

**MEDI-CAL  
MAY 2011  
LOCAL ASSISTANCE ESTIMATE  
for  
FISCAL YEARS  
2010-11 and 2011-12**

# **ASSUMPTIONS**

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**MEDI-CAL ASSUMPTIONS**  
**May 2011**  
**FISCAL YEARS 2010-11 & 2011-12**

**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 (PC-9)	X	X	<u>Medi-Cal Covered Inpatient Services for Inmates</u>  AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the California Department of Corrections and Rehabilitation (CDCR) to claim federal reimbursement for inpatient hospital services for Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. Effective April 1, 2011, the Department will accept Medi-Cal applications from the California Prison Health Care Services (CPHCS) for eligibility determinations. Claims will be processed retroactive to January 1, 2011. The Department will budget the FFP and CDCR will continue to budget the GF. Previously these services were paid by CDCR with 100% GF.
E 0.2 (PC-248)		X	<u>Lomeli, et al, v. Shewry</u>  The Department finalized a settlement of the <i>Lomeli, et al., v. Shewry</i> lawsuit, which alleged that the Department did not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage. Once system changes are implemented, the Department will send notices to new SSI applicants who did not have Medi-Cal eligibility for all three months before applying for SSI and new SSI recipients, informing them of the availability of retroactive coverage.

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 "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-253) (CA-15) (PC-FI)		X	<u>Shift of Healthy Families Children to Medi-Cal</u>  Effective January 1, 2012, children in the Healthy Families Program who have attained 6 years of age but not attained 19 years of age, with incomes above 100% and up to and including 250% of the federal poverty level will be shifted to the Medi-Cal program. Coverage of this population under Medicaid programs is permissible pursuant to Section 1902(a)(10)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV)) to provide full scope Medi-Cal benefits with no share of cost to such eligible children who are optional targeted low-income children pursuant to 1905(u)(2)(B) of the Social Security Act (42 U.S.C. section 1396d(u)(2)(B)), with family incomes above 100% and up to and including 250% of the federal poverty level. Consistent with the Affordable Care Act of 2010, these children will be mandatorily enrolled into Medicaid programs beginning January 1, 2014. Under this option, the benefits provided to these children are eligible for enhanced federal funding of 65% under Title XXI, and the associated administrative costs are eligible for 50% federal funding under Title XIX. To the extent possible, the children will be mandatorily enrolled into Medi-Cal managed care delivery systems; and to the extent such delivery models are not available, benefits will be provided under Medi-Cal fee-for-service arrangements. Implementation is contingent upon enactment of State statute and receiving necessary federal approvals.  MAXIMUS, the HCO enrollment broker, will be required to send informing materials to each eligible beneficiary.

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 1	(OA-46)	X	X	<p><u>Single Point of Entry</u></p> <p>The Department and the Managed Risk Medical Insurance Board (MRMIB) developed an application form for the Healthy Families Program (HFP), which is also used as a screening tool for the Medi-Cal children’s percent programs. 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 for the children’s percent programs 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	<p><u>Bridge to HFP</u></p> <p>The one-month Bridge from Medi-Cal to Healthy Families is currently for children who become ineligible for full-scope, zero share-of-cost (SOC) Medi-Cal 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 250% of poverty (although the use of an income disregard effectively raises the upper limit to more than 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 one month of additional eligibility. Plans receive an additional capitation payment for each of these member months.</p>
E 3	(PC-11)	X	X	<p><u>Resource Disregard – % Program Children</u></p> <p>Based on the provisions of 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>
E 4	(PC-10)	X	X	<p><u>New Qualified Aliens</u></p> <p>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 New 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</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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.

E 5    (PC-6)    X    X

Refugees

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 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 Office of Refugee Resettlement (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. This requirement was implemented with the publication of ACWDL 08-53 dated November 25, 2008. On March 11, 2009, the Afghan Allies Protection Act of 2009 was signed into law. The Act extends RMA eligibility to eight months for Afghan Special Immigrants, spouses, and unmarried children under 21 years of age.

