direct care services primarily rendered by licensed nurses, and whose HCBS costs exceed the Level of Care cost cap under the new NF/AH Waiver. Each IHO participant’s LOC and waiver costs will remain the same as previously authorized.</p>

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 3	(PC-125)	X	X	<p><u>Waiver Personal Care Services</u></p> <p>AB 668 (Chapter 896, Statutes of 1998) requires Medi-Cal to add waiver personal care services (WPCS) to NF A/B and NF SA Levels of Care. This service is not available to those individuals at the Hospital LOC due to their extensive medical needs. WPCS is one option on the Menu of Health Services (MOHS) that NF/AH and IHO waiver participants may choose from, to the extent that waiver cost neutrality is assured. There is no longer a requirement that waiver consumers receive the maximum of 283 hours of State Plan Personal Care Services prior to receiving WPCS or by home health agencies, employment or personal care agencies.</p>
H 4	(PC-112) (OA-30) (OA-37)	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 IHSS Program under the administrative control of CDSS.</p> <p>CMS 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.</p> <p><u>The In-Home Supportive Services Plus \$1115 Waiver Demonstration approved for the period of August 1, 2004 through July 30, 2009 will convert to a 1915(j) option within the State Plan at the end of the waiver term.</u></p>

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 5	(PC-20) (PC-32)	X	X	<p><u>Money Follows the Person Demonstration</u></p> <p>In January 2007, CMS awarded the Department a Money Follows the Person Rebalancing Demonstration Grant for \$130 million in federal funds. The demonstration, authorized under section 6071 of the federal Deficit Reduction Act of 2005, is effective for the five-year period from January 1, 2007 through September 30, 2011. It requires the Department to develop and implement strategies to assist 2,000 Medi-Cal eligible individuals who have resided continuously in health care facilities for six months or longer to transition to federally-allowed home and community-based settings.</p> <p>During the time a participant is enrolled in the demonstration, the Department will receive enhanced FFP for the provision of certain HCB services, and regular FFP for supplemental services, subject to approved by CMS approval. After 12 months individuals who had participated in the demonstration will participants are disenrolled from the demonstration and continue to receive services under the State Plan or via an appropriate HCBS waiver for which they are eligible. The Department submitted the Operational Protocol for the demonstration with input from stakeholders to CMS for approval on November 30, 2007. CMS approved the Operational Protocol on June 30, 2008. <u>Transition work by four participating providers began in September 2008.</u></p>
H 6	(PC-NA)	X	X	<p><u>AIDS Waiver</u></p> <p>This waiver serves Medi-Cal eligible beneficiaries with mid-to-late stage HIV/AIDS disease as an alternative to 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. The AIDS waiver is administered by the CDPH, Office of AIDS through an interagency agreement.</p>
H 7	(OA-32)	X	X	<p><u>Health-Related Activities</u></p> <p>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.</p>

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 8	(PC-16) (OA-40)	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% are adjusted effective August 1, 2006 <u>of each year based on the weighted average NF-A increase.</u></p> <p>In December 2003, CMS notified the Department that ADHC must be approved under a waiver or 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, authorizes the Department 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> <p>The tightening of medical necessity criteria was implemented February 1, 2008; the remainder of the provisions (unbundling of the all-inclusive procedure code and a new rate methodology) are scheduled for August 1, 2010.</p> <p>CMS conducted a federal audit of the ADHC program which focused on the ADHC services currently being reimbursed, whether or not this reimbursement is allowable under federal law and regulations, and the impact and federal legality of SB 1755. The Department is currently responding to the findings released by CMS in July 2008.</p>

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 9	(PC-34)	X	X	<u>Adult Day Health Care Reforms</u>

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:

- 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.
- Tightening medical necessity criteria so that only those recipients that truly require specific services can receive authorization for ADHC.
- 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.
- Change in reimbursement to a prospective cost-based methodology.
- 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.

The tightening of medical necessity criteria was implemented February 1, 2008 **and clarifying the role of the patient's personal care doctor and assist in establishing a personal care doctor for the patient was implemented January 1, 2007**; the remainder of the provisions (unbundling of the all-inclusive procedure code and a new rate methodology) are scheduled for August 1, 2010.

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 10	(PC-55)	X	X	<u>PACE: Program of All-Inclusive Care for the Elderly</u>

The Department contracts with five PACE organizations for risk-based capitated care of the frail elderly. PACE programs provide all medical services, home and community-based long-term care (including adult day health care **and in-home support**) to Medi-Cal and Medi-Cal/Medicare beneficiaries who are determined by the Department to be at the skilled nursing or intermediate care facility level of care. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at a minimum of 90% of the FFS Upper Payment Limits. Beginning January 1, 2009, PACE rates are set on a calendar year basis, rather than October 1 through September 30, to coincide with the time period of the contracts. The 2009 rate setting methodology will use a FFS population more comparable to PACE participants than the Medi-Cal nursing home resident population historically used for setting PACE rates.

On Lok Senior Health Services (On Lok) currently operates in San Francisco and Alameda Counties. On Lok ~~will expand~~ **expanded** into Santa Clara County and ~~be~~ **became** operational ~~February~~ **January 1, 2009**.

The Center for Elders Independence (CEI) currently operates in Alameda and Contra Costa Counties. Expansion to an additional site in Alameda County is targeted to become operational ~~March~~ **April 1, 2009**. **An additional expansion application is expected in Fall 2009 for either a new site in Hayward or a service area expansion into Richmond.**

Sutter Senior Care (Sutter) currently operates **two sites** in Sacramento ~~and Yolo Counties~~ **County**.

Alta Med Senior Buena Care (Alta Med) ~~currently~~ operates in Los Angeles County. ~~An additional~~ **its second** site in LA County became operational June 1, 2008. An additional expansion site for Los Angeles is expected to become operational in September 2009.

The Department ~~expects to receive~~ **received** an application **from LA Jewish Home for the Aging** for a new PACE program in Los Angeles County ~~in FY 2008-09~~. The new program is expected to become operational ~~in January 2010~~ **September 1, 2011**.

Community Elder Care of San Diego (CESD), doing business as St. Paul's PACE, became operational February 1, 2008.

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

Applicable F/Y
C/Y B/Y

FY 2008-09 funding includes:

- Projected LTC and AB 1629 rate adjustment effective 08/01/08.
- Projected costs for the 01/01/09 annual rate redetermination.

H 11 (PC-131)

X

Self-Directed Services Waiver - CDDS

~~Subject to approval by the CMS of a 1915(c) Waiver, beginning in FY 2008-09 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 Health Trailer Bill of 2005 authorized implementation of the Self-Directed Services (SDS) program in FY 2006-07. Implementation has been delayed due to CDDS needing time to resolve information system-related issues. Since then, has continued to develop~~ **The development of a 1915(c) waiver**, components for program implementation including drafting regulations, informational and training materials, and modifications to the existing information system **continue**. ~~In addition, the~~ **The** Department has submitted the SDS Waiver to CMS for approval and anticipates a phased-in enrollment beginning in FY 2008-09. **on April 2, 2008 and temporarily placed it on hold in September 2008 pending resolution of outstanding issues.**

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 12	(PC-54)	X	X	<u>Senior Care Action Network</u>

The Senior Care Action Network (SCAN) is a Medicare Special Needs Plan located in designated areas of Los Angeles, San Bernardino, and Riverside Counties. The Department received approval from CMS to prepare a comprehensive risk managed care contract authorized under 1915a to fund State Plan Only Medi-Cal services to its members. SCAN provides medical, social, and case management services to Medicare beneficiaries ages 65 and over in Medi-Cal's aged, disabled, and long term care aid group categories (dual eligibles). All necessary medical services are provided by SCAN. Enrollees who are SNF or ICF certifiable are eligible for additional services.

SCAN holds a five-year contract with the Department. Rates are determined by federal law on an actuarially sound basis. In addition, California state law requires that rates be no more than the rates determined on a FFS equivalent basis. Beginning January 1, 2009, SCAN's rates are re-determined on a calendar year basis, rather than October 1 through September 30, to coincide with the time period covered by its contract. The 2009 rate setting methodology will use a FFS population more comparable to SCAN participants who are SNF or ICF eligible than the Medi-Cal nursing home resident population historically used for setting these rates.

Beginning with the new contract, retroactive to January 1, 2008, SCAN provides In Home Supportive Services (IHSS) to its members. Approximately one-third of SCAN members currently receive IHSS through the counties and will be required to disenroll from the county if they wish to continue to receive services through SCAN. The plan believes that some members will opt to disenroll from SCAN in order to remain with their current providers through the county. SCAN's provision of IHSS will be phased-in over a year, based on members' annual redetermination dates.

FY 2008-09 funding includes:

- Projected LTC and AB 1629 rate adjustment effective 08/01/08.
- Projected costs for the 01/01/09 annual rate redetermination.
- A retroactive adjustment of \$5.2 million for rate adjustments not paid in FY 2006-07 and FY 2007-08.

**HOME & COMMUNITY BASED SERVICES:
OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 13	(OA-24) (PC-180)	X	X	<p><u>Pediatric Palliative Care Waiver Evaluation</u></p> <p>AB 1745 (Chapter 330, Statutes of 2006) required the Department to submit an application to CMS for a federal waiver for a Pediatric Palliative Care Pilot Project. The waiver was submitted in May 2008, with an estimated start date of <u>approved on December 3, 2008 for three years, beginning</u> April 1, 2009, <u>through March 31, 2012. The waiver will be implemented and begin enrollment on July 1, 2009.</u></p> <p>The waiver makes available services comparable to those available through hospice that can be provided at the same time that the child would receive curative services. The pilot is assumed to be cost neutral.</p> <p>The legislation mandates the Department to evaluate the pilot project, and an evaluation of the waiver is also required to meet federal assurances. The evaluation will begin July 2009.</p> <p><u>Additional CCS nurse liaisons are needed to determine eligibility, enroll children, authorize medically necessary waiver and State Plan services and perform a range of quality assurance activities. The increased nursing costs will be offset by benefits savings.</u></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, testing for sexually transmitted infections (STIs), and sterilizations. 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 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 and assumed to be 17.79% from July 1 population through September 30, 2008, and 24% of the Family PACT population from October 1, 2008 and ongoing) have been are 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. The Department continues to work with CMS to finalize the terms and conditions of the renewal of the Family PACT waiver. Costs associated to comply with CMS eligibility requirements would be significant. The Waiver is currently operating under short-term extensions.</p>
FP 2	(OA-45)	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> <p>The Department budgets the Title XIX federal Medicaid funds for the contract. The matching GF is budgeted in the CDPH budget.</p>

FAMILY PACT: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FP 3	(OA-43)	X	X	<p><u>Family PACT Support, Provider Education and Client Outreach</u></p> <p>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. Education and support services are provided to Family PACT providers and potential providers, as well as clients and potential clients. Services include, but are not limited to: public education, awareness provider enrollment, recruitment and training; training and technical assistance for medical and non-medical staff; education and counseling services; and preventive clinical services; sexually transmitted infection/HIV training and technical assistance services; and the toll-free referral number. 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> <p>Due to budget constraints, the TeenSmart Outreach Program was eliminated, effective July 1, 2008.</p> <p>The Department budgets the Title XIX federal Medicaid funds for these activities. The matching GF is budgeted in the CDPH budget.</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 125 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>

FAMILY PACT: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FP 6	(OA-42)	X	X	<p><u>Family PACT Male Involvement and I&E Programs</u></p> <p>The Health Trailer Bill of 2003 required the Department to require contractors and grantees under the Office of Family Planning, Male Involvement Program (MIP) and Information and Education (I&E) Programs to establish and implement clinical linkages to the Family PACT program, effective in the 2003-04 fiscal year. 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.</p> <p>Due to budget constraints, the MIP was eliminated, effective July 1, 2008.</p> <p>The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.</p>
FP 7	(OA-5)	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 8	(PC-28)	X	X	<p><u>Family PACT State Only Services</u></p> <p>CMS 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, some services will continue to be provided with 100% State GF.</p>

FAMILY PACT: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FP 9 (PC-19)	X	X	<u>FPACT Implanon and Essure</u>

W&I Code section 14132 (aa) requires the Family PACT program to include all United States Department of Agriculture, federal Food and Drug Administration- approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which Family PACT beneficiaries may choose. However, under the current circumstances surrounding renewal of California's Family PACT waiver, the Department is not able to obtain CMS approval to add newly approved contraceptive devices, including IMPLANON™ and the Essure® System, to the waiver. In order to comply with state statutes, the Department must add IMPLANON™ and the Essure® System to the Family PACT program as state-only benefits, until such time that the waiver is renewed. Medi-Cal has already added these two contraceptive devices as benefits, effective July 1, 2008 because they are changes in the practice of medicine with costs under the amount required for DOF approval.

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

Breast and Cervical Cancer Treatment Program

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 at or below 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. The state-funded program is 100% GF, but may receive 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, women over the age of 65, undocumented women of any age, 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.

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. DHCS 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.

With additional staffing, the Department began processing annual redeterminations. 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. Those persons determined no longer BCCTP program 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.

Current managed care rates fully incorporate BCCTP costs.

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/or cervical cancer who have other health insurance but are underinsured. <u>Eligibility is limited to 18 months for breast cancer and 24 months for cervical cancer.</u> The criteria for participation in the state funded premium payment program include the following:</p> <ul style="list-style-type: none"> • Family income at or below 200% of FPL as determined by the enrolling provider • California resident • 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 • Diagnosis of breast and/or cervical cancer and in need of treatment • Not eligible for full-scope, no cost Medi-Cal
BC 3 (OA-5)	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, including postage-paid return envelopes for counties to mail copies of DRA/citizenship documentations received from BCCTP beneficiaries. 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 annual redetermination packets to beneficiaries in the federal BCCTP program, retroactive Medi-Cal applications, letters to all applicants to request additional information, notices of approval or denial of eligibility, and referral packets to the counties for redetermination under other Medi-Cal programs as required under SB 87 when a federal BCCTP beneficiary is determined ineligible for full-scope Medi-Cal under BCCTP.</p>

PHARMACY: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
PH 0.1(PC-176)	X	<p><u>Physician-Administered Drugs</u></p> <p>The DRA of 2005 required states to collect rebates on physician-administered drugs beginning January 1, 2008. CMS granted California a waiver to delay implementation of this provision until April 1, 2008, so the Department could complete the system changes necessary to capture the drugs' National Drug Code (NDC) that allows for the collection of rebates. Due to other system upgrade priorities, the Department was unable to comply with the April 1, 2008 implementation and began capturing the needed information from the physician claims on April 1, 2009.</p>
PH 0.2(PC-188)	X	<p><u>Medi-Cal Pharmacy Reforms</u></p> <p>Beginning in October 2009, the Department will implement four pharmacy reforms. These reforms include conducting therapeutic category reviews on atypical antipsychotic drugs, expanding and changing the rebate program for HIV/AIDS and cancer drugs, implementing an upper billing limitation requirement on pharmacies and requiring that all 340B entities dispense only 340B purchased drugs to Medi-Cal beneficiaries.</p>
PH 0.3(PC-202)	X	<p><u>Estimated Acquisition Cost Savings</u></p> <p>Beginning July 1, 2009, the Department will reimburse pharmacies billing for drugs at the Estimated Acquisition Cost (EAC) plus a dispensing fee. The EAC is defined as the lowest of the State Maximum Allowable Ingredient Cost (MAIC), the Federal Upper Limit (FUL) price or the Average Wholesale Price (AWP).</p>

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 3 (PC-37)	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 has established claiming procedures to ensure that FFP is claimed correctly. Effective March 2007, an automated quarterly report identifies the costs of drugs for which there is no FFP. This report is used to reduce the FFP appropriately. The Department has retroactively adjusted the FFP for drugs purchased since January 2004.</p>
PH 4 (PC-41)	X	X	<p><u>Medical Supply Contracting</u></p> <p>The Health Trailer Bill of 2002 allows contracting with medical supply manufacturers and changes the reimbursement methodology for establishing the Maximum Allowable Product Cost (MAPC) for medical supplies from AWP to WSP. Savings are 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 HCPCS code conversion, have further slowed the contracting process. Contracts for all major product categories have been completed as of December 31, 2008.</p> <p>The Health Trailer Bill of 2007 mandated that the Department meet with provider stakeholder groups at the conclusion of each product category contract negotiation, and establish a rate of reimbursement that may be higher than the contracted Maximum Acquisition Cost.</p> <p>Medical Supply Contracting was formerly a component of the Medical Supply Reduction assumption and incorporates both Medical Supply Contracting and MAPC for Medical Supplies.</p>
PH 5 (PC-44)	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. Due to the intricacies involved in categorizing product types, <u>issues involved with manufacturers obtaining and listing UPN numbers with First Data Bank (FDB)</u>, as well as a thorough review of the current State Plan and statute language regarding the scope of products allowed as benefits, June 2009 <u>2010</u> is the target date to have all products under contract.</p>

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 6 (PC-42)	X	X	<u>New Therapeutic Category Reviews</u>

The Department performs annual drug therapeutic category reviews (TCRs) to determine safety, efficacy, essential need, potential misuse, and cost, prior to including drugs in the List of Contract Drugs. Drugs are organized into therapeutic categories, such as antibiotics, or drug that treat hypertension, acid reflux, etc. There are as many as 114 of these therapeutic categories. Drugs on the List do not require prior authorization prior to dispensing. The TCRs to date are:

- Statin drugs for hypercholesterolemia (Contract Date 7/2004)
- Angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARB) (cardiac drugs) (Contract Date 7/2004)
- Non-sedating antihistamines (Contract Date 8/2004)
- Antidepressants, oral (Contract Date 7/2004)
- Proton pump inhibitors (Contract Date 1/2005)
- Papain/urea and papain/urea/cholorhyllin debriding products (Contract Date 9/2005)
- Short Acting Beta 2 Agonist Inhalers (Contract Date 6/2006)
- Statin drugs for hypercholesterolemia (Contract Date 1/2008)
- ACE inhibitors and ARBs (Contract Date 4/2008)
- Nucleoside Analog drugs to treat Hepatitis B (Contract Date 7/2008)

Many of the above TCRs' savings have been incorporated into the Medi-Cal base. The Department had delayed additional TCRs until the impact of Medicare Part D was assessed. Statin drugs for hypercholesterolemia and ACE inhibitors/ARBs have had new generic drugs introduced since their first TCR, necessitating a new TCR. The Department had scheduled a TCR on Antibiotics effective January 2009. However, this TCR will not be conducted, as it has been determined that not enough single source drugs in this category exist and therefore no savings would be achieved. Additional TCR categories will be considered after the impact of the new AMP pricing and the implementation of the FUL list is known.