**Beginning December 19, 2009 Iraqi and Afghan Special Immigrants and their eligible family members became eligible to receive regular Medi-Cal, rather than time-limited RMA, to the same extent as refugees.**

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 6	(OA-16)	X	X	<p><u>SSA Costs for Health Coverage Information</u></p> <p>The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for SSI/SSP recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.</p>
E 7	(OA-5)	X	X	<p><u>Postage &amp; Printing</u></p> <p>Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Postage and printing costs may be charged to local assistance if the postage and printing is for items that will be sent to or used by Medi-Cal beneficiaries. Beginning in October 2008, the design, translation, focus testing and printing of certain informing and application forms and the mailing to beneficiaries or distribution to community based organizations and counties are performed by the Health Care Options vendor. 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.</p> <p>Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are included as a 100% General Fund cost.</p>
E 8	(CA-9)	X	X	<p><u>Systematic Alien Verification Entitlement System</u></p> <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-38)	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. Effective July 1, 2009, all GF was eliminated from the Maternal and Child Health programs. Local agencies continue to match Title XIX funds with Certified Public Expenditures.</p>
E 10	(OA-48)	X	X	<p><u>Outreach – Children</u></p> <p>The Budget Act of 1997 and AB 1572 (Chapter 625, Statutes of 1997 established funding for children’s outreach. Activities included media, public relations, collateral, certified application assistance, and a toll-free line.</p> <p>In the Budget Act of 2003, outreach was 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>
E 11	(CA-2)	X	X	<p><u>Statewide Automated Welfare System (SAWS)</u></p> <p>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 June 2010 when the counties who currently use ISAWS complete their planned migration to C-IV.</p> <p>The 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.</p> <p>The LEADER is the automated system for LA County. The County began the process to replace the LEADER system and is completing contract negotiations with the successful bidder. While the replacement system is being developed, the County has extended the existing LEADER maintenance and operations contract for an additional four</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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 and is currently in the maintenance and operation phase.

The C-IV system is fully implemented in 39 counties and is currently in the maintenance and operation phase.

E 12    (CA-1)    X        X        CalWORKs Applications

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

E 13    (PC-3)    X        X        CHDP Gateway  
           (PC-FI)

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 CHDP cover letter and Healthy Families application form that is also used to screen for the Medi-Cal children's percent programs. The application contains a toll-free telephone number available to families who have questions about the program, and is printed in twelve languages. The Healthy Families application is returned to the Single Point of Entry (SPE) and is screened for the Medi-Cal children's percent programs and forwarded to the county for a Medi-Cal determination or to Healthy Families.

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. Funding 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.

Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment, so claims are no longer Title XXI funded. Children screened to HFP continue to be claimed under Title XXI.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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.

E 14    (OA-58)    X        X

Merit System Services for Counties

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.

E 15    (CA-5)  
           (CA-8)    X        X

County Cost of Doing Business

Based on the Medi-Cal County Administration Cost Control Plan, county welfare department administrative cost increases for Medi-Cal eligibility determinations are limited to a maximum increase the California Necessities Index (CNI) as calculated by the Department of Finance, or state employee salary increases, whichever is greater. The FY 2010-11 increase, based on the CNI, ~~would have been~~ **was** 1.57%. The FY 2011-12 increase is ~~assumed to be 1.57%~~ **1.92%**.

E 16    (CA-6)    X        X

Los Angeles County Hospital Intakes

Los Angeles County uses Patient Financial Services Workers (PFSWs) to provide intake services for 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 (DPSS) eligibility workers. The federal share for any costs not covered by the DPSS rate is passed through to the county.

E 17    (CA-3)    X        X

Eligible Growth

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.

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 18	(OA-41)	X	X	<p><u>Department of Social Services Administrative Costs</u></p> <p>The Department provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS), via interagency agreements (IAs), for the administrative costs related to services provided to Medi-Cal beneficiaries under the In-Home Supportive Services Personal Care Services Program (IHSS PCSP), the Child Welfare Services/Case Management System (CWS/CMS), and the Statewide Automated Welfare System (SAWS). The IHSS Plus Waiver (IPW) expired on September 30, 2009. The Independence Plus Option Section 1915 (j) (IPO) waiver was approved beginning October 1, 2009. The new IPO absorbed the IPW caseload and provides the same services as the IPW plus an enhanced support system.</p>
E 19	(CA-4)	X		<p><u>Medi-Cal Data Privacy and Security Agreements</u></p> <p>The Department has entered 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 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. In August 2009, the Department completed the signing of all 58 agreements.</p>
E 20	(OA-57)	X	X	<p><u>Health-e App</u></p> <p>Health-e App is an electronic, web-based alternative to the traditional paper Healthy Families application, which is also used to screen for Medi-Cal children's percent programs, and is intended to reduce application processing time so that children can obtain needed Healthy Families or Medi-Cal coverage as quickly as possible and is available to enrollment entities in all California counties. The California Health Care Foundation (CHCF) 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 CHCF grants the matching funds for the federal Title XIX and Title XXI funding.</p> <p><del>Private foundations funded a study to define the technical requirements needed for expansion to public use. MRMIB released the final report on the public access assessment in October 2008.</del></p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The ~~projected~~ implementation date for of Health-e-App to launch **public access** statewide is ~~November~~ **was December** 2010. FY 2010-11 **and FY 2011-12** costs include the design of an outreach campaign which will promote the statewide launch of Health-e-App public access.

E 21 (PC-13) X X  
(OA-20)

Program Integrity and Eligibility Verification

The Department is implementing two activities to increase program integrity and ensure appropriate enrollment into the Medi-Cal Program. The two areas are the Public Assistance Reporting Information System (PARIS) and Asset and Eligibility Verification.

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.

Under the Asset and Eligibility Verification program, the Department will procure a direct service contractor beginning in FY ~~2010-11~~ **2011-12** 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.

E 22 (CA-10) X

County Administration Reconciliation

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 2010-11, the Department will complete the reconciliation for FY 2008-09.

E 23 (CA-13) X X

CHIP Reauthorization Act of 2009 - DRA Citizenship Option

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/identity from Medi-Cal applicants and beneficiaries as required by federal law. Applicants and beneficiaries who are not successfully matched will have 90 days to provide acceptable DRA documentation or contact the SSA to resolve the mismatch result. During this period, the applicant or beneficiary will receive full-scope Medi-Cal benefits. If citizenship/identity is not verified within the 90 days, the Department will have 30 days to reduce full-scope Medi-Cal benefits to restricted scope. States who choose this option could be subject to a penalty for the 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.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

County administration workload will decrease because counties will not need to verify citizenship/identity if there is an SSA data match. System development modifications for the electronic daily verification system were made in FY 2009-10. Due to the successful rate of Social Security Number and citizenship matches with SSA, it has been determined that a real-time verification system at the county level is no longer critical. As such, the FSR will not be required at this time.

E 24	(PC-5) (CA-7)	X	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 requires all states to process SSA Low-Income Subsidy (LIS) applications (Part D) as an application for the Medicare Savings Program (MSP). Counties have also been instructed to use the LIS application as an application for Medi-Cal. 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 25	(CA-14)	X	X	<p><u>Reduction to County Administration Funding</u></p> <p>The amendments to the Budget Act of 2009 include a reduction of \$121,138,000 TF (\$60,569,000 GF) to county administration. The FY 2010-11 and FY 2011-12 County Administration budget will also be reduced by the same amount.</p>
E 26	(OA-26)	X	X	<p><u>Q5i Automated Data System Acquisition</u></p> <p>The Department will acquire the Q5i automated quality control data system, associated software, maintenance and support. The existing automated data system is technologically obsolete and will become unsupported, leaving the state vulnerable to HIPAA violations. The Q5i system will be used to support quality control efforts for the following state and federally mandated programs: Medi-Cal Eligibility Quality Control, County Performance Standards, Payment Error Rate Measurement and Anti-Fraud/Program Integrity.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 27	(OA-11)	X	X	<p><u>Medi-Cal Eligibility Data System (MEDS)</u></p> <p>MEDS is currently the only statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status.</p> <p>Funding is required for MEDS master Client Index maintenance, data matches from various federal and state agencies, SSI termination process support, Medi-Cal application alerts, MMA Part D buy-in process improvements, eligibility renewal process, and reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities. Costs are offset by reimbursements made from other state departments using MEDS.</p> <p>In addition, maintenance funding is required for the Business Objects (BO) software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS.</p>
E 28	(CA-12)	X	X	<p><u>Reduction of CNI-Based COLA to Counties for FY 2010-11</u></p> <p>The July 1, 2010 Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process will be eliminated.</p>
E 29	(OA-51)	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>
E 30	(PC-12)	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</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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. **The Department has received federal approval to implement this option effective April 1, 2009.**

E 31 (PC-7)    X    X

Lanterman Developmental Center Closure

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. ~~Lanterman currently serves 393 residents.~~ CDDS is working with **consumers, families, and** the regional centers to transition residents to community living arrangements beginning in FY 2010-11. Residents moving into the community will be enrolled in a Medi-Cal managed care health plan or will receive services through the fee-for-service (FFS) system.