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 7 (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. Based on an Office of Inspector General (OIG) audit, the Department estimated \$29.5 million as being potentially recoverable from the aged drug rebate payment disputes.</p> <p>Seven permanent positions approved in the Budget Act of 2007 (Chapter 188, Statutes of 2007), have been designated to complete the resolution of all aged disputes and to allow the Department to remain current in its future dispute resolutions and collection activities.</p> <p><u>Significant progress was made over the past year, but has slowed recently due to high employee turnover and increased workload from contractor-initiated disputes.</u></p>
PH 8 (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> <p><u>Beginning October 2008, the Department will no longer collect rebates for drugs that are not eligible for FFP.</u></p>
PH 9 (PC-48)	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>
PH 10 (PC-49)	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 38 days to make payment after being billed.</p>

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 11 (PC-43)	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>
PH 12 (PC-47)	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> <p>Collection and closure of outstanding disputes has been slowed and workload increased recently by several large pharmaceutical manufacturers that have hired contractors to dispute payments made during these years. <u>Employee turnover has impacted the Department's ability to collect rebates.</u></p>
PH 13 (OA-19)	X	X	<p><u>Epocrates</u></p> <p>The Department entered 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. Epocrates' formulary is free to health professional users.</p>

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 14 (OA-25)	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 reconciles 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 entered into a contract 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 began in FY 2007-08 and are incorporated into the Federal Drug Rebate Program and the State Supplemental Drug Rebates policy changes.</p>
PH 15 (PC-39)	X	X	<p><u>Coagulation Factor State Supplemental Rebate</u></p> <p>The Health Trailer Bill of 2008 requires manufacturers of FDA-approved coagulation factors to pay a supplemental rebate for products dispensed to individuals in the Medi-Cal and Title XIX waiver programs. This legislation provides the Department with the ability to obtain rebates on blood factor products while serving the medical conditions hemophilia patients. Contracts are scheduled to be completed by the first quarter of July 2009 and initial rebates are estimated to be received in June 2009 January 2010.</p>
PH 16 (PC-40)	X	X	<p><u>Pharmacy TAR Auto-Adjudication</u></p> <p>Due to an increase in pharmacy TARs, the Department utilized used an auto-adjudication process on National Drug Codes (NDCs) submitted on TARs which have with a high approval rate and low cost risk in order to meet the federally mandated TAR processing timelines. Auto-adjudication introduces the risk of approving a percentage of NDCs which would have been denied. Based on a pre and post auto-adjudication comparison, a A higher number of NDCs are approved by the through through auto-adjudication process than if a pharmacist reviewed than when Department pharmacists review the NDC NDCs NDCs for medical necessity. In FY 2008-09, the Department plans to hire nine new pharmacists by June 30, 2009, by June 30, 2009, under the Electronic Data Systems fiscal intermediary (FI) contract to review TARs and. It is anticipated that the Department will reduce the need for auto-adjudication. Review of NDCs submitted via a TAR for medical necessity by a pharmacist will by mid-year in FY 2009-10 after the contract pharmacists are hired and fully trained, which would result in a decrease in pharmacy expenditures.</p>

HOSPITAL FINANCING: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 0.1 (PC-87) (PC-88)	X	X	<p><u>ARRA – DSH Allotment and DSH Replacement Payments</u></p> <p>California’s annual allotment of federal funds for the Disproportionate Share Hospital (DSH) program is expected to increase on a temporary basis for FY 2008-09 and FY 2009-10 by 2.5%, due to the enactment of the ARRA. The distribution of the DSH allotment is determined by a formula specified in State statute and the State Medi-Cal Plan. When the DSH allotment is increased and more federal funds are available for distribution, the formula results in an increase in General Funds needed as the non-federal share of the DSH payments for NDPHs and DSH replacement payments to private hospitals.</p>
HF 0.2 (PC-201)		X	<p><u>Reduction to Hosp Financing-DSH Replacement by 10%</u></p> <p>Effective October 1, 2009, the Medi-Cal DSH replacement payments to private hospitals will be reduced by 10%. These payments are determined using the formulas and methodology in effect for the 2004-05 fiscal year. The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.</p>

HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 1 (PC-89)	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 Designated Public Hospitals (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.

The reconciliation process for each Demonstration Year 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 SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.

HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 2 (PC-87)	X	X	

Hospital Financing DSH Payments

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

DPHs 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 constitute the non-federal share of these payments. These IGTs are deposited into the MIPA Fund, Item 4260-606-0834 and are used to claim federal reimbursement. The federal reimbursement that is claimed based on the IGTs is drawn from the Federal Trust Fund.

Non-Designated Public Hospitals (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 is drawn from the Federal Trust Fund.

Based on SPA 05-022, private hospitals on the final DSH list 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 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.

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

HOSPITAL FINANCING: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The reconciliation process for each Demonstration Year 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.

HF 3 (PC-88) X X

Private Hospital DSH Replacement

Effective for dates of service on or after July 1, 2005, private hospitals 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), will satisfy the payment obligations with respect to those hospitals under the Federal DSH statute. The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment.

HF 4 (PC-91) X X

Private Hospital Supplemental Payment

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, private hospitals 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.

HF 5 (PC-99) X X

NDPH Supplemental Payment

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.

HOSPITAL FINANCING: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
HF 6	(PC-92)	X	X	<u>DPH Physician and Non-Physician Costs</u>
<p>Effective for dates of service on or after July 1, 2005 reimbursement based on CPEs will be available to each DPH for the costs incurred for physician and non-physician practitioner professional services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. SPA 05-023 that authorizes federal funding for this reimbursement was approved by CMS in December 2007. CMS has required the Department to submit a time-study protocol for the claiming of federal funds.</p> <p>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. It is anticipated that the Department will begin payments by the end of FY 2007-08. Payments for 2006-07 were made in FY 2007-08; payments for 2005-06 and 2007-08 will be made in FY 2008-09. <u>Payments for 2007-08 and 2008-09 will be made in FY 2009-10.</u> Based on discussions with the DPHs, it was agreed to process the payments for 2006-07 first. The Department's request for the DPHs' 2006-07 costs included updated language related to the determination of the physician costs as approved by CMS.</p>				
HF 7	(PC-96)	X	X	<u>Distressed Hospital Fund</u>
<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 prior supplemental funds, including the ESSP Fund (SB 1255/VGT), (Item 4260-601-0693), the Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0550), the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0549), and the Small and Rural Hospital Supplemental Payments Fund (Item 4260-601-0688), 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"> • The hospital serves a substantial volume of Medi-Cal patients. • The hospital is a critical component of the Medi-Cal program's health care delivery system. • The hospital is facing a significant financial hardship. 				
HF 8	(PC-100)	X	X	<u>MIA LTC Program– Safety Net Care Pool</u>
<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 Medically Indigent Adult Long-Term Care program.</p>				

HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 9 (PC-101)	X	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-97)	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 11 (PC-98)	X	X	<p><u>DPH Interim and Final 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 DPH's 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>The reconciliation process for each Demonstration Year may result in an overpayment or underpayment to a DPH and will be handled as follows:</p> <ul style="list-style-type: none"> • 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 DPH's computed Medi-cal cost, and the share of cost, third liability and Medi-Cal payments. <p>The interim reconciliation process for Demonstration Year 1 2005-06, was completed in February 2008 and the interim reconciliation for 2006-07 is expected to be completed in June September 2009. The interim reconciliation for FY 2007-08 is expected to be completed in June September 2010.</p>

HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 12 (PC-94)	X	X	<u>Stabilization Funding</u>

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&I Code section 14166.20, will be determined as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between the sum of \$.544 million and 0.64 percent of the total stabilization funding and the aggregate payment increase in the fiscal year, compared with their aggregate baseline.
- Private hospitals will receive total funds payments equal to the difference between the aggregate payment increase in the fiscal year, compared with their aggregate baseline, and the sum of \$42.228 million and an additional amount based on the formulas specified in W&I Code 14166.20.
- Distressed hospitals will receive total funds payments equal to the lesser of \$23.5 million or 10 percent of the total stabilization funding with a minimum of \$15.3 million.
- DPHs will receive GF payments to the extent that the state-funded programs' CPEs are used for FFP from the SNCP and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, private hospitals, and distressed hospitals.

Stabilization funding to NDPHs, private hospitals, and distressed hospitals is comprised of GF made available from the federalizing of four state-only programs and 50% FFP. Stabilization funding is also available to DPHs through the SNCP.

The stabilization funding amounts to NDPHs, private hospitals, and distressed hospitals will be calculated following the completion of the final reconciliations of the interim Medicaid inpatient hospital payment rates, interim DSH payments, and interim SNCP payments. CMAC determines the actual stabilization payments for a portion of the total stabilization amount due to NDPHs and private hospitals and all of the distressed hospital stabilization amount. The Department distributes these payments.

HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 13 (PC-90)	X	X	<p><u>Health Care Coverage Initiative</u></p> <p>An amount of \$180 million in federal funds is available each year in Demonstration Years 3-5 to expand health care coverage to eligible low-income, uninsured persons. SB 1448 (Chapter 76, Statutes of 2006) provided the statutory framework for the Health Care Coverage Initiative (CI) and directed 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. A total of ten programs have been selected to participate in the CI program.</p> <p>The federal funds available will reimburse the CI counties an amount equal to the FMAP of their CPEs for health care services provided to eligible low-income, uninsured persons. The CI counties will submit their CPEs to the Department for verification and the Department will submit the claim for FFP that will reimburse the CI counties. No GF will be expended for this program.</p> <p><u>In FY 2008-09, the Department began reimbursement and interim quarterly payments to the CI counties. The final reconciliation and settlement process may result in payment and recovery in future years.</u></p>
HF 14 (PC-102)	X	X	<p><u>Base Adjustment – DPH Interim Rate</u></p> <p>Effective July 1, 2005, based on SPA 05-021, DPHs no longer received CMAC negotiated per diem rates (50% GF/50% FFP.) DPHs receive interim per diem rates based on estimated costs using the hospitals' Medi-Cal costs trended forward. The interim per diem rates are 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 15 (PC-95)	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 costs 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>

HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 16 (OA-2)	✗	X	<p><u>Health Care Coverage Initiative – Administrative Costs</u></p> <p>FFP is available for costs incurred on or after March 29, 2007 through August 31, 2010, that are associated with the start-up, implementation and closeout administration of approved CI programs. The federal funds will reimburse the CI counties an amount equal to the FMAP of their CPEs for administrative costs. The administrative activities for which FFP is being requested were submitted to CMS on December 22, 2006, and approved in October 2007. The Department has developed and submitted for CMS approval the required administrative cost claiming document which includes the time study implementation plan, and training materials.</p> <p><u>The required administrative cost claiming protocol was approved by CMS in October 2008 for prospective costs after the implementation of the time study. The Department implemented the time study in February 2009 for prospective costs and will begin reimbursement to the CI counties in FY 2009-10. The Department will develop and submit to CMS cost claiming methodologies for the administrative costs for the period prior to the implementation of the time study, along with the start-up and close-out costs, to CMS.</u></p>
HF 17 (OA-22)		X	<p><u>MMA – DSH Annual Independent Audit</u></p> <p>MMA requires an annual independent certified audit that primarily certifies:</p> <ul style="list-style-type: none"> • 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. • That DSH payment calculations of hospital-specific limits include all payments to DSH hospitals, including supplemental payments. For Demonstration Years 1, and 2, and 3 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. <p>CMS will finalize the federal regulations to provide guidance on criteria to validate the reduction in the uncompensated care costs by hospitals. <u>CMS has released the final regulation and criteria for the annual independent certified audit. The Department’s methodology and audits for Demonstration Years 1 and 2 are due to CMS by December 31, 2009.</u></p>

HOSPITAL FINANCING: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HF 18 (PC-93)	X	X	<p><u>South LA Preservation Fund</u></p> <p>SB 474 (Chapter 518, Statutes of 2007) created the South Los Angeles Medical Services Preservation (SLAMSP) Fund to ensure adequate funding for the continued health care services to the uninsured population of South Los Angeles, which had been provided by Martin Luther King Jr.-Harbor Hospital. In 2007, Martin Luther King Jr.-Harbor hospital, a DPH receiving SNCP funds, was closed. Through the SLAMSP Fund, the County of Los Angeles will be able to receive federal funds using the county’s CPEs related to compensating other providers for health services rendered to the uninsured population of South Los Angeles that would have been served at Martin Luther King Jr.-Harbor Hospital. The County of Los Angeles can also use this funding to cover indirect costs associated with adequately maintaining the hospital building for reopening. Up to \$100 million in SNCP federal funds for the last three years of the Demonstration Project are to be allocated to the SLAMSP fund.</p>
HF 19 (PC-169)		X	<p><u>Reduction to Hospital Financing – DPH SNCP by 10%</u></p> <p>The SNCP payments to DPHs and the South Los Angeles Medical Services Preservation Fund will be reduced by 10% beginning February 1, 2009, and savings will begin July 1, 2009. The Department will increase the amount of CPEs of the four State-only programs to utilize any remaining federal funds in the SNCP.</p>

MANAGED CARE: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

M 0.1 (PC-172) X Court-Ordered Managed Care Rate Adjustments

In the case of *Health Net of California v. Department of Health Services*, the Third District Court of Appeal ruled that the Department must pay approximately \$14.6 million to Health Net for a dispute over Two Plan Model capitation rates for years ranging from 1997 to 2002.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 1	(PC-50)	X	X	<u>Two-Plan Model</u>
<p>Under the Two-Plan Model program, the Department contracts with two managed care plans in a county. One plan is a locally developed or designated 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.</p> <p>2008-09 capitation rates include:</p> <ul style="list-style-type: none"> • Rate redetermination effective 10/1/08. • SB 94 – Family Planning rate increase effective 1/1/08. • Mirena IUC Reimbursement effective 7/1/08. • ABX3 5 and Health Trailer Bill of 2008 provider payment reductions. • Non-SPCP <u>Non-contract</u> hospital post stabilization payment savings. • <i>Independent Living v. Shewry</i> impact. 				
M 2	(PC-62)	X	X	<u>PHP</u>
<p>Kaiser is the only remaining Prepaid Health Plan (PHP) and has contracts in Marin and Sonoma Counties.</p> <p><u>Sonoma is one of the targeted expansion counties under the Managed Care expansion plan. It is scheduled to join Partnership Health Plan of California (PHC), a County Organized Health System health plan in October 2009. Once this expansion is completed, Kaiser PHP will no longer operate as the Medi-Cal managed care contractor in Sonoma County. It will continue to operate in Marin County.</u></p> <p>2008-09 capitation rates include:</p> <ul style="list-style-type: none"> • Rate redetermination effective 10/1/08. • SB 94 – Family Planning rate increase effective 1/1/08. • Mirena IUC Reimbursement effective 7/1/08. 				