E 32 (PC-8)    X

250% Working Disabled Program (WDP) Changes

The WDP, established in April 2000, allows for employed individuals with disabilities to earn up to 250% of the federal poverty level and receive full scope Medi-Cal benefits. All eligible individuals and couples are required to pay a monthly premium based on their countable income.

AB 1269 (Chapter 282, Statute of 2009) requires the Department to implement changes to the program 30 days after ARRA **enhanced federal** funding ends ~~which is~~ on June 30, 2011. The provisions are:

1. Exemption of disability income that converts to retirement income.
2. Exemption of retained income from the resource calculation when held in a separately identifiable account and not comingled with other resources.
3. Allows beneficiaries to remain eligible for Medi-Cal up to 26 weeks while unemployed, provided premiums continue to be paid.
4. Allows the monthly premium calculation to be based on five percent of an individual's countable income.

However, under the Maintenance of Effort (MOE) requirements of the Patient Protection and Affordable Care Act (PPACA) 2010, states cannot implement more restrictive Medicaid eligibility policies, procedures or methodologies without the possibility of losing federal funding for their Medicaid programs; **the MOE provisions are in effect** until January 1, 2014. Therefore, the Department will not be able to implement provision four **at this time**, since it would be more restrictive. **The first three provisions will be implemented August 1, 2011.**

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 33	(CA-11)		X	<u>Reduction of CNI-Based COLA to Counties for FY 2011-12</u>  The July 1, 2011 Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process will be eliminated.

**BENEFITS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**BENEFITS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 1	(OA-39)	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>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. On January 1, 2010, the Department, through CDSS, implemented the new requirements to provide Health Oversight and Coordination.</p>
B 2	(PC-15)	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&amp;I Code Section 14132.06.</p>
B 3	(PC-122)	X	X	<p><u>Medi-Cal TCM Program</u></p> <p>The Targeted Case Management (TCM) program <del>assists</del> <b>provides funding to county providers for assisting</b> Medi-Cal beneficiaries in accessing needed medical, social, educational, and other services. TCM services include needs assessment, individualized service plans, linkage and consultation, assistance with accessing services, crisis assistance planning, and periodic review. Through rates established in the annual cost reports, local governments claim FFP for these case management services. The TCM Program is regulated by W&amp;I Code section 14132.44. <del>The existing target populations of Medi-Cal beneficiaries that can receive TCM services are public health, public guardian, linkages, outpatient, adult probation, community, and Native American Indian tribes, tribal organizations, and subgroups of these entities.</del></p>
B 4	(PC-119)	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</p>

**BENEFITS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

a ~~rate~~ **time** study every three years **and an annual administrative cost survey** 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 **annually**. 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.

B 5    (OA-33)    X    X

Disease Management Program

W & I Code Section 14132.27 requires the Department 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. Enrollment into (DM1) began on August 1, 2007 and ~~will end~~ **ended on** November 30, 2010. Positive Health Care (PHC) (DM2), which ~~focuses~~ **focused** on individuals diagnosed with HIV/AIDS, began services in February 2009 and suspended their operations on December 31, 2009. **The PHC contract expired on February 1, 2011.** UCLA has been contracted to conduct program evaluations for both contracts. ~~The evaluation for DM2 ended in FY 2009-10.~~

B 6    (OA-1)    X    X

Medi-Cal Administrative Activities

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.

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.

**BENEFITS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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. 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. On December 18, 2009, CMS approved reimbursement for non-emergency, non-medical transportation expenditures for Tribal entities.

B 7    (PC-25)    X    X

SCHIP Funding for Prenatal Care

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

B 8    (OA-7)    X    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.

APS Healthcare Inc. has been awarded both contracts, which will require a six month implementation phase. Enrollment for CCM-1 began in January 2010 and enrollment for CCM-2 began in April 2010.

B 9    (PC-121)    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.