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
M 3	(PC-51)	X	X

County Organized Health Systems

Five County Organized Health Systems (COHSs) are operational in nine counties. With the exception of the Health Plan of San Mateo, all COHS plans provide long term care services to their enrollees. The Partnership Health Plan of California (PHC) includes undocumented **alien residents and documented alien** beneficiaries (~~aid codes 55, 58, 5F, 5G, 5N~~). The rate year for COHS plans begins July 1st and ends June 30th.

Health plans and counties currently operating under the COHS model:

CalOPTIMA
Orange County

Santa Barbara San Luis Obispo Regional
Health Authority (SBSLORHA); dba: CenCal Health
Santa Barbara County
San Luis Obispo County

Health Plan of San Mateo (HPSM)
San Mateo County

Partnership Health Plan
of California (PHC)
Solano County
Napa County
Yolo County
Sonoma County (July 2009)

Central Coast Alliance for Health
(CAAH)
Santa Cruz County
Monterey County
Merced County (July 2009)

PHC will be expanding into Sonoma County and Central Coast Alliance for Health into Merced County in FY 2009-10.

2008-09 capitation rates include:

- Rate redetermination effective 7/1/08.
- SB 94 – Family Planning effective 1/1/08.
- Mirena IUC Reimbursement effective 7/1/08.
- ABX3 5 and Health Trailer Bill of 2008 provider payment reductions.
- ~~Non-SPCP~~ **Non-contract** hospital post stabilization payment savings.
- *Independent Living v. Shewry* impact.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 4	(PC-60) (PC-70)	X	X	<u>AIDS Healthcare Centers</u>

Managed Care Organization (MCO): Positive Healthcare Services (dba AIDS Healthcare Centers) is located in Los Angeles.

All drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) are included in the plan's contracted scope of services ~~effective January 1, 2009~~, 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 plan¹. 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.

Savings Sharing/Incentive Distributions: Prior obligations exist for AIDS Healthcare Centers. 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~~ **take up to one year**. 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 are needed in FY 2008-09 and FY 2009-10 to provide payments for prior years' savings sharing.

~~The Department has extended the plan's current contract through June 30, 2009 and the new full risk contract is expected to begin July 1, 2009~~
The policy change includes the impact of the rate change that was effective April 1, 2009. The current contract was not converted to full risk and will terminate December 31, 2009.

¹List 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, Maraviroc and Etravirine.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
M 5	(PC-52)	X	X

Geographic Managed Care

Sacramento: Geographic Managed Care (GMC), as authorized by AB 336 (Chapter 95, Statutes of 1991), was implemented in Sacramento County as of April 1994. The contractors are: Health Net Community Solutions, Inc., ~~Blue Cross of California Partnership Plan, Inc.~~ **Anthem Blue Cross Partnership Plan**, KP Cal, LLC, Western Health Advantage Community Health Plan, Molina Healthcare of California Partner Plan, Inc., and Care 1st Partner Plan, LLC. ~~Molina Healthcare of California Partner Plan, Inc. acquired the enrollment of Care 1st Partner Plan, LLC effective December 31st, 2007.~~

San Diego: 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., KP Cal, LLC, Molina Healthcare of California Partnership Plan, Inc., Care 1st Partnership Plan, LLC, and Community Health Group Partnership Plan.

~~Blue Cross did not renew its managed care contract in San Diego County. Effective December 31, 2007, it is no longer a managed care plan choice in San Diego County. Beneficiaries enrolled under this plan were required to choose another GMC plan offered in the county.~~

~~Placer: GMC, as authorized by the Budget Act of 2005, will be implemented in Placer County in March 2009. Molina, Blue Cross, Health Net, and Kaiser submitted proposals and were accepted to participate as managed care plans in Placer County.~~

2008-09 capitation rates include:

- GMC San Diego – CMAC negotiated rates effective 7/1/08.
- GMC Sacramento – CMAC negotiated rates effective ~~4/1/09~~ **7/1/08 – 12/31/09**.
- SB 94 – Family Planning effective 1/1/08.
- Mirena IUC Reimbursement effective 7/1/08.
- ABX3 5 and Health Trailer Bill of 2008 provider payment reductions.
- ~~Non-SPGP~~ **Non-contract** hospital post stabilization payment savings.
- *Independent Living v. Shewry* impact.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 6	(PC-61)	X		<p><u>Risk Payments for Managed Care Plans</u></p> <p>Medi-Cal managed care plans that have opted for the reinsurance protection option offered by the Department 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. Santa Barbara San Luis Obispo Regional Health Authority was the only managed care plan that had reinsurance protection. Estimated expenditures for risk provisions are \$8,000,000 to be paid in FY 2008-09 for prior periods of coverage.</p> <p>Reinsurance is no longer offered by the Department effective July 1, 2008.</p>
M 7	(PC-63)	X	X	<p><u>Family Mosaic Capitated Case Management</u></p> <p>Family Mosaic Project (FMP): 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.</p> <p>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.</p> <p>The Family Mosaic Project executed a new contract with the Department, effective January 1, 2008 through December 31, 2012. A retroactive payment for the period January 1, 2008 through June 30, 2008 will be paid was made in FY 2008-09 August 2008.</p>
M 8	(OA-12)	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 executed a new contract with the State; the contract term is July 1, 2007 through June 30, 2012.</p>

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 9	(PC-53)	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 initial transfer of funds began in June 2006, effective retroactively to July 2005 and will continue on an ongoing basis.</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 is effective October 2006. The Department has received federal approval to proceed with the IGT; the transfer of funds will begin in FY 2008-09 and continue on an ongoing basis. <u>All retro-active payments will be completed by June 30, 2009.</u></p> <p>IGTs for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Joaquin, and Santa Clara counties were effective <u>retroactive to</u> October 1, 2008. <u>An IGT for Santa Barbara County will be effective July 1, 2009.</u></p>
M 10	(PC-72)	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 CCS services and anti-psychotic drugs. Additionally, the Department pays federally qualified health care centers and rural health clinics under the fee-for service system for certain costs associated with serving Medi-Cal managed care enrollees which are not fully paid by Medi-Cal managed care plans.</p>

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y										
		<u>C/Y</u>	<u>B/Y</u>									
M 11	(PC-50) (PC-51) (PC-52)		X	<p>Capitated Rate Methodology Rate Adjustments Annual Redetermination of Capitation Rates</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 capitation rate development process and reimbursement structure. Mercer issued a report recommending that the Department adopt an experience-based rate methodology, in which capitation payments to contracted health plans are matched to their relative risk. Managed care rates were adjusted to implement the Mercer recommendations, effective with the 2007-08 rate years.</p> <p>Adjustments were implemented based on the rate year of the managed care model types. <u>Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.</u></p>								
M 12	(OA-14)	X	X	<p><u>SPD Education and Outreach</u></p> <p>To target barriers to enrollment of seniors and persons with disabilities (SPDs) into managed care, the Department has entered into an interagency agreement (IA) with UC Berkeley for the development of a guide as part of education and outreach activities to increase the voluntary enrollment of Medi-Cal SPDs in all managed care counties. The IA also provides for development of the guide in alternative formats such as Braille, audio, large font, etc. and development and implementation of complementary interventions to ensure greater understanding of Medi-Cal choices for seniors and persons with disabilities.</p> <p>On a cash basis, the local assistance funding is expected to be expended in the following fiscal years:</p> <table border="0" style="margin-left: 40px;"> <tr> <td>FY 2007-08</td> <td>\$1,040,000</td> </tr> <tr> <td>FY 2008-09</td> <td>\$598,500 \$371,000</td> </tr> <tr> <td>FY 2009-10</td> <td>\$562,000 \$723,000</td> </tr> <tr> <td><u>FY 2010-11</u></td> <td><u>\$67,000</u></td> </tr> </table>	FY 2007-08	\$1,040,000	FY 2008-09	\$598,500 \$371,000	FY 2009-10	\$562,000 \$723,000	<u>FY 2010-11</u>	<u>\$67,000</u>
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<u>FY 2010-11</u>	<u>\$67,000</u>											

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 13	(PC-59)	X	X	<p><u>Coverage for Former Agnews Residents</u></p> <p>The CDDS submitted a plan to the Legislature in January 2005 to close the Agnews Developmental Center. The CDDS has indicated that Agnews will close when the housing and support services are available and all consumers have been transitioned to the community. Approximately As of April 1, 2009, all 300 Agnews clients have moved or will move into communities into the community, primarily in Alameda, San Mateo, and Santa Clara counties.</p> <p>The Department believes that Medi-Cal managed care provides the best assurance that former Agnews clients will get the services they need, and has developed agreements with three health plans, regional centers and CDDS. The agreements to address the medical health needs of consumers transitioning from Agnews into Alameda, San Mateo, and Santa Clara counties pursuant to the Agnews Closure Plan for the Closure of Agnews Developmental Center, whose Individual Program Plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal fee-for-service system and who choose to enroll in managed care. Due to the significant behavioral, health and personal care needs of these clients, current capitation rates will not provide sufficient funding. The Department has established a mechanism whereby the plans will be are paid a supplemental payment in addition to the capitation rate for these individuals, followed by periodic reconciliations to fully reimburse the plans for all appropriate reasonable costs. This arrangement will last until the Department is able to provide an appropriate capitation rate for these individuals. This agreement is with the Medi-Cal managed care health plans which are currently operational in these counties as a county organized health system or a local initiative if consumers, where applicable, choose to enroll.</p>
M 14	(PC-65) (PC-64) (PC-57) (PC-68)	X	X	<p><u>Managed Care Expansion</u></p> <p>The Budget Act of 2005 included geographic expansion of managed care into 13 additional counties. As of March 2008, Medi-Cal managed care has completed expansion into San Luis Obispo County. The next phase will include Placer (GMC), Sonoma (COHS), and Merced (COHS) counties. The anticipated start up date for Placer County is March 2009, and the start up date for Merced and Sonoma Counties is July October 2009.</p>

MANAGED CARE: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 15 (PC-69)		X	<p><u>Addition of LTC, and CHDP - Health Plan of San Mateo</u></p> <p>The Health Plan of San Mateo (HPSM) will add long term care (LTC) and Children's Health Disability Program services to its contract effective July 1, 2009 February 1, 2010. Currently these services are being provided under the fee-for-service system.</p>
M 16 (PC-71)		X	<p><u>Working Disabled in Managed Care</u></p> <p>Effective July 1, 2009, beneficiaries eligible under the 250% Working Disabled Program (aid code 6G) currently covered under fee-for-service may now be covered under managed care. Enrollment will be voluntary in the Two-Plan and GMC counties, and mandatory for COHS counties.</p>
M 17 (PC-159)		X	<p><u>QIF Sunset For Managed Care</u></p> <p>The Quality Improvement Fee (QIF) assessed on Medi-Cal Managed Care plans will sunset on October 1, 2009.</p> <p>FY 2009-10 rates for Managed Care plans will reflect the reduction in the plans' costs due to the termination of the QIF. It is assumed that the rates will be reduced in the amount of the QIF revenues to the GF, which are approximately \$239,877,000 \$263,469,000 TF annually.</p> <p>The State GF revenues from the QIF are not reflected in the Medi-Cal budget, but the amounts are provided as Information Only in the Medi-Cal Assumptions.</p>

PROVIDER RATES: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PR 0.1(PC-181)	X	X	<p><u>Cal Pharmacy Provider Payment Injunction</u></p> <p>On April 6, 2009, in the case of <i>Cal Pharmacy, et al. v. Maxwell-Jolly</i>, the U.S. Court of Appeals issued an injunction on several of the payment reductions enacted by AB 1183 (Chapter 758, Statutes of 2008). The court ordered the Department to restore payment reductions for DP/NF and DP Subacute facilities, hospital outpatient services, inpatient services for non-contract hospitals, ADHC services and pharmacy services, as of that date.</p>
PR 0.2 (PC-184)		X	<p><u>Rollback of Family Planning Rate Increase</u></p> <p>Effective October 1, 2009, the January 2008 increase to reimbursement rates for eight specified office visit codes billed for family planning services by FPACT and the Medi-Cal program will be rolled back to pre-January 2008 levels.</p>
PR 0.3 (PC-190)		X	<p><u>Expansion of Revenue Base for AB 1629 QA Fee</u></p> <p>AB 1629 (Chapter 875, Statutes of 2004) required the Department to collect a quality assurance fee for freestanding skilled nursing facilities (NF-Bs), including adult sub-acute days and excluding pediatric and rural swing bed days. Currently, skilled nursing facilities pay the fee based on their Medi-Cal and private pay revenues. The State uses a portion of the fee to draw down FFP. The FFP and GF are then returned to the NF-Bs facilities through increased rates.</p> <p>Effective August 1, 2009, the Department will expand the amount of revenue upon which the quality assurance fee is assessed, to include Medicare revenues.</p>

PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
PR 1	(PC-74)	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 5.5% for FY 2008-09 and 5% for FY 2009-10. 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.</p> <p>The QA fee is capped at 6% of net revenue (excluding Medicare) thru July 31, 2009 2011. The rate methodology and QA fee provisions sunset on July 31, 2011.</p> <p>AB 1807 (Chapter 74, Statutes of 2006) which was effective July 12, 2006, prohibits nursing facilities from passing on the cost of fingerprinting and background checks to nursing trainees. The increased costs to the nursing facilities will result in an add-on to the reimbursement rates. The add-on will be applied to the rate effective August 1, 2009 and will be retroactive to July 12, 2006.</p>
PR 2	(PC-77)	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 Clinics (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 1st of each year.</p>

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PR 3 (PC-76)	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 2008-09, new LTC rates were effective August 1, 2008. Funds for the rate adjustment will be included in the appropriate policy changes for Managed Care, PACE, SCAN, and On LOK. It is assumed that new LTC rates for rate year 2009-10 will be effective August 1, 2009. The rates for 2009-10 are estimated based on increases from the prior rate year. Additionally, the minimum wage increase (AB 1835, Chapter 230, Statutes of 2006) impacted reimbursement rates as of January 1, 2007 and January 1, 2008. This increase resulted in an add-on to the reimbursement rates.

The following facilities receive State Plan LTC rate adjustments:

- Intermediate Care Facilities/Developmentally Disabled (ICF-DD)
- ICF/DD-Habilitative
- ICF/DD-Nursing
- Freestanding Nursing Facilities – Level A (NF-A)
- Distinct Part Nursing Facilities (DP/NF) – Level B
- DP/NF Subacute
- Pediatric Subacute Care
- Rural Swing Beds
- Adult Day Health Care

Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) are required to pay a Quality Assurance (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 is capped at 5.5% of the total gross revenue. In addition, any changes in the facilities' licensing fees will also impact the August 1, 2008 reimbursement rates and the allowable QA fee amount to be collected.

PR 4 (PC-79)	X	X	<u>Hospice Rate Increases</u>
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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 1st of each year.

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.

PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
PR 5	(PC-BA)	X	X	<u>Alternative Birthing Centers</u>
<p>Pursuant to W & 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>				
PR 6	(PC-86)	X	X	<u>Reduction to Provider Payments</u>
<p>Effective July 1, 2008, as required by ABX3 5 (Chapter 3, Statutes of 2008), the Department will reduce reduced payments to Medi-Cal providers by 10%. Effective March 1, 2009, as required by the Health Trailer Bill of 2008, BCCTP provider payments will be were fully restored, the pharmacy and LTC provider payments will be were reduced by 5% and the FFS provider payments will be were reduced by 1%. This reduction will affect all provider types except hospital inpatient departments, hospice, Federally Qualified Health Centers, and Rural Health Clinics. Also exempted are payments to managed care plans for consumers transitioning from Agnews Developmental Center, payments for BCCTP beneficiaries (federal program only), and payments for FPACT beneficiaries. Payment reductions for LTC facilities are addressed separately. Medi-Cal managed care plans have incorporated this reduction in their FY 2008-09 and FY 2009-10 rates.</p>				
PR 7	(PC-84)	X	X	<u>Reduction to Long Term Care Provider Payments</u>
<p>Effective July 1, 2008, as required by ABX3 5 (Chapter 3, Statutes of 2008), the Department will reduce reduced payments to LTC facilities by 10%. Effective March, 1, 2009, as required by the Health Trailer Bill of 2008, LTC provider payments will be were reduced by 5%. Facilities affected by this reduction include Nursing Facilities Level A (NF-As), Distinct Part Nursing Facilities Level B (DP/NF-Bs), Distinct Part Pediatric Subacutes, Rural Swing Beds, Distinct Part Subacutes, and Adult Day Health Care (ADHC). This reduction does not affect Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) or facilities under the AB 1629 reimbursement methodology. Medi-Cal managed care plans have incorporated this reduction in their FY 2008-09 and FY 2009-10 rates.</p>				

PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PR 8 (PC-80)	X	X	<p><u>Mirena IUC Reimbursement</u></p> <p>Effective July 1, 2008, the Department will augment the reimbursement rate for Mirena Intrauterine Contraceptive (IUC). Mirena is one of only two IUCs available for use by Medi-Cal and FPACT providers and approved by the Federal Drug Administration. The cost for Mirena has increased and the existing reimbursement does not cover provider costs. This change in reimbursement will address the increased manufacturer's price for Mirena Intrauterine System.</p>
PR 9 (PC-82)	X	X	<p><u>Non-SPCP Hospital Reimbursement Change</u></p> <p>Effective October 1, 2008, the Department will reduce payments to <u>those non-Selective Provider Contracting Program (SPCP) hospitals located in either a closed health facility planning area as identified by CMAC or residing in an open health facility planning area with three or more licensed acute care hospitals,</u> excluding rural hospitals, to the lower <u>lesser</u> of the average regional rate established by CMAC minus five percent (or for the tertiary hospitals, to the CMAC regional average tertiary rate minus five percent), or the hospital's interim rate minus ten percent. <u>Small and rural hospitals are excluded from this reduction.</u> Medi-Cal managed care plans have incorporated the post stabilization payment savings in their FY 2008-09 rates.</p>
PR 10 (PC-15)	X	✕	<p><u>Provider Payment Reduction Litigation</u></p> <p>On July 1, 2008, the Department implemented a 10% payment reduction for providers of various services. On August 18, 2008, in the case of <i>Independent Living Center v. Shewry</i>, the U.S. District court issued a preliminary injunction on the payment reductions and ordered the Department to restore the rate reduction to the following provider types: prescription drugs, ADHC, dental, physician services, optometry services, and clinics <u>for dates of service on and after August 18, 2008.</u> Medi-Cal managed care plans have incorporated these restorations into their FY 2008-09 rates.</p> <p><u>On November 17, 2008, a second preliminary injunction was issued on this lawsuit, which ordered the Department to refrain from applying the payment reduction to specified home health and non-emergency medical transportation services for dates of service on and after November 17, 2008.</u></p> <p><u>The Department filed a notice of appeal for each of these injunctions and on February 18, 2009, the U.S. Court of Appeals decided not to overturn the district court's ruling.</u></p>

SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
SP 1	(PC-104)	X	X	<u>Capital Project Debt Reimbursement</u>
<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&I Code. The two DPs that qualify for this reimbursement have commenced their capital construction projects.</p>				
SP 2	(PC-103)	X	X	<u>Hospital Outpatient Supplemental Payments</u>
<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. Interim payments are expected to be made in June 2009 for FY 2007-08 and in June 2010 for FY 2008-09. Interim payment adjustments are made upon receipt and review of amended claims.</p> <p>The reconciliation mandated by AB 915 of FY 2002-03 against audited cost reports is scheduled to occur during FY 2008-09. Interim payments, or recoupment of overpaid funds, are expected during the current fiscal year. Reconciliation of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.</p>				
SP 3	(PC-106)	X	X	<u>IGTs for Non-SB 1100 Hospitals</u>
<p>W&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 will enter into an Interagency Agreement with a county to accept an IGT to be matched with federal funds and distributed to the hospitals designated by the county.</p>				

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
SP 4	(PC-107)	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>
SP 5	(PC-108)	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>
SP 6	(PC-109)	X	X	<p><u>Medi-Cal Reimbursements 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 Payment Action Notice (PAN) to the Fiscal Intermediary (FI). The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
SP 7	(PC-110)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient Small and Rural Hospitals</u></p> <p>Health and Safety Code section 124870 requires the Department 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 PAN to the FI. The payment represents one quarter of the total annual amount due to each eligible hospital.</p>

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

SP 8 (PC-105) ✕ X Freestanding Outpatient Clinics and State Veterans' Homes Supplemental Payments

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.

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.

The non-federal match is paid from public funds of the participating facilities.

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 for FY 2006-07 and FY 2007-08 for both programs are expected to be made beginning in FY ~~2008-09~~ **2009-10**.

OTHER: AUDITS AND LAWSUITS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

A 0.1 (OA-70) X X Litigation Related Services

The Department continues to experience significant and increasing litigation costs in defense of the Medi-Cal program. The number of open cases has increased, and the Department of Justice rates for litigating these cases have increased. The Department is also required to retain files related to litigation well beyond the normal retention, causing data storage costs to increase.

Ongoing litigation filed by managed care plans against the Department regarding their capitation rates has resulted in increased work and costs for the Department's consulting actuaries to comply with the requirements of the court rulings.

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

A 1 (PC-132) <u>Lawsuits / Claims*</u>	<u>Applicable F/Y</u>	<u>Change from</u>
	<u>C/Y</u>	<u>B/Y Nov Assumptions</u>
a. <u>Attorney Fees of \$5,000 or Less</u>		
1. <i>Julia Albarado</i> 34-2008-00001790	\$4,000	
2. <i>Pamela Peterson</i> 37-2008-00087126	<u>\$230</u>	New
Total	\$4,230	\$0
Fund Balance	\$45,770	\$50,000
b. <u>Provider Settlements of \$75,000 or Less</u>		
1. <i>Alta Healthcare System</i> BC363597	\$48,638	
2. <i>Gardenia Hospital</i> BC372607	\$40,035	
3. <i>Catholic Healthcare</i> BC 366257	\$16,290	
4. <i>Catholic Healthcare</i> BC 376755	\$5,785	
5. <i>Catholic Healthcare</i> BC 359980	\$39,491	
6. <i>Pomona Valley</i> BC 375674	\$51,676	
7. <i>Anaheim Memorial</i> BC 380249	\$237	New
8. <i>Eden Medical Center</i> CGC 07469261	\$49,600	New
9. <i>Intercare Health Systems, Inc.</i> BC 380016	<u>\$740</u>	New
Total	\$252,491	\$0
Fund Balance	\$1,347,509	\$1,600,000
c. <u>Beneficiary Settlements of \$2,000 or Less</u>		
1.	\$0	
2.	<u>\$0</u>	
Total	\$0	\$0
Fund Balance	\$15,000	\$15,000
d. <u>Small Claims Court Judgments of \$5,000 or Less</u>		
1.	<u>\$0</u>	
Total	\$0	\$0
Fund Balance	\$200,000	\$200,000
e. <u>Other Attorney Fees</u>		
1. <i>Sutter Medical Center Sacramento</i> 07CS00583	\$30,812	
2. <i>Emily Q.</i> CV-98-4181 AHM (AJWx)	\$449,853	
3. <i>Donna Stewart</i> 06CS01762	<u>\$8,000</u>	New
Total	\$488,665	\$0
f. <u>Other Provider Settlements / Judgments</u>		
1. <i>Protestant Episcopal Church</i> LA GC038201	\$200,000	
2. <i>Ygnacio Valley Care Center</i> C0701047	\$410,000	
3. <i>Park Marino Convalescent Ctr.</i> 0007449	\$760,000	
4. <i>B. V General</i> 00066-56	\$232,500	
5. <i>Kindred AB</i> 1629 0066231	\$600,000	
6. <i>Good Samaritan Hospital, et. al. v. DHCS</i>	\$94,296	New
7. <i>Avalon Care Center – Sonora, LLC v. Shewry</i>	<u>\$1,393,425</u>	New
Total	\$3,690,221	\$0
g. <u>Other Beneficiary Settlements</u>		
1.	<u>\$0</u>	
Total	\$0	\$0

Amounts may exclude interest payments.

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
A 2	(PC-133) (PC-FI)	X	X	<u>Audit Settlements</u>
<p>Federal audit A-09-06-00032 determined that FFP was incorrectly claimed for Medicaid Management Information System costs at the enhanced rate of 75% FFP during the period of July 1, 2003 through June 30, 2005. The Department will repay repaid \$2,273,000 in FY 2007-08. For the period of July 1, 2005 through June 30, 2007, the Department will repay \$728,000 in FY 2008-09. The Department has remediated its claiming allocation methodology to ensure these audit deficiencies are corrected.</p> <p>Federal audit A-09-01-00055 determined that FFP was improperly claimed for medical services, other than inpatient psychiatric services, provided to IMD residents aged 22 through 64 temporarily released to acute care hospitals. The Department has repaid CMS for services provided through February 28, 2001, and will repay \$542,000 in FY 2008-09 for services from March 1, 2001 through February 29, 2008, and \$81,000 annually thereafter.</p> <p>Federal audit A-09-02-00083 determined that FFP was improperly claimed for medical services, other than inpatient psychiatric services provided to IMD residents under age 21 in private psychiatric hospitals. The Department has repaid CMS for services provided through January 31, 2001, and will repay \$307,000 in FY 2008-09 for services from February 1, 2001 through February 29, 2008, and \$44,000 annually thereafter.</p> <p>Federal audit A-09-02-00084 determined that FFP was improperly claimed for medical services, other than inpatient psychiatric services, provided to IMD residents under age 21 in State-operated psychiatric hospitals. The Department has repaid CMS for services provided through February 28, 2001, and will repay \$364,000 in FY 2008-09 for services from March 1, 2001 through February 29, 2008, and \$54,000 annually thereafter.</p>				
A 3	(PC-135)	X	X	<u>Notices of Dispute / Administrative Appeals – Settlements</u>
<p>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 2008-09 and \$1,000,000 for in FY 2009-10.</p>				
A 4	(PC-127)	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.</p>				

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

A 5 (PC-137) X

Dental Managed Care Disallowance of Cost

CMS determined that there is an incorrect program cost allocation related to state-only Medi-Cal Dental Managed Care Plan reimbursements ~~for~~ **after** the contract period of July 1, 2007 for dental PHPs, and after the contract period of May 1, 2008 for dental GMC plans. CMS disallowed those costs and is requiring the State to refund these payments because federal rules **consider them illegal provider donations and** prohibit the match of Medicaid expenditures from Medi-Cal plans or providers.

OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 0.1	(PC-179)		X	<u>Refugee Medical Assistance/Entrant Medi-Cal Assistance Reimbursement</u>
<p>A 2004 review by the Department of Refugee Medical Assistance/Entrant Medi-Cal Assistance (RMA/EMA) cases in the four counties with the highest number of cases 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) for all four counties in FY 2005-06 for Federal Fiscal Year (FFY) 2001-02, 2002-03, and 2003-04. At ORR's request, the Department will conduct a review of all RMA/EMA cases in all counties for FFY 2002-03, FFY 2003-04, and FFY 2004-05. The three-year review is expected to begin in October 2009. Because RMA is 100 percent federally funded, the Department anticipates that the federal government will seek reimbursement in FY 2009-10. Monitoring by the Department will be done annually on an ongoing basis. New MEDS programming has been implemented to automatically terminate RMA eligibility for refugees who have reached the end of their 8-month eligibility period. Terminations based on this programming will start with the March 2009 month of eligibility.</p>				
R 0.2	(PC-182) (PC-203)	X	X	<u>ARRA – Additional FFP for DHCS</u>
<p>On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010 which provides an across-the-board increase to all states of 6.2 percent and an additional increase in the form of a decrease in the state share based on increased unemployment rates. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period. Among other conditions, ARRA requires that eligibility standards, methodologies, or procedures in place in the Medicaid state plan or a Section 1115 waiver program cannot be more restrictive than those in effect as of July 1, 2008. Compliance with provider prompt payment requirements, including hospitals and nursing homes, is also a condition of receiving the enhanced FMAP.</p>				

OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
R 0.3 (OA-65)	X	<p><u>ARRA HITECH Incentive Program</u></p> <p>The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of ARRA, authorizes the outlay of federal money estimated to be roughly \$36 billion over six years between 2011 and 2016 for Medicare and Medicaid incentives to qualified health care providers who adopt and use Electronic Health Records (EHR) in accordance with the Act's requirements.</p> <p>Providers will be required to demonstrate the "meaningful use" of their electronic health records to qualify for incentives. The Department will expand the current MMIS Health Information Exchange (HIE) for e-prescribing to ensure Medi-Cal providers are qualified for meaningful use of their electronic health records and to add automated consent features available to the Medi-Cal beneficiary community.</p> <p>ARRA will require funding for planning, development and implementation of the Medi-Cal incentive program, expansion of HIE, and the modification of the MMIS and MEDS systems. HITECH establishes a 90% federal funding match specific to the state for this work.</p> <p>Due to the complex nature of both the policy and technical aspects of ARRA, the Department will contract with an outside vendor to help analyze and create appropriate IT project documentation. The 10% General Fund match will be covered by the California Healthcare Foundation. Therefore, there will be no impact to the General Fund.</p>
R 0.4 (PC-191)	X	<p><u>Additional 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 Medi-Cal hospital outpatient services for FY 2009-10.</p>

OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
R 0.5 (PC-185)		X
		<u>Federal Medi-Cal Flexibility and Stabilization</u>
		<p>The Governor will petition the Obama Administration to work with California to secure essential program flexibilities to slow the rate of program growth and manage Medi-Cal within available resources; support the state's authority to determine eligibility, the adequacy of provider rates and scope of benefits; and recognize the state's long-standing record of cost-containment. In addition, the Administration will work with Congress and other states to resolve longstanding, unreimbursed Medicaid claims owed to states associated with the delayed federal classification of certain permanent disability cases. Taken together, this federal support will help stabilize the Medi-Cal program and its ability to preserve essential health services to low-income Californians. These flexibilities are expected to result in savings to the Medi-Cal program during 2009-10.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 1	(PC-NA)	X	X	<u>FMAP Changes</u>

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, 2009~~ **September 30, 2009**. ~~Beginning July 1, 2009, the FMAP is assumed to remain at 50.0%.~~

On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 2	(PC-116) (PC-128)	X	X	<u>Dental Contract</u>

The dental rates for the period August 2007 through July ~~July~~ **June** 2008 will be **were**:

Refugees	All Others
\$40.07	\$8.62

The dental rates for the period July 1, 2008 through July 31, 2008 will be:

<u>Refugees</u>	<u>All Others</u>
<u>\$36.06</u>	<u>\$7.77</u>

The dental rates for the period August 2008 through July 2009 will be:

Refugees	All Others
\$39.76	\$8.97

Dental rates for the period August 2007 through July ~~July~~ **June** 2008 increased from \$8.51 to \$8.62 for regular eligibles, and increased from \$35.92 to \$40.07 for refugees. ~~The retroactive change order to implement this effective August 2007 is expected to be approved in FY 2008-09.~~ **The current rates will remain in effect until the new rates are negotiated and approved by control agencies through a change order.**

Pursuant to ABX3 5 (Chapter 3, Statutes of 2008) dental rates for the period July 1, 2008 through July 31, 2008 decreased by 10 percent from \$8.62 to \$7.77 for regular eligibles and from \$40.07 to \$36.06 for Refugees. On August 18, 2008, in the case of *Independent Living Center v. Shewry*, the U.S. District Court issued a preliminary injunction on the payment reductions and ordered the Department to restore the rate reduction.

Dental rates for the period August 2008 through July 2009 increased from \$8.62 ~~\$7.77~~ to \$8.97 for regular eligibles and ~~decreased~~ **increased** from \$40.07 ~~\$36.06~~ to \$39.76 for Refugees.

~~The current rates will remain in effect until the new rates are negotiated and approved by control agencies through the change order instrument.~~

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 3	(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 dental plans. As of July 1, 2008, there are five dental GMC plans.</p> <p>The five GMC contracts are in effect through December 31, 2012.</p>
R 4	(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.</p> <p>The Department has contracted with eight dental plans that are providing services as voluntary PHPs in Los Angeles County. These contracts are effective through June 30, 2009.</p> <p><u>Contract amendments will be implemented by May 2009 to extend the eight PHP contracts through June 30, 2011.</u></p>
R 5	(PC-146)	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 6	(OA-6)	X	X	<u>MIS/DSS Contract</u>
<p>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 Department units, including the Medi-Cal Managed Care Division in its monitoring of Health Plan performance, and the Audits and Investigations Division in its anti-fraud efforts.</p> <p>A new four year contract with the option to extend the contract for an additional three years for development, maintenance, operation, and updating of the Next Generation MIS/DSS data warehouse was executed with Bull Services, Inc. Ingenix in February 2007. FY 2007-08 expenditures represented one-time and ongoing costs associated with system design, development, and implementation. FY 2008-09 and FY 2009-10 expenditures represent ongoing operation and maintenance costs.</p>				
R 7	(OA-17)	X		<u>MIS/DSS Oversight Contract</u>
<p>The new Next Generation MIS/DSS contract was executed with Bull Services, Inc. in February 2007. As required by the Department of Finance's Project Oversight Framework for this high criticality project, the Independent Verification & Validation (IV&V) Contractor will remain throughout the project implementation phases and production acceptance period to provide oversight of the project management and implementation processes.</p> <p>On December 19, 2006, CMS approved the Next Generation MIS/DSS Implementation Advanced Planning Document (IAPD), including enhanced funding for this project at 90% FFP for the IV&V. On January 10, 2007 DOF approved the Next Generation MIS/DSS IAPD in lieu of Special Project Report (SPR). The contract will end June 30, 2009.</p>				
R 8	(PC-143)	X	X	<u>Indian Health Services</u>
<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. 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 9	(OA-44)	X	X	<p><u>Baby Welcome Kits</u></p> <p>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.</p>
R 10	(PC-117)	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 CDDS Developmental Centers (DCs) and two State-operated small facilities.</p>
R 11	(OA-34)	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>
R 12	(PC-113) (OA-31)	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 California Department of Mental Health (CDMH).</p> <p>On June 26, 2007, CMS approved renewal of the Specialty Mental Health Waiver for the term July 1, 2007 through June 30, 2009. <u>Currently, activities for the next waiver renewal are in process.</u></p> <p>Beginning in FY 2006-07, the GF cost of EPSDT mental health services and the San Mateo Pharmacy/Lab contract was included in the CDMH budget rather than in the Department's budget. <u>Beginning February 1, 2010, HPSM will provide laboratory and pharmacy services to mental health patients enrolled in the plan.</u></p> <p><u>As a result of the settlement of several lawsuits by specialty mental health providers subcontracted to Los Angeles County, payments for improperly denied claims under the waiver for FYs 2003-04, 2004-05 and 2005-06 will be paid in FY 2009-10.</u></p>
R 13	(PC-124)	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>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 14	(PC-126)	X		<u>State Hospitals – CDMH</u>
<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. The Budget Act of 2008 eliminated the GF authorized to match Medi-Cal FFP from the CDMH budget. Claims for services provided in FY 2007-08 will be paid in FY 2008-09.</p>				
R 15	(PC-120) (OA-38)	X	X	<u>Mental Health Drug Medi-Cal – CDADP</u>
<p>The Drug/Medi-Cal program provides substance abuse treatment services to Medi-Cal beneficiaries in an outpatient setting.</p> <p>Drug/Medi-Cal services are reimbursed on a fee-for-service (FFS) basis. These community treatment services are carved out from the regular Medi-Cal program and are administered by the CDADP.</p> <p>Title XIX FFP is claimed for Drug Medi-Cal services administered by the CDADP.</p>				
R 16	(OA-41)	X	X	<u>Perinatal HIV Testing Project</u>
<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 17	(PC-134) (OA-39)	X	X	<u>CLPP Case Management Services</u>
<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 18	(PC-139)	X	X	<u>Cigarette and Tobacco Products Surtax Funds</u>
<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>				

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 19	(OA-50)	X	X	<p><u>California 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 California Health and Human Services Agency. Title XIX FFP is available for HIPAA activities related to Medi-Cal.</p>
R 20	(OA-4)	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 21	(OA-3) (OA-74)	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 who receive CCS services who are Medi-Cal eligible.</p> <p>The CMS Net automated eligibility, case management, and service authorization system is used by the CCS program to provide administrative case management for CCS clients in the CCS Medi-Cal, CCS State Only, and CCS-Healthy Families programs. The costs for CCS clients in Medi-Cal are budgeted in the Medi-Cal Estimate.</p> <p><u>For FY 2008-09 the Medi-Cal CCS County Administration allocation which funds these reimbursements is \$118,596,000 TF. For FY 2009-10 the allocation is \$135,676,000 TF. County funds expended above the allocations on administrative activities in support of a county’s CCS/Medi-Cal caseload may be used as certified public expenditures to draw down Title XIX federal financial participation.</u></p>
R 22	(PC-142)	X	X	<p><u>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>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 23	(OA-7)	X	X	<p><u>Postage and Printing – Third Party Liability</u></p> <p>The Department 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 ensure 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 24	(OA-18)	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 25	(PC-130)	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>
R 26	(PC-111)	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, 2007, premiums were \$410 for Part A and \$93.50 for Part B. Premiums were set at \$423 and \$96.40, respectively, beginning January 1, 2008. The premiums for Calendar Year 2009 are estimated to be \$436 \$443 and \$99.40 \$96.40, respectively.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 27	(OA-48)	X	X	<u>Immunization Registry</u>
<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 claimed 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 28	(OA-54)	X	X	<u>PIA Eyewear Courier Service</u>
<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 with DHL Express, Incorporated, expired in August 2008.</p> <p>PIA began transitioning to a new courier company, Sacramento Overnight, Incorporated (SOI), on July 1, 2008. The transition was completed by September 19, 2008.</p> <p><u>The Department will stop providing optometry/optometrist services to adults over 21 years of age or older who are not in nursing facilities, except for pregnant women, beginning July 1, 2009. As a result, packages shipped are expected to decrease in FY 2009-10.</u></p>				

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 29	(OA-15)	X		<p><u>MIS/DSS Interim Operations</u></p> <p>The MIS/DSS contract with Medstat expired on January 17, 2007. To ensure the availability of the critical data in the MIS/DSS database while the new system is developed, implemented and accepted, the Department hired California Multiple Award Schedule (CMAS) contractors 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 and has been tested with complete documentation including review, comparison, and validation of data sources from the interim system to the new data warehouse which was completed in July 2008. This interim operation provides status quo operations, and is used to benchmark the new system. However it does 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>
R 30	(OA-36)	X	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 CDPH budget.</p>
R 31	(PC-35)	X	X	<p><u>Unspecified Budget Reduction</u></p> <p>The Budget Act of 2008 2009 included an unspecified reduction in the Medi-Cal budget of \$646.6 \$841.7 million TF (\$323.3 million GF) for FY 2008-09 2009-10. For FY 2009-10, an unspecified reduction of \$646.6 million TF (\$323.3 million GF) has been included.</p>
R 32	(OA-27)	X	X	<p><u>Data Center Cost Reduction</u></p> <p>Control Section 15.25, Budget Act of 2007 (Chapter 171, Statutes of 2007), provides that the Director of Finance may adjust amounts in any appropriation item resulting from changes in rates for data center services approved by the Technology Services Board in the 2007 or 2008 calendar year. There will be small reductions in costs for FY 2008-09 and FY 2009-10.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 33	(PC-121)		X	<p><u>ICF-DD Transportation and Day Care Costs - CDDS</u></p> <p>Beneficiaries that reside in Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) also receive active treatment services from providers located off-site from the ICF/DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars. The Department has submitted a SPA to the CMS requesting FFP for the active treatment and transportation costs.</p> <p>Upon federal approval, FFP will be paid to the CDDS for the transportation and day care costs for the ICF-DD beneficiaries. These costs may be retroactive back to July 1, 2007.</p>
R 34	(OA-28)	X	X	<p><u>Reduction to EPSDT Case Management by 10%</u></p> <p>Effective July 1, 2008, the Department will reduce reduced the funding for EPSDT Case Management by 10%. Medi-Cal provides funding for the county administration of the CHDP Program for those children who receive CHDP screening and immunization services who 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.</p>
R 35	(PC-83)	X	X	<p><u>Reduction to Non-Contract Hospitals</u></p> <p>Effective for dates of service on or after July 1, 2008, as required by ABX3 5 (Chapter 3, Statutes of 2008), Medi-Cal payments to non-contract hospitals will be reduced by 10%. Effective October 1, 2008, as required by the Health Trailer Bill of 2008, Non-SPCP hospitals are exempt from this reduction. Non-SPCP hospitals will be reduced to the lower of the average regional rate established by the California Medical Assistance Commission (CMAC) minus five percent or to the hospital's interim rate minus ten percent. Effective November 1, 2008, as required by the Health Trailer Bill of 2008, small and rural hospitals are exempt from this reduction. Medi-Cal managed care plans have incorporated this reduction in their FY 2008-09 rates.</p>
R 36	(PC-153)	X	X	<p><u>Discontinue Part B Premium for Unmet SOC Beneficiaries</u></p> <p>Effective November December 1, 2008, the Department will eliminate eliminated payment of the Medicare Part B premiums for Medi-Cal unmet SOC beneficiaries who have a SOC greater than \$500.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 37	(OA-29)	X	X	<p><u>Reduction to MIS/DSS Contract by 25%</u></p> <p>Effective July 1, 2008, the Department will reduce the funding for the MIS/DSS Contract operations costs by 25%.</p>
R 38	(PC-31) (OA-23)		X	<p><u>DME Contracting Project</u></p> <p>The Department will enter into a competitive bid procurement process to contract with an organization on a pay-for-performance basis to reduce durable medical equipment (DME) costs. The scope of work would be developed in two phases. Phase two builds on phase one and each phase provides a deliverable which can be used by the Department as a stand-alone product that enables the Department to integrate the product into its development plan if it chooses.</p> <p>The Department will require a pay-for-performance option for the DME Contracting Project under which no payments would be made to the contractor until actual savings are realized and validated by the Department. The Department will acquire this service contract through a competitive bid process. The maximum payable to the contractor is \$990,000. The first \$360,000 in savings will go to the contractor. Savings above \$360,000 will be split 50/50 up to the maximum of \$990,000 paid to the contractor. The contractor began work on the project in October 2008. Contracting costs and services savings would not begin until FY 2009-10.</p>
R 39	(PC-129)	X	X	<p><u>Non-Contract Hospital Inpatient Cost Settlements</u></p> <p>All non-contract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the non-contract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 40	(PC-75)	X	X	<u>FQHC/RHC Reconciliation Process</u>
<p>The Medi-Cal reimbursement policy for Federally Qualified Health Centers/Rural Health Clinics (FQHC/RHCs) participating in the Medi-Cal PPS is applied as follows:</p> <p>Each FQHC/RHC has an individual PPS rate for its Medi-Cal clinic visits. For the FQHC/RHC visits from beneficiaries enrolled in managed care plans or dual eligible beneficiaries, an interim rate is established in order for the clinic to be reimbursed the difference between the Medi-Cal PPS rate and the payments received from managed care plans and Medicare. There is no established interim rate for CHDP visits.</p> <p>The difference between the interim rate and the payments from managed care plans and Medicare, and the difference between the PPS rate and the payments from CHDP, is reconciled by an annual reconciliation request that is filed by each FQHC/RHC within 5 months of the close of their fiscal period.</p> <p>A tentative settlement is prepared by the Department after review of the reconciliation request. Within three years after the date of submission of the original reconciliation report, as required by W & I Code § 14170, a final audit is performed and either a final settlement or recovery invoice is prepared.</p>				
R 41	(OA-13)	X	X	<u>HIPAA Capitation Payment Reporting Project</u>
<p>The Department currently pays contracted managed care health plans through a manual process which is only capable of reporting capitation amounts at the aid code level or above. HIPAA mandates that these types of payments be reported using a standard HIPAA transaction (820 Premium Payments transaction). The currently implemented version of the 820 transaction is compliant; however, business processing requires that more detail be included on the transaction.</p> <p>This project will make significant improvements to the existing capitation calculation process, allowing capitation reporting to be detailed at the beneficiary level and implementing automation of aspects of the calculation process. The resulting 820 HIPAA transaction will be able to report data at the same level enabling monthly reconciliation between Medi-Cal and the contracted managed care plans to be much more effective. The electronic storage of the data will also support research efforts to perform recoveries from the estates of deceased Medi-Cal beneficiaries.</p>				

OTHER: RECOVERIES: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
RC 0.1 (PC-199)		X	<u>IHSS Anti-Fraud Initiative</u> Effective July 1, 2009, the Department will conduct statewide program integrity reviews to validate the services billed to the Medi-Cal program by IHSS providers. This program will consist of DHCS investigators, other state staff and county IHSS social workers conducting unannounced home visits to IHSS recipients and their providers.
RC 0.2 (PC-186)		X	<u>Anti-Fraud Initiative</u> Effective July 1, 2009, the Department proposes to expand its anti-fraud activities. The activities will focus on adult day health care (ADHC) services, pharmacy services and physician services.

OTHER: RECOVERIES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
RC 1	(PC-140) (PC-145) (PC-152) (PC-154)	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, random claims reviews, field audits, desk audits, self audits 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-155)	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	(OA-49)	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>
RC 4	(PC-148)	X	X	<p><u>Medical Support Enhancements</u></p> <p>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. Implementation of the California Child Support Automation System (CCSAS), which will allow for automated reporting of other health coverage, was delayed due to problems with the record creation process. Implementation began in March 2008. Savings began in April 2008.</p>

OTHER: RECOVERIES: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
RC 5 (PC-138)	X	X	<p><u>Personal Injury - Recovery of Federal Repayments</u></p> <p>In 1993, a federal audit of the Personal Injury Recovery program found that the Department did not give the CMS its full financial credit from personal injury settlements and awards during the period of July 1988 through July 1992. Instead, the Department allowed Medicaid recipients to keep amounts received from third party sources prior to Medicaid's full recovery of FFP (W&I Code Sections 14124.71(b) and 14124.78, also known as the "50 percent rule"). One of the audit recommendations required the Department to establish procedures to ensure that the federal government is given full credit for third party settlements and awards in accordance with federal laws.</p> <p>In October 2007, CMS followed up on its 1993 audit and requested <u>determined that</u> the Department <u>had not established procedures to ensure full recovery of FFP. CMS requested the Department to</u> assess how much FFP should have been paid to CMS for cases where the 50 percent rule and hardship waivers <u>compromise reduction</u> were applied from July 1992 to present. In response, the Department performed an internal audit and found that CMS should have received approximately 4.9 percent more of what the Department recovered for the period October 2003 to December 31, 2007. <u>For the period of July 1992 through December 2008, the</u> Department estimates <u>identified</u> that it owes CMS \$30.7 million for the period of July 1, 1992 to December 31, 2007 <u>\$32,679,000</u> and will refund <u>repay</u> this amount to CMS during FY 2008-09.</p> <p>In addition, CMS has requested that the Department <u>continue to</u> determine, on a quarterly basis, how much it owes for cases where the 50 percent rule applies, beginning with the quarter ending March 31, 2008. <u>The Department has found that it owes CMS approximately \$600,000 for the quarter ending March 31, 2008, and will make this refund in FY 2008-09. and the hardship compromise reduction apply.</u> Additional amounts on claims settled by the 50 percent rule and hardship waivers <u>compromise reduction</u> are estimated to cost \$2.4 million GF annually</p>
RC 6 (PC-136)		X	<p><u>Estate Recovery – Medicare Premiums</u></p> <p>House Resolution 6331, the Medicare Improvement for Patients and Providers Act of 2008, which became law on July 15, 2008 (Public Law No: 110-275), prohibits states from recovering Medicare cost sharing amounts (including Medicare premiums) from deceased Medicaid beneficiaries' estates, effective January 1, 2010. Seventy-four percent of the Department's Estate Recovery (ER) claims include Medicare premiums. Medicare premiums comprise approximately 6.6 percent of the total claims received.</p>

FISCAL INTERMEDIARY: EDS: NEW ASSUMPTIONS

Applicable F/Y

C/Y B/Y

FI 0.1 (PC-FI) X CA-MMIS Takeover by New FI Contractor

CA-MMIS is the medical claims processing system used for Medi-Cal, and is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal providers. The current medical FI contract is ending on June 30, 2010 and an RFP is currently in progress to establish a new FI contract. Upon award of a new Medi-Cal FI contract, the new FI is required to complete contract required activities necessary for the assumption of operations from the current contractor. The takeover activities of the new contractor are scheduled to begin ~~October~~ **December** 1, 2009 and will be bid as part of the FI RFP.