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 10 (PC-27)	X	X	<p><u>Reduce ADHC Program</u></p> <p>The Department <del>will implement a reduction in</del> <b><u>continues to reduce</u></b> Adult Day Health Care expenditures by conducting onsite Treatment Authorization Request reviews.</p>
B 11 (PC-18)	X	X	<p><u>Reinstatement of Optometry Services</u></p> <p>As required by ABX3 5 (Chapter 20, Statutes of 2009), effective July 1, 2009, the Department discontinued the optional Medi-Cal optometry services for adults 21 years of age or older who were not in nursing facilities and excluding pregnant women. On July 26, 2010, the Department reinstated optometry services retroactive to July 1, 2009, to comply with federal law, which prohibits the elimination of optometrist services if physicians could still provide them, and the State previously funded these services.</p>
B 12 (PC-36)	X	X	<p><u>Elimination of Acetaminophen Drugs</u></p> <p>The Budget Act of 2010 eliminates specific nonprescription acetaminophen-containing products as Medi-Cal benefits for adults.</p>
B 13 (PC-20)	X		<p><u>Lanterman Regional Center Disallowance</u></p> <p>Federal disallowance CA/09/002/MAP determined that FFP was improperly claimed for the period beginning July 1, 2001 through June 30, 2005 for targeted case management (TCM) payments to Lanterman Regional Center. These payments were not calculated in compliance with the reimbursement methodology in the California State Medicaid Plan. FFP is paid to the California Department of Developmental Services (CDDS) for TCM services provided to Medi-Cal eligible clients by the Regional Centers. The Department will return the federal portion of the TCM payments to CMS and will be reimbursed by CDDS.</p>
B 14 (PC-239)		X	<p><u>Physician <del>Office</del> and Clinic <b>Seven</b> Visits (including FQHCs/RHCs) <b>Soft Cap</b></u></p> <p>Legislation <del>will be proposed to</del> <b><u>The Health Trailer Bill of 2011</u></b> caps the number of physician <del>office</del> visits and clinic visits (including FQHCs/RHCs) allowed per Medi-Cal beneficiary at <del>40</del> <b>seven</b> per year. The cap on the number of physician <del>office</del> visits and clinic visits is for adults 21 years of age or older, except those in nursing facilities, pregnant women, presumptive eligibility and FFACT beneficiaries. The cap applies in both the FFS and managed care settings.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 15 (PC-230)		X	<p><u>Hearing Aid Cap</u></p> <p>Legislation will be proposed to cap the maximum expenditures <del>The Health Trailer Bill of 2011 implements a \$1,510 cap</del> per beneficiary for hearing aid expenditures <del>at a level in which 90% of the beneficiaries who use the benefit will not be affected.</del> Hearing aid reimbursements are composed of three primary categories: 1) repairs, 2) ear molds, and 3) hearing aids. The majority of the reimbursements are for the actual costs of hearing aids. Hearing aids may be dispensed individually (monaural) or as a pair (binaural). The hearing aid cap is for adults 21 years of age or older who are not in nursing facilities or pregnant women.</p>
B 16 (PC-238)		X	<p><u>Copayments for Physician/FQHC/RHC Office Visits</u></p> <p>Legislation will be proposed to <del>The Health Trailer Bill of 2011</del> implements mandatory copayments of \$5 for physician and Federally Qualified Health Center/Rural Health Center (FQHC/RHC) office visits at the point of service. This copayment does not apply to FFACT beneficiaries. The copayment will be implemented in both the fee-for-service and managed care settings. The providers will collect the \$5 copayment from the beneficiaries at the time of service, and the providers will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$5 copayment.</p>
B 17 (PC-225)		X	<p><u>Copayment for Non-Emergency ER Visits</u></p> <p>Legislation will be proposed to implement <del>The Health Trailer Bill of 2011 implements</del> mandatory copayments of \$50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented without exemptions in both the fee-for-service and managed care settings. The hospital will collect the \$50 copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$50 copayment.</p>
B 18 (PC-224)		X	<p><u>Copayment for Emergency ER Visits</u></p> <p>Legislation will be proposed to implement <del>The Health Trailer Bill of 2011 implements</del> mandatory copayments of \$50 for emergency use of the emergency rooms at the point of service. This copayment will be implemented without exemptions and in both the fee-for-service and managed care settings. The hospital will collect the \$50 copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$50 copayment.</p>