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 1	(PC-FI)	X	X	<u>Insurance Identification Contracts</u>
<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. The Department is currently engaged in procurement to award awarded the Other Health Coverage Identification and Recovery Project contract, for the next cycle which will begin began in January 2009.</p>				
FI 2	(PC-FI) (PC-146)	X	X	<u>EDS Cost Containment Proposals – Savings Sharing</u>
<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>				

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 3	(PC-FI)	X	X	<u>HIPAA – Provider Relations</u>
<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>				
FI 4	(PC-FI)	X	X	<u>BIC Production and Postage</u>
<p>Costs for production and mailing of Medi-Cal Benefits Identification Cards are paid through the Fiscal Intermediary.</p>				
FI 5	(PC-FI)	X	X	<u>Expansion of Drug Rebate Program</u>
<p>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.</p>				

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 6	(PC-FI)	X	X	<p><u>HIPAA UPN Exception Request</u></p> <p>The <u>Implementation of the original scope of the</u> Universal Product Number (UPN) <u>pilot</u> project was cancelled <u>in March of 2006</u> because it was determined that the modifications to the current California Medicaid Management Information System (CA-MMIS) infrastructure would be too costly and could not be implemented in an efficient manner. Further analysis determined that in order to implement the use of the UPN into a claims processing environment, it would be necessary to bring forth new technology in order to allow for the system to be flexible, cost effective and easily modified for future requirements. Until the design of the new CA-MMIS infrastructure can occur, DNCS needs to move forward with implementing HCPCS codes in order to meet HIPAA compliance. However, DHCS has received approval to incorporate the use of the UPN wherever possible to improve claims payment accuracy and reduce program costs.</p> <p>While the UPN project has been cancelled, the code conversion project for medical supplies will continue and will convert medical supply codes to the HCPCS code standard required by HIPAA.</p> <p><u>The Department received 90% funding approval from CMS to revise the scope of the UPN pilot in order to reduce costs and to leverage system changes needed to comply with the Federal Deficit Reduction Act of 2005 which mandates the collection of rebates for physician administered drugs using the NDC. Changes are scheduled for implementation on April 1, 2009, followed by a two-year evaluation period of the UPN pilot project.</u></p>
FI 7	(PC-FI)	X		<p><u>AB 3029 Medi-Cal Billing Requirements - Benefit Identification Cards</u></p> <p>AB 3029 (Chapter 584, Statutes of 2004) prohibits the use of a beneficiary's Social Security Number (SSN) for billing Medi-Cal and requires providers to use the 14-digit Benefit Identification Card (BIC) ID. AB 3029 excludes certain providers and services from this billing requirement. System changes to enforce the AB 3029 billing requirements were implemented in February 2008.</p> <p>AB 381 (Chapter 265, Statutes of 2007) requires the Department to implement an automated HIPAA-compliant system that enables a provider to access a Medi-Cal beneficiary's 14-digit BIC ID for the purpose of billing Medi-Cal. Once the Department establishes the automated HIPAA-compliant system, all current exemptions to the prohibition of using the SSN for billing can be discontinued. The HIPAA-compliant system changes were implemented on October 27, 2008.</p> <p>The policy and system changes for the billing exemptions will be implemented in early 2009 to allow for sufficient provider notification.</p>

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 8	(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 (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, 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, 2008 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 Revisions (~~NPRM pending~~ **Final Rules published January 16, 2009**)

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 began in October 2003 and the remaining transactions and code conversions will continue to be phased-in and implemented ~~through June 2010~~. **The January 16, 2009 published HIPAA rules will require MMIS changes in order to incorporate updated transactions for Medi-Cal and prescription drug claims by the federal compliance date of January 1, 2012. The final rules also require the implementation of a new diagnosis and inpatient hospital procedure coding standard, ICD-10, by October 1, 2013.**

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 9	(PC-NA)	X	X	<u>Extension of the EDS Contract</u>
<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 10	(OA-16)	X	X	<u>Medicaid Information Technology Architecture (MITA) Assessment</u>
<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 has hired a contractor that is using used 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>				
FI 11	(OA-9)	X	X	<u>CA-MMIS Replacement and Oversight Contractors</u>
<p>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, is extremely complex, difficult to maintain, and nearing the end of its useful life cycle. 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 which recommends that modernization of CA-MMIS begin immediately. Therefore, the Department will contract with various vendors to assist with development of Request for Proposal (RFP) language for current and replacement CA-MMIS maintenance and operations, documentation of business rules, IT evaluation assistance, project management assistance during transition and IV&V assistance for the replacement system.</p>				

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
FI 12 (OA-8)	X	X	<p><u>MEDS Replacement Contractor</u></p> <p>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 27 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, an 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 two vendors to help analyze the existing functionality of the system and help develop detailed business requirements to provide necessary information for RFP and FSR development.</p>
FI 13 (PC-FI)	X	X	<p><u>Reduction to FI Systems Group</u></p> <p>Effective July 1, 2008, the Department will reduce reduced the FI Systems Group by 70 system analysts and programmers from the current level of 190 positions to 120 positions.</p>
FI 14 (PC-FI)	X	X	<p><u>Reduction to CA-MMIS Modification</u></p> <p>Effective July 1, 2008, the Department will reduce reduced the CA-MMIS Modification expenditures</p>
FI 15 (PC-FI)	X	X	<p><u>Transition to Electronic Media Transfer (EMT)</u></p> <p>Effective July November 1, 2008, the Department will reduce reduced the cost reimbursement for Print, Postage and Parcel due to the transitions of hardcopy provider bulletins, manuals, and notification of information to an EMT format, allowing access via the Internet.</p>
FI 16 (PC-FI)	X	X	<p><u>Discontinue Vector Messages on TSC Provider Phone Lines</u></p> <p>Effective July 4 October 3, 2008, the Department will eliminate eliminated recorded vector messages from provider call lines.</p>
FI 17 (PC-FI)	X	X	<p><u>Medi-Cal Fiscal Intermediary Contract Turnover</u></p> <p>The Turnover period is to ensure an orderly transfer of the Medi-Cal Fiscal Intermediary contract from the current contractor to the successor contractor at the end of the contract. The period of extended operations is projected to end June 30, 2010. Turnover activities began January 1, 2008.</p>

FISCAL INTERMEDIARY: EDS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 18	(OA-21)		X	<u>CA-MMIS Takeover – Other State Transition Costs</u>
<p>CA-MMIS is the claims processing system used for Medi-Cal. The current FI contract is ending on June 30, 2010 and an RFP is currently in progress to establish a new FI contract. In the event the incumbent loses and the contract is awarded to a new FI contractor, additional costs will be incurred to support two vendors during Takeover of the existing system. This transition would occur during FY 2009-10. The Department will be required to obtain additional consultative contractor resources for setup, testing activities and management of new environments in support of transition activities from the incumbent FI contractor to a new FI contractor. CA-MMIS Takeover activities include mission critical systems such as MEDS, EMBER, and PCES applications. CA-MMIS is a mission critical system that must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during Takeover.</p>				

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

- *Conlan v. Bontá; Conlan v. Shewry*

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: NEW ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
HO 0.1(PC-FI)	X	<p><u>Additional Contractual Services (ACS) – Informing Materials/DVDs</u></p> <p>ACSs are additional services the Department elected to incorporate into the HCO contract. The HCO contract contains ten ACSs. Each ACS has a Design, Development and Implementation (DD&I) phase. Once the DD&I phases are complete, the ACSs will be incorporated into standard contract operations. Beginning in FY 2009-10, the Department plans to implement two ACSs.</p> <p>Review of Health Care Options Informing Materials – The Enrollment Broker will review all HCO informing materials and present a report to the Department with recommendations to improve readability and accuracy. Improved informing materials are expected to increase the choice rate and the beneficiaries’ understanding of the program.</p> <p>Multi-Media Informing Materials (DVDs) Enhancement - Introducing the HCO program into the beneficiary’s home enhances their ability to make an informed choice. This DVD-based delivery will guide them through HCO informing materials and show beneficiaries that their choice is important.</p>
HO 0.2(PC-FI)	X	<p><u>Additional Contractual Services (ACS) – Initial Health Screen Questionnaire</u></p> <p>The Department will implement the Initial Health Screen Questionnaire ACS beginning in FY 2009-10. This questionnaire will help ensure that applicants and beneficiaries with existing disabilities or chronic conditions identify themselves so as to receive immediate access to care. The questionnaire will be mailed within the HCO informing packet and will be available at Enrollment Presentation Sites. This ACS is consistent with the Department’s continued commitment to serve this population.</p>

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
HO 1 (PC-FI)	X			<p><u>Turnover of Existing Health Care Options Contract</u></p> <p>The Turnover period is to ensure an orderly transfer of the HCO contract from the current contractor to the State or successor contractor at the end of the contract. The period of extended operations is projected to end December 31, 2008. Turnover activities began January 1, 2007.</p> <p>Due to a delay in the evaluation of the Request for Proposal for the new contract, Turnover, <u>which began on January 1, 2007</u>, was suspended <u>on</u> June 29, 2007, and resumed on April 1, 2008. <u>Turnover activities will end on March 31, 2009.</u></p>
HO 2 (PC-FI)	X	X		<p><u>Personalized Provider Directories</u></p> <p>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 Health Trailer Bill of 2007 authorized the implementation of a Personalized Provider Directory as a pilot project in one Two-Plan Model county (Los Angeles) and one GMC county (Sacramento). The content and format of the Personalized Provider Directories will be determined in consultation with health plans and stakeholders. <u>The pilot project will begin in March 2009 and will continue for a period of two years.</u> At the end of the pilot project period (December <u>January 31, 2010 2011</u>), 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, and if they should be implemented statewide in all managed care counties. This determination will be based on the outcomes set forth in the evaluation provided to the Legislature. If necessary, the pilot project will continue beyond the initial two year period until this determination is made.</p>
HO 3 (PC-FI)	X	X		<p><u>Takeover of New Health Care Options Contract</u></p> <p>The current Health Care Options (HCO) contract 01-15932 ends December 31, 2008. Takeover activities, which start nine months prior to the end of the current HCO enrollment broker contract, began in April 2008. There will be an overlap between the current contract (Operations and Turnover) and the new contract (Takeover). <u>Takeover of the new HCO contract began April 1, 2008, and final payment is expected to be made in early FY 2009-10.</u></p>

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 4(OA-59)	X		<u>HCO Takeover Consultant Contract</u>

The Department is processing the contract Takeover functions under the new Health Care Options contract through a **Project Management** consultant contract during FY 2008-09. This contract ~~expires~~ **expired** at the end of March 2009. The ~~Project Manager~~ consultant is responsible for providing project management services (e.g., risk management, issue management, quality assurance, change management, resources management, and configuration management) as the new Enrollment Broker assumes the operation of the Health Plan Enrollment System. The Project Manager works closely with the Department to ensure the success of the project.

FISCAL INTERMEDIARY: DELTA DENTAL: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
DD 0.1(PC-FI)		X	<u>Medi-Cal Dental FI Contract Turnover</u> The Turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, in addition to supporting the Department's procurement effort by ensuring that all required system documentation is included in the Office of Medi-Cal Procurement's data library. Turnover support services will commence on January 1, 2010.
DD 0.2 (PC-FI)		X	<u>Elimination of Optional Medi-Cal Benefits, Temporary Call Center</u> As required by ABX3 5 (Chapter 20, Statutes of 2009), effective July 1, 2009, the Department will no longer provide specified services for adults 21 years of age or older who are not in nursing facilities and excluding pregnant women. Notifications of these changes will be mailed to beneficiaries in mid to late May 2009. The Department anticipates that the notices will generate inquiries from beneficiaries. As a result, the Department determined that it is necessary to establish a temporary call center for up to three months, specifically for the purpose of answering beneficiary questions about the elimination of these benefits. The expanded call center capability will be available through the Dental Fiscal Intermediary.

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 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). The advance planning document updates (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, 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)
- 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 Revisions (~~NPRM pending~~ **Final Rules published January 16, 2009**)

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 transactions (in terms of provider impact), code sets, and NPI first, without interrupting payments to providers or services to beneficiaries. **The January 16, 2009 published HIPAA rules will require CD-MMIS changes in order to incorporate updated transactions for dental claims by the federal compliance date of January 1, 2012.**

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 \$115,600,000 \$140,755,000	ICF-DD Quality Assurance Fee Skilled Nursing Facility Quality Assurance Fee (AB 1629) Total
FY 2005-06: \$ 27,582,000 \$234,447,000 \$231,893,000 \$493,922,000	ICF-DD Quality Assurance Fee Managed Care Quality Improvement Assessment Fee Skilled Nursing Facility Quality Assurance Fee (AB 1629) Total
FY 2006-07: \$ 27,136,000 \$241,238,000 \$247,406,000 \$512,205,000	ICF-DD Quality Assurance Fee Managed Care Quality Improvement Assessment Fee Skilled Nursing Facility Quality Assurance Fee (AB 1629) Total
FY 2007-08: \$ 22,783,000 \$239,967,000 \$274,300,000 \$537,742,000	ICF-DD Quality Assurance Fee Managed Care Quality Improvement Assessment Fee Skilled Nursing Facility Quality Assurance Fee (AB 1629) Total
FY 2008-09: \$ 44,884,000 \$ 18,623,000 \$ 239,877,000 \$251,921,000 \$ 289,387,000 \$282,424,000 \$544,148,000 \$552,968,000	ICF-DD Quality Assurance Fee Managed Care Quality Improvement Assessment Fee Skilled Nursing Facility Quality Assurance Fee (AB 1629) Total
FY 2009-10: \$ 17,584,000 \$ 19,246,000 \$ 59,969,000 \$ 65,867,000 \$ 292,621,000 \$287,263,000 \$ 28,325,000 \$ 370,174,000 \$400,701,000	ICF-DD Quality Assurance Fee Managed Care Quality Improvement Assessment Fee Skilled Nursing Facility Quality Assurance Fee (AB 1629) Additional Skilled Nursing Facility Quality Assurance Fee (AB 1629) Total

The Budget Act and Health Trailer Bill of 2004 required managed care plans to pay a Quality Improvement Fee (QIF) to the State and, in turn, the State repays the plans through increased reimbursements. Since Medi-Cal costs are split between the state and federal government, this mechanism allows the state to draw down additional federal funds. The QIF provision will sunset in October 2009.

Effective August 1, 2009, the Department will expand the amount of revenue upon which the quality assurance fee is assessed, to include Medicare.

INFORMATION ONLY:**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.

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 1999-00 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 1999-00 base year, no fiscal impact is expected in FY ~~2005-06~~ **2008-09** and FY ~~2006-07~~ **2009-10** due to the spending limit.

3. Accelerated Enrollment for Foster Care

AB 430 (Chapter 171, Statutes of 2001), the Health Trailer Bill of 2001, added Section 14007.45 to the W&I Code to require the Department to submit for federal approval, a SPA to implement accelerated eligibility (also known as presumptive eligibility or PE) for children just entering the foster care system. The Department determined that federal approval of a SPA was unlikely at the time. 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 issuance of this ACWDL has not achieved the anticipated outcome. CMS has subsequently provided guidance on a modification to the State Plan that is likely to be approved. A SPA is now under development and will be submitted to CMS. The SPA will request approval to expand the definition of the "qualified entities" allowed to determine PE to foster care youths to include social workers, probation officers, and public health nurses.~~

INFORMATION ONLY:4. 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 **which is not premised upon federal eligibility criteria** and costs solely ~~existing~~ **resulting** due to domestic partnerships will be State-only funded. The costs are expected to be insignificant.

5. 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. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. ~~The President's Budget~~ **ARRA** has extended the QI-1 program through December 31, ~~2009~~ **2010**.

6. 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 and/or hours 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. The current sunset date is ~~June 30, 2009~~ **has been extended to December 31, 2010 by ARRA**.

7. 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.

INFORMATION ONLY:

8. 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.

9. ISAWS Migration to C-IV County Administrative Costs

The thirty-five counties using the ISAWS system to determine eligibility will migrate to the C-IV system beginning in 2008-09. This system is newer and has many features not available in ISAWS. The system costs associated with this migration are budgeted through the State Department of Technology Services and the CDSS. Only the federal funding for the Medi-Cal related share of the system costs is included in the CDHS budget. The ISAWS migration costs are currently identified in the SAWS policy change in the County Administration Section.

There may 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. Migration to the C-IV system may result in the counties requesting additional staff, which will reduce productivity, at least initially, and increase costs.

INFORMATION ONLY:

10. Deficit Reduction Act of 2005 – Transfer of Assets Provisions

The Deficit Reduction Act of 2005 (DRA), enacted February 8, 2006, **and SB 483 (Chapter 379, Statutes of 2008)**, ~~makes~~ **made** 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:

11. Deficit Reduction Act of 2005 – Treatment of Annuities

The Department will propose legislation for **SB 483 (Chapter 379, Statutes of 2008) made** 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.

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

The Department will propose legislation for **SB 483 (Chapter 379, Statutes of 2008) made** 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.

13. Deficit Reduction Act of 2005 – Entrance Fees Paid to Continuing Care Retirement Communities and Life Care Communities

The Department will propose legislation for **SB 483 (Chapter 379, Statutes of 2008) made** 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.

14. CalWORKS Budget Reduction

The Governor's 2008-09 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.

INFORMATION ONLY:

15. 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. The requirements for this program will be implemented by an ACWDL.

16. Determining Medi-Cal Eligibility for County Wards

SB 1469 (Chapter 657, Statutes of 2006) requires, effective January 1, 2008, all county juvenile detention facilities to provide information to county welfare departments that will enable them to determine Medi-Cal eligibility for wards immediately upon release. Wards who are subject to this requirement are youths who have been committed to a county juvenile hall, camp, or ranch, for 30 days or longer by a juvenile court. The legislation is not expected to result in significant costs to the Medi-Cal program. This requirement was implemented by All County Welfare Directors Letter 07-34.

17. PARIS –Veterans Match

The federal Public Assistance and Reporting Information System (PARIS) is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS system includes three different data matches. The PARIS-Veterans match allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs. The PARIS-Federal match allows states to compare their beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management. The PARIS-Interstate match allows states to compare their beneficiary information with other states.

The PARIS-Veterans match would allow the Department to improve the identification of veterans enrolled in the Medi-Cal program. Improved veteran identification would enhance the Department's potential to shift health care costs from the Medi-Cal program to the United States Department of Veterans Affairs (USDVA). The Department is implementing a Veterans Match Pilot Program that would filter the PARIS match results and focus outreach efforts on veteran Medi-Cal beneficiaries receiving long term care services in three counties. The Department would refer high-cost beneficiaries to County Veteran Services Officers (CVSOs) who would inform them and assist them in obtaining USDVA health coverage. The PARIS-Veterans Match pilot program would begin in July 2009, and workload would be absorbed by existing Department staff. Potential savings cannot be determined at this time.

The Department is planning to implement a pilot program of the PARIS-Interstate and PARIS-Federal matches, effective July 1, 2009. Savings associated with this pilot program are budgeted in the Program Integrity and Verification Policy Change.

INFORMATION ONLY:**18. SB 437 – Health Care Coverage**

SB 437 (Chapter 328, Statutes of 2006) requires the Department to implement a process that allows applicants and beneficiaries to self-certify income and assets. It also requires the Department to establish the Medi-Cal and Healthy Families Presumptive Eligibility Program and the Medi-Cal and Healthy Families Accelerated Enrollment Program and to conduct a feasibility study report to implement a WIC Gateway. The Department, in conjunction with the CDPH and the MRMIB, is required to implement these programs in order to streamline, simplify, and enhance the application process for Medi-Cal and HFP. Implementation has been delayed due to budget constraints.

19. Same Sex Marriage Court Order

The California Supreme Court ruled that the statutory requirement that a marriage is only between a man and a woman is unconstitutional. Potentially, this provides access to State-Only Medi-Cal programs to individuals in same-sex marriages in the same manner and extent to which those programs are accessible to individuals in opposite sex unions. The Department will issue ~~a dual~~ **an ACWDL for both the Domestic Partner Act and interim instructions for the Same Sex Marriage order until a court decision is released on Proposition 8**, as both will be applied to state-only Medi-Cal programs at this time. The Estate Recovery (ER) program is one of several controls adopted by Congress and the Legislature to mitigate Medi-Cal costs. State and federal law require the Department to seek recovery of Medi-Cal costs from the estates of deceased Medi-Cal beneficiaries or from anyone receiving estate assets after the death of a beneficiary. ~~Effective immediately, the~~ **The ER claim is deferred until after death of the surviving same sex or domestic partner spouse. The net impact to the Department is unknown at this time.**

20. Lomeli, et al., v. Shewry

The Department is currently negotiating a settlement of the *Lomeli, et al., v. Shewry* lawsuit. ~~which claims **The petitioners in Lomeli allege** that the Department does not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage, and would require **and demand** the Department to allow **provide** those applicants **an a meaningful** opportunity to apply for retroactive Medi-Cal coverage. Once **if** a settlement is reached, the Department will either need to amend its current agreement with SSA, or send out notices to all SSI beneficiaries **applicants** informing them of the availability of retroactive coverage. The SSA indicates that amending the agreement will result in increased workload and will require additional payment to SSA to cover the cost of SSI's increased workload. Once the Department receives records from SSA that a person has indicated that they had medical expenses in the three months prior to the application, a notice will be sent to the applicant informing them of the availability of retroactive coverage.~~

21. SB 1147 – Limited Suspension of Medi-Cal Eligibility for Incarcerated Minors

SB 1147 (Chapter 546, Statutes of 2008) requires suspension of Medi-Cal eligibility for up to one year if a Medi-Cal beneficiary under the age of 21 becomes an inmate of a public institution. Specifically, the suspension becomes effective on the date of incarceration and lasts for up to one year unless the inmate is released sooner. The statute mandates the Department to implement the new requirement by January 1, 2010. This will require implementation of MEDS changes to suspend rather than terminate Medi-Cal eligibility in accordance with the new law. This legislation is not expected to result in significant costs to the Medi-Cal program.

INFORMATION ONLY:

22. CHIPRA – Miscellaneous Provisions

CHIPRA includes a requirement to provide U.S. citizens with the same reasonable opportunity to provide citizenship and identity documents as is currently provided for immigrants to provide immigration status documents. Under this new rule, citizens will be provided a reasonable opportunity period or the time it takes to determine eligibility, whichever is longer, to provide evidence of citizenship and identity. During this time citizens will be eligible for full scope Medi-Cal if they meet all other eligibility requirements. Under current rules, citizen applicants do not receive any benefits until evidence of citizenship has been provided. Otherwise eligible citizens who are unable or unwilling to provide citizenship or identity documents only receive restricted scope Medi-Cal limited to emergency, pregnancy and long-term care services. Implementation of this new requirement will result in full scope Medi-Cal for otherwise eligible citizen applicants while they obtain citizenship and identity documents. This requirement is effective immediately. The Department is not able to assess the cost at this time because the number of citizen applications processed is not available. However it is not anticipated that program costs will increase as under current rules once a citizen applicant provides evidence of citizenship, eligibility is granted retroactive to the date of application.

CHIPRA includes a performance enrollment bonus if the state meets five of eight simplified enrollment and retention processes. California cannot claim the bonus if it does not meet these criteria or if it receives increased FMAP in any month in which the state has more restrictive eligibility criteria than what was in effect on July 1, 2008. The Department believes it meets these requirements and anticipates receiving the performance enrollment bonus after June 2010.

CHIPRA bars states from preventing an FQHC from entering into a contractual relationship with private practice dental providers in the provision of FQHC services. To the extent private practice dental providers enter into such contracts, it is unclear whether this provision would require payment at the PPS rate paid to FQHCs or at the State Plan rate under FFS. The Department will seek guidance from CMS on this issue.

INFORMATION ONLY:**BENEFITS**1. Civil Rights of Institutionalized Persons Act

On August 3, 2004, following the settlement of the *Davis* lawsuit, the United States Department of Justice (USDOJ) issued a findings letter against the State to Governor Schwarzenegger. This letter set forth the USDOJ's detailed allegations and conclusion that the State has contributed to the inappropriate institutionalization of people at Laguna Honda Hospital (a large 1200 bed nursing facility in San Francisco). This federal investigation is conducted pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The USDOJ is requesting that the State 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 (with the assistance of privately retained counsel) is coordinating the State's defense during the federal investigation. 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 investigation is limited to Laguna Honda at this point, the concepts of state-wideness and comparability under the federal Medicaid Program would almost certainly require that any changes made at Laguna Honda must be applied to all nursing facilities statewide. These changes, if implemented, will result in significantly increased costs to the Medi-Cal program.

2. 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.

3. 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:

- The national HCPCS billing code associated with payment for telehealth transmission, based on time units, ~~will be~~ **was** activated **effective July 1, 2008**. ~~Rates will be developed based on three~~ **A single rate was developed for all** modes of transmission: Telephone line, Dedicated Line, or Wireless/Satellite.
- Providers operating as the "hub" site, the site at which the patient is located and the site at which the consulting provider 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 2008-09.~~ At this time, there is not enough information available to calculate the budget impact.

INFORMATION ONLY:

HOME & COMMUNITY BASED-SERVICES

1. 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~~ **institutionalized**, living in shelters or ~~institutionalized~~ **at risk of being homeless**. The City and County of San Francisco is providing county funds for State Administration and for matching federal funds provided under the waiver. The Department anticipates submission of a waiver application to CMS by ~~March 2009~~ **January 2010**, and CMS approval by ~~August 2009~~ **April 2010**, with implementation by ~~October 2009~~ **July 2010**.

2. AB 1410--Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007) to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds or if other sources of funding were available. There is currently no appropriation or monies in the Traumatic Brain Injury Account to initiate and sustain this pilot project.

FAMILY PACT

BREAST AND CERVICAL CANCER TREATMENT

PHARMACY

HOSPITAL FINANCING

INFORMATION ONLY:

MANAGED CARE

1. Managed Care Expansion

The Budget Act of 2005 included geographic expansion of managed care in 13 additional counties. Medi-Cal managed care was implemented in San Luis Obispo County on March 1, 2008, as a COHS. Two 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 has determined that the environment and timing do not appear optimal to continue expansion efforts in ~~four~~ **five** of the counties originally targeted for expansion (i.e., San Benito, El Dorado, Imperial, ~~and Marin~~ **and Placer**), and has removed them from the list below. The Department continues to work with the stakeholders in the ~~eight~~ **seven** remaining expansion counties.

Below is the proposed list of expansion counties:

<u>County</u>	<u>Plan Type</u>
Placer	GMC (March 2009)
Sonoma	COHS (July October 2009)
San Luis Obispo	COHS (Completed in March 2008)
Lake	COHS (Pending)
Mendocino	COHS (Pending)
Kings	Two Plan (October 2010)
Madera	Two Plan (October 2010)
Merced	COHS (July October 2009)
Ventura	COHS (Pending)

2. Family Planning Increased Federal Matching Funds

The Department ~~is examining various methodologies~~ **has completed an assessment of the methodology** to draw down enhanced federal funding for family planning services that are a component of the capitation rates paid to contracting managed care health plans. Currently, a 50% federal funding match is drawn down. Implementation of a new cost accounting methodology will result in 90% federal funds being available. **The Once the Department has consulted with CMS on the validity of the methodology and retroactive claiming, the** Department will **implement the new cost accounting methodology and** claim enhanced funding retroactively for a 24-month period and on an ongoing basis.

3. Maternity Supplemental Payment

The reimbursement structure for maternity services will be changed. Currently, maternity services are accounted for as part of Family and Adult capitation rates. The Department will initiate a separate maternity payment to the plans, and the capitation rates will be reduced accordingly. The maternity supplemental payments ~~are expected to~~ **may** begin in FY 2009-10.

INFORMATION ONLY:

4. ARRA – Payments for Services Provided by Certain Indian Health Care Providers

Under ARRA, non-Indian Medicaid managed care plans are required to make payments to participating and non-participating Indian health care providers, for services provided to Indian enrollees, at a rate equal to the rate negotiated between the managed care plan and the Indian health care provider. To the extent such a rate has not been negotiated, payment would be at a rate no less than what would have otherwise been paid to a participating provider who is not an Indian health care provider.

Additionally, for payments made by the Medicaid managed care plan, for services to Indian enrollees that are provided by Indian health care service providers that are FQHCs, but are not participating providers, payment would be the amount that the Medicaid managed care plan would pay a FQHC that is a participating provider but not a Indian health care provider.

Also, for Indian enrollees who receive services from Indian health care providers that are not FQHCs, whether they are participating or non-participating providers, to the extent the managed care payments to these providers are less than what would otherwise be required under the State Plan for that provider, the Medicaid managed care plan shall pay the amount required by the State Plan for that provider. California managed care contracts already require managed care plans, for services provided to Indian enrollees by non-FQHCs, to pay the State Plan rate for that facility.

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

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) 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). 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.

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. No hearing date has been set for the trial court to hear the parties' arguments in this case.

3. Mission Hospital Regional Medical Center et al. v. Shewry
Kaiser Foundation Hospitals et al. v. Shewry

The plaintiffs in the *Mission Hospital Regional Medical Center* 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 appealed the one issue it lost. ~~The case is now pending at the Court of Appeal, Third Appellate District.~~ **On November 20, 2008, the Court of Appeal, Third Appellate District issued a decision in which it held that the State had violated title 42 United States Code section 1396a (a)(13) in implementing section 32 (b). On December 29, 2008, the Department filed a petition for review with the California Supreme Court.**

INFORMATION ONLY:

4. California Association for Health Services At Home, et al., v. Sandra Shewry (Reworded)

Plaintiffs/Petitioners, an association of home health care providers, a home health care provider, and a disability rights advocacy group filed this lawsuit on April 27, 2004, and sought 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" and efficiency, economy, and quality of care ("EEQ") provisions; federal regulation (42 C.F.R. § 447.204) and the State Plan.

In March 2007, following an appeal of a trial court decision, the Court of Appeal issued a published decision holding that 1) the Department was required to review reimbursement rates for home health services annually for years 2001 through 2005 to ensure that they comply with the former State Plan provision incorporating 42 United States Code 1396a(a)(30)(A), and 2) the Department was not obligated to set new rates - i.e., for years after 2005.

The Department has completed a rate review believed to be consistent with the appellate court decision and has nearly completed the public notice, comment and review process as coordinated by the Office of Regulations. The rate review may be amended in light of the comments received. The final rate review incorporating the public notice, review and comment process will be submitted to the court in order to comply with the trial court's writ.

5. 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. ~~A court hearing is scheduled for August 25, 2008 on the plaintiff's motion for the court to invalidate the current rate methodology and order the Department to recalculate rates for rate years 2001-02 to present.~~ **On November 14, 2008, the trial court denied the plaintiff's motion for injunctive relief that would have invalidated the current rate methodology and required the Department to recalculate rates for the rate years 2001-02 to present. The plaintiff has both requested a new trial and also appealed this judgment.**

INFORMATION ONLY:6. Craig v. Bontá Deferral

As a result of an order issued against the Department in the litigation entitled *Craig v. Bontá* counties were instructed that Medi-Cal beneficiaries losing SSI/SSP based Medi-Cal on or after June 30, 2002, cannot have their Medi-Cal eligibility automatically discontinued. These cases must first be reviewed and evaluated for eligibility in other Medi-Cal programs using the three-step SB 87 redetermination process as codified in W & I Code section 14005.37. The three-step process includes, prior to beneficiary contact, an evaluation by the county to complete a Medi-Cal eligibility determination. If the county is unable to establish continued Medi-Cal without beneficiary contact the county must attempt to contact the beneficiary by telephone. If the county's effort to obtain the information necessary to redetermine eligibility is unsuccessful the county shall send the Request for Information Form (MC 355) to the beneficiary to ask for information necessary to establish continued Medi-Cal eligibility. The redetermination process set forth in W & I Code section 14004.37 and as ordered in the *Craig v. Bontá* litigation continues to be administered as part of the Medi-Cal Program.

The Department is responding to an April 1, 2003 – September 30, 2004 federal deferral of FFP for *Craig v. Bontá* Medi-Cal cases that CMS determined were ineligible for federal Medicaid funding. CMS estimated that the Department owes approximately \$17.6 million in FFP for the period prior to December 31, 2003. The Department believes there should be no repayment because *Craig v. Bontá* cases can take longer to process given the federal requirements for completing these reviews. The Department also believes the federal estimate should be no more than \$12 million based on Medi-Cal claims data from ineligible *Craig v. Bontá* beneficiaries. However, the Department may be required to pay back the FFP, depending on how the deferral is resolved.

7. Molina Healthcare Deferral

CMS contacted the Department to settle a long standing deferral of \$9 million in FFP involving Molina Healthcare, a Medi-Cal Managed Care provider, that goes back over 10 years and involves a short time period when Molina was a comprehensive HMO that did not meet the 75% rule. This rule required HMOs to serve no more than 75% Medicaid beneficiaries. This rule was repealed by Congress, which brought Molina into compliance. On March 27, 2008, CMS notified the Department that it is formally disallowing a reduced amount of \$2.5 million in FFP. The Department plans to appeal the disallowance, but will pay the \$2.5 million in FY 2008-09 to avoid interest costs in the event it loses the appeal. If the Department loses the appeal, it will recover the amount from Molina Healthcare, also in FY 2008-09. If the Department wins the appeal, it will receive the funds back from CMS and will not need to recover against Molina Healthcare.

8. Emily Q. – Special Master

The Department is engaged in implementation of the *Emily Q.* litigation. *Emily Q.* is a class action case for children in foster care that was filed in Federal Court in Los Angeles in 1999. The case was settled in 2002 and the parties have been working towards finalizing implementation pursuant to the stipulated settlement. The Department was ordered to provide individualized comprehensive home and community-based mental health benefits and services to Medicaid-eligible children as required under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The court ordered the parties to collaborate on a plan for increasing "therapeutic behavior services" (TBS) utilization, and appointed a special master to assist the parties in resolving the outstanding issues. ~~The court has now appointed a special master for an 18 month period. The appointment began in March 2008 and is set to expire in September 2009.~~ **The appointment for the special master will be extended through December 31, 2010.**

INFORMATION ONLY:9. City and County of San Francisco, County of Santa Clara v. Shewry (Reworded)

In October 2007, the City and County of San Francisco and County of Santa Clara filed a lawsuit to challenge the Department's policy terminating the eligibility of incarcerated juveniles and failing to pay for inpatient psychiatric services. SB 1147 (Chapter 546, Statutes of 2008) changed the law regarding termination of eligibility and allows counties to suspend eligibility for up to one year from the date of incarceration beginning in 2010. The Department continues to seek clarification from CMS that no FFP is available for services to incarcerated juveniles. The parties continue settlement discussions. The hearing on the writ is scheduled for November 2009.

10. Santa Rosa Memorial Hospital, et al. v. Sandra Shewry, Director of the Department of Health Care Services

On December 9, 2008, 17 hospitals filed a lawsuit contending the Medi-Cal payment reductions that the Department implemented violate various federal Medicaid laws, including 42 United States Code sections 1396a(a)(8) and 1396a(a)(30), the Supremacy clause and Equal Protection clause of the United States Constitution, the State Plan, and State law. The Medi-Cal payment reductions are mandated by W&I Code section 14166.245. The plaintiffs seek declaratory relief and a permanent injunction against the payment reductions.

OTHER: REIMBURSEMENTS1. 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 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.

3. Selective Provider Contracting Program Waiver Renewal

The 1915(b) waiver that authorized the 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 SPCP under the Medi-Cal Hospital/Uninsured Care Demonstration.

INFORMATION ONLY:4. 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 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.

5. 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 has implemented pilot projects with several county mental health plans to reduce unnecessary provider practice variability, including inappropriate prescribing of antipsychotic medications, through initiation of decision-support guidelines to facilitate appropriate 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. The Department has begun sharing protected health information with other state agencies to improve care for persons with serious mental illness (SMI) or serious emotional disturbance (SED).

Currently, evaluation of interventions to determine how to improve health outcomes and cost experiences in the use of drugs for mental illness is being conducted in several counties. Inappropriate use of drugs is a major driver of costs to Medi-Cal and decreasing inappropriate prescribing could result in savings if appropriate interventions are implemented system-wide as a result of this work. Additional studies to determine how to improve care, including prescribing of antipsychotic medications for children and youth with serious emotional disturbance, are nearing completion. Also nearing completion is the initial evaluation of the excess non-psychiatric hospitalization and emergency room costs attributable to persons with SMI compared to a similar Medi-Cal cohort without SMI. It is anticipated that the results of this work may be published and pilot interventions designed for implementation. Improvements in health outcomes and cost experiences will be tracked.

6. Katie A. v. Diana Bontá (Reworded)

On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, 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. On appeal, the Ninth Circuit Court ruled in favor of the State Defendants, reversed the granting of the preliminary injunction and remanded the case to District Court. The District Court is now reviewing each component service of wraparound and TFC services to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program effectively provides each mandated component service. The court has ordered the parties to conduct meetings to resolve questions regarding coverage of Wraparound process component services and to stipulate to the appointment of the special master. Further, while the court has refused to issue a preliminary injunction, the court will allow the plaintiffs to refile such a motion in the future.

INFORMATION ONLY:

7. 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.

8. 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.

9. Accrual Costs Under Generally Accepted Accounting Principles

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to accrual. For the most recently completed fiscal year (FY 2007-08), the June 30, 2008 Medi-Cal accrual amounts were estimated to be \$2.3 billion state General Fund and \$3.3 billion federal funds, for a total of \$5.6 billion.

INFORMATION ONLY:

10. Freestanding Clinic – Former Agnews State Hospital

The 2003-04 Governor’s Budget directed the California Department of Developmental Services (CDDS) to develop a plan to close Agnews Developmental Center (Agnews) by July 2005. The facility is now officially closed and all of the former residents have been placed in community settings or other alternate locations.

As part of the closure plan, Agnews agreed to continue to operate a freestanding clinic at the former Agnews location in order to continue to cover services that were previously provided as part of the general acute care hospital. The clinic services include health, dental and behavioral services which are offered to former Agnews residents as well as referrals from the various developmental centers in the area. The freestanding clinic became operational on April 1, 2009, and will remain open until CDDS is no longer responsible for the Agnews property.

The Department has submitted a State Plan Amendment (SPA) to CMS to establish a cost-based reimbursement methodology for the freestanding clinic. When approved, the SPA will authorize cost-based reimbursement for outpatient services provided at the clinic. The SPA has an effective date of July 1, 2008; however, since the freestanding clinic did not become effective until April 1, 2009, reimbursement will begin with the April 1, 2009 date of service.

The Department will enter into an Interagency Agreement with CDDS to reimburse the FFP for Medi-Cal clients served at the clinic.

OTHER: RECOVERIES

1. Retroactive Medicare Premium Payment for SSI/SSP Administrative Error Cases

The Social Security Administration has determined that approximately up to **potentially** 31,000 SSI/SSP recipients may have been qualified to receive Medicare benefits as far back as the mid-1970's and has been retroactively approving Medicare benefits back to the point of erroneous denial. 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 and is paying retroactive premiums totaling \$1.3 million per month for this population **an average of 238 such buy-ins each month**. California has only been able to obtain Medicare reimbursement for services provided to these beneficiaries for the last three years, limiting our recoveries to approximately 14 percent of the premiums. The result is **Premiums paid for earlier periods of Medicare entitlement cannot be offset by Medicare reimbursement for Medi-Cal services and are** a net loss of \$1.2 million per month.

FISCAL INTERMEDIARY: EDS

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

ELIGIBILITY

1. State-Funded KinGAP

Assembly Bill 1808 (Chapter 75, Statutes of 2006), established a program to enhance benefits in the existing Kinship Guardianship Assistance Payment (KinGAP) Program. The enhancements include additional benefits such as Specialized Care Increment for those children that qualify and an annual clothing allowance for all children. This new KinGAP Enhanced Program was implemented on October 1, 2006. Currently, all KinGAP children are covered by full scope, no share of cost, federally-funded Medi-Cal without an actual Medi-Cal determination.

In order to be in compliance with federal law, a separate Medi-Cal eligibility determination must be done for all KinGAP children. This would result in some children that would no longer be eligible for-federally funded full-scope Medi-Cal due to unsatisfactory immigration status.

Legislation has been proposed to establish a State Only Medi-Cal program, effective October 2008, which will provide full scope, no share of cost, Medi-Cal for KinGAP children.

2. PE for HFP Disenrollees

The 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.

The Bridge was approved in 2002 by the CMS as a component of the parental waiver. The parental waiver was scheduled to expire on January 24, 2007. The CMS has extended 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 part of the extension, CMS sought 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 MRMIB sent a letter on February 9th 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. CMS' terms were rejected and the HF to Medi-Cal Presumptive Eligibility program was implemented September 1, 2007.

The HFP to Medi-Cal Bridge was replaced by this program. 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.

There will be savings reflected in the MRMIB Budget for no longer providing the HFP to Medi-Cal Bridge coverage.

3. Reduction to County Administration Base

Effective July 1, 2008, the Department will reduce the County Administration Base by 3.32% for a savings of \$21.06 million in GF.

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

BENEFITS

1. Home Tocolytic Therapy

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.

This benefit began in February 2008. Matria Healthcare is working with an existing home health agency provider to offer this service. An evaluation of the medical and cost effectiveness of the treatments is due to the Legislature on October 1, 2009. The cost of the evaluation is no longer needed since state staff will be completing the evaluation. The statute sunsets January 1, 2010.

2. Newborn Hearing Screens Expansion

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.

AB 2651 (Chapter 335, Statutes of 2006) expands the requirement to the estimated additional 100 general acute care hospitals that were not previously CCS-approved.

HOME & COMMUNITY-BASED SERVICES

1. Expansion of NF/AH Waiver (SB 643)

SB 643 (Chapter 551, Statutes of 2005) required the Department to increase the number of NF A/B Level of Care (LOC) slots by 500, reserving 250 for Medi-Cal beneficiaries transitioning from facilities, and also adding community transition services and habilitation services as available waiver services. The new services were implemented on July 1, 2007 when new procedure codes were implemented. SB 643 allows implementation of the expansion only to the extent fiscal neutrality within the overall Department budget for these slots, and federal fiscal neutrality as required under the terms of the federal waiver, can be demonstrated.

2. Nursing Facility/Acute Hospital (NF/AH) Waiver

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 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.

DISCONTINUED ASSUMPTIONS

Fully Incorporated Into Base Data/Ongoing

FAMILY PACT

BREAST AND CERVICAL CANCER

PHARMACY

1. Maximum Allowable Ingredient Cost for Generic Drugs

The Maximum Allowable Ingredient Cost (MAIC) is an upper payment limit that creates the maximum reimbursement for generically equivalent drugs. In 2007, State statute defined MAIC to equal the mean of the Average Manufacturer's Price (AMP) of drugs generically equivalent to the innovator drug plus a percent markup determined by the Department. This allows the MAIC to represent the average purchase price paid by retail pharmacies in California. The AMP information would be provided to states by CMS pursuant to the provisions of the Deficit Reduction Act of 2005. Implementation of those provisions was stopped by a temporary injunction barring CMS from sharing such information with states. Recently, House Resolution (HR) 6331 was enacted over veto (Public Law 110-275) to officially delay AMP reporting until October 1, 2009. Because the Medi-Cal MAIC relies on the use of AMP reported by CMS, it has been impacted by both the federal court injunction as well as the delay due to HR 6331. The Department is proposing legislation that would allow the use of Wholesaler Acquisition Cost (WAC) as reported by its primary pricing reference source or a vendor that develops similar prices for other state Medicaid programs and private payers to establish MAIC prices. Implementation of the MAIC prices based on WAC is scheduled to occur in June 2010. **This assumption has been incorporated into the Estimated Acquisition Cost Pharmacy Savings policy change.**

HOSPITAL FINANCING

MANAGED CARE

PROVIDER RATES

1. Family Planning Office Visit Rate Increase

SB 94 (Chapter 636, Statutes of 2007) requires the Department to augment the reimbursement rates for eight specified office visit codes billed by the Family Planning Access Care and Treatment (Family PACT) program and the Medi-Cal program for comprehensive family planning services to the equivalent of the weighted average of at least 80 percent of the federal Medicare reimbursement rate for the same or similar service. The increase was implemented effective for services on and after January 1, 2008 and is now fully incorporated into the base.

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

DISCONTINUED ASSUMPTIONS**Fully Incorporated Into Base Data/Ongoing****OTHER: REIMBURSEMENTS**1. Non-Institutional Provider Overpayments

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 60th 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, and repayment of FFP for these overpayments began in FY 2006-07. For non-institutional overpayments identified prior to July 1, 2006, \$92 million FFP was repaid in FY 2006-07. Subsequent accounts receivable activity has resulted in an additional \$15 million in FFP that must be repaid to the federal government in FY 2007-08. If any of these debts are subsequently discovered to be uncollectible, the Department will initiate the necessary documentation to obtain reimbursement from CMS. There are no continuing costs therefore this item will be rolled into the base.

2. Reduction to Department of Aging Admin. Costs

In FY 2008-09 and FY 2009-10, the California Department of Aging's administrative costs related to services provided by the Adult Day Health Care Program and the Multipurpose Senior Services Program Administrative Costs to Medi-Cal eligibles will be reduced. **This assumption was incorporated into the Adult Day Health Care - CDA assumption.**

3. Reduction to CDPH Administrative Costs

In FY 2008-09 and 2009-10, the CDPH administrative costs related to services provided to Medi-Cal beneficiaries will be reduced. **This assumption was incorporated into the Department of Public Health Administration Costs Assumption.**

OTHER: RECOVERIES1. 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 Health Trailer Bill of 2007 includes 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 began in November 2007.

FISCAL INTERMEDIARY: EDS**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS****FISCAL INTERMEDIARY: DENTAL**

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

ELIGIBILITY

1. PE for Children Under Title XXI Claims Adjustment

States were given options for adjusting claims when a period of Presumptive Eligibility (PE) for a child was identified under Title XXI and the period of PE was followed by Medi-Cal approval for full-scope benefits. Effective October 2008, the Department will adjust these claims from Title XXI to Title XIX. This will allow the Department to appropriately claim these costs to Title XIX, thereby conserving Title XXI funds.

BENEFITS

HOME & COMMUNITY-BASED SERVICES

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SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Applicable

OTHER: REIMBURSEMENTS

1. Los Angeles County Medicaid Demonstration Project

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 required 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. Close-out activities, including processing of administrative claims, and additional costs for audits and evaluations required at the end of the Project will be finalized in FY 2008-09.

2. Delay Checkwrite from June 2008 to July 2008

Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. Beginning with FY 2007-08, an additional checkwrite for all Medi-Cal providers whose claims are processed by the fiscal intermediary was to have been delayed and paid during the next fiscal year. However, the Department had unanticipated savings in FY 2007-08, and this delay was not implemented.

OTHER: RECOVERIES

FISCAL INTERMEDIARY: EDS

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

1. Period of Extended Operations

The Department has notified MAXIMUS of its intention to extend operations for a period of three months. An amendment will extend the contract from September 30, 2008 to December 31, 2008. The bid rates for Extension Phase 3 are being used during this period.

2. Managed Care Expansion

The Budget Act of 2005 included geographic expansion of managed care in 13 additional counties. Managed Care will be expanding into three counties during FY 2008-09 and FY 2009-10. HCO will develop new informing materials specific to these counties and establish Presentation Sites. The three new counties will experience increased mailings, call center minutes and enrollment/disenrollment transactions. Costs will begin in FY 2008-09.

FISCAL INTERMEDIARY: DELTA DENTAL

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY

1. Month-to-Month Eligibility for Undocumented Immigrants

Effective May 2009, the period of eligibility for restricted scope eligible immigrants for emergency services (except pregnancy-related services) will be limited to the month or months during which emergency services are received. Eligibility for emergency services (except pregnancy-related services) would begin on the first day of the month in which emergency services are initially needed and end on the last day of the month in which the need for emergency treatment concludes.

2. 1931(b) Expansion Rollback

The Section 1931(b) Program is a program that provides Medi-Cal coverage with no share of cost to needy families with children. Beginning in May 2009, the allowable income level for 1931(b) applicants will be rolled back from 100% of the Federal Poverty Level (FPL) to the CalWORKs level, which is approximately 72% of the FPL. The Department will also reinstate the 100-hour rule without regard to income. The 100-hour rule for 1931 (b) applicants, and families on the medically needy program, states that when applying for Medi-Cal, the principal wage earner has to work less than 100 hours a month to be eligible for Medi-Cal. This will reduce the number of parents that qualify for no share of cost Medi-Cal.

3. Aged and Disabled Expansion Reduction

Beginning May 1, 2009, the A&D FPL Program income levels will be reduced to SSI/SSP income levels. This will reduce the number of individuals who qualify for no share of cost Medi-Cal.

4. Reduce CEC and Implement Mid-Year Status Reports

Effective December 1, 2008, the Department will eliminate the continuous eligibility for children and implement the mid-year status reports.

BENEFITS

HOME & COMMUNITY-BASED SERVICES

FAMILY PACT

BREAST AND CERVICAL CANCER

PHARMACY

HOSPITAL FINANCING

DISCONTINUED ASSUMPTIONS

Withdrawn

MANAGED CARE

1. Enrollment of All Medi-Cal Beneficiaries in HIO Counties

Federal law requires all Medi-Cal beneficiaries receiving services in counties operating under a Health Insurance Organization (HIO) to be served by the HIO. All COHS counties with the exception of San Mateo, Santa Barbara, and San Luis Obispo are considered HIOs. Currently, not all Medi-Cal aid codes are included in the HIO contracts. Therefore, some beneficiaries are receiving services under the fee-for-service program. The Department will modify the HIO contracts so that all Medi-Cal aid codes are covered beginning in FY 2009-10.

PROVIDER RATES

1. FQHC ADHC Reimbursement Methodology

Beginning October 1, 2009, the Department will reimburse adult day health care services provided in FQHCs/RHCs based on the fee-for-service methodology. Currently, FQHCs/RHCs that provide ADHC services are reimbursed based on the PPS methodology, which is an all-inclusive clinic-specific per-visit payment that is based on costs. Under the new methodology, ADHC services will be reimbursed based at the fee-for-service rate.

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

1. Institutional Provider Checkwrite Delay

In order to ensure that Medi-Cal expenditures do not exceed the 2008-09 Budget Act Appropriation, a checkwrite for institutional providers may need to be delayed to 2009-10. This checkwrite delay would be for the third-to-the-last weekly checkwrite of 2008-09.

At this time, it is estimated that \$171,076,000 Total Funds (\$85,538,000 GF) in institutional provider expenditures would need to be rolled from 2008-09 into 2009-10. ~~The need to roll the checkwrite will be reassessed in the May 2009 Estimate.~~ **As a result of ARRA, this assumption is being withdrawn in order to be in compliance with the prompt payment requirement,**

DISCONTINUED ASSUMPTIONS

Withdrawn

2. Delay Checkwrite from June 2009 to July 2009

Beginning with FY 2007-08, an additional checkwrite for all Medi-Cal providers whose claims are processed by the fiscal intermediary was to have been delayed and paid during the next fiscal year. However, the Department had unanticipated savings in FY 2007-08, and this delay was not implemented. **As a result of ARRA, this assumption is being withdrawn in order to be in compliance with the prompt payment requirement.**

OTHER: RECOVERIES

FISCAL INTERMEDIARY: EDS

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DELTA DENTAL