**BENEFITS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 19	(PC-226)		X	<p><u>Copayments for Hospital Inpatient Days</u></p> <p>Legislation will be proposed to implement <b><u>The Health Trailer Bill of 2011 implements</u></b> mandatory copayments of \$100 per hospital inpatient day up to a maximum of \$200 per admission. This copayment will be implemented without exemptions and in both the fee-for-service and managed care settings. The hospitals will request the copayment from the beneficiaries in accordance with the hospital's collection policy for all copayment clients. The hospitals will be reimbursed the appropriate Medi-Cal reimbursement rate minus the copayment.</p>
B 20	(PC-223)	X	X	<p><u>Copayment for Dental Services</u></p> <p>Legislation will be proposed to implement mandatory copayments of \$5 for adult dental visits. The provider will collect the \$5 copayment from the beneficiaries at the time of service, and the provider will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$5 copayment. <b><u>The Health Trailer Bill of 2011 requires all Medi-Cal beneficiaries to pay a \$5 copayment for each dentist visit at the point of service. The dental FI will reimburse providers at the appropriate Medi-Cal reimbursement rate less the \$5 copayment, and the provider will collect the \$5 copayment from the beneficiary at the time of service.</u></b></p>
B 21	(PC-229)		X	<p><u>Pharmacy Copayments</u></p> <p><b><u>The Health Trailer Bill of 2011 requires</u></b> Legislation will be proposed to implement mandatory copayments of \$3 for preferred drugs and \$5 for non-preferred drugs. This copayment will be implemented without exemptions and in both the fee-for-service and managed care settings. The pharmacy will collect the \$3 or \$5 copayment from the beneficiaries at the time of service, and the pharmacy will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$3 or \$5 copayment.</p>
B 22	(PC-246)	X	X	<p><del>Eliminate Multipurpose Senior Services Program</del> <b><u>Savings From Attrition in MSSP</u></b></p> <p>Legislation will be proposed to eliminate the <b><u>There will be a reduction to the</u></b> Multipurpose Senior Services Program (MSSP), <b><u>which will be achieved through attrition beginning in FY 2011-12.</u></b></p>
B 23	(PC-235)	X	X	<p><u>Eliminate ADHC Services</u></p> <p>Legislation will be proposed to eliminate <b><u>The Health Trailer Bill of 2011 eliminated</u></b> Adult Day Health Care (ADHC) services from the Medi-Cal program.</p>

**BENEFITS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 24	(PC-231)	X	X	<p><u>Limit Enteral Nutrition to Tube Feeding</u></p> <p>Legislation will be proposed to limit <b><u>The Health Trailer Bill of 2011 limited</u></b> enteral nutrition products, <del>when used by adult</del> <b><u>for adults to tube-fed only</u></b> beneficiaries, <del>to only those individuals who must be tube-fed</del> <b><u>21 years of age and older</u></b>. A product may be exempted from this limitation when used as part of a therapeutic regimen <b><u>a benefit</u></b> for patients <b><u>a non-tube-fed adult beneficiary</u></b> with conditions <b><u>a documented medical condition</u></b> for which regular food, or standard processed foods, cannot be consumed without causing risk to the health and/or life of the patient. <del>Conditions which require tube feeding include, but are not limited to, malabsorption syndromes or inborn errors of metabolism, anatomical defects of the digestive tract or neuromuscular diseases.</del> <b><u>Medical conditions may include, but not limited to, malabsorption syndromes or inborn errors of metabolism.</u></b> Pregnant women, <del>and</del> beneficiaries in LTC facilities, <b><u>and children eligible for EPSDT</u></b> are exempt from this limitation.</p>
B 25	(PC-237)	X	X	<p><u>Elimination of Cough and Cold Products</u></p> <p>Legislation will be proposed to eliminate <b><u>The Health Trailer Bill of 2011 eliminated selected</u></b> nonprescription cough and cold products as Medi-Cal benefits for adults <b><u>and children</u></b>.</p>

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
H 0.1 (PC-254)		X	<u>IHSS Provider Tax</u>  AB 1612 (Chapter 725, Statutes of 2010) mandates that IHSS providers be taxed at the State sales tax rate. In exchange, the providers will receive a supplementary payment through CDSS equal to the amount of the tax, plus the federal income, Social Security and Medicare tax liabilities on that supplementary payment. DHCS will provide the Title XIX federal funds for the supplementary payments for services provided to Medi-Cal beneficiaries, retroactive to October 1, 2010, and upon approval of a SPA that was submitted to CMS in December 2010.
H 0.2 (PC-256)		X	<u>ADHC Transition</u>  The Health Trailer Bill of 2011 eliminated ADHC services from the Medi-Cal program in FY 2011-12. As part of the process of ending ADHC, the Department will help transition existing ADHC enrollees to other appropriate Medi-Cal services.

**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, and intermediate care facilities for persons with developmental disabilities, or State Developmental Centers. HCBS also provide 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-114) 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~~ **and vehicle modifications-, prevocational services, skilled nursing, residential services, specialized therapeutic services, and transition/set-up expenses. The additional services have been approved by CMS, effective July 1, 2009.**

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 was 75,000, and the cap will increase to 95,000 by the fifth year. **An extension of the waiver is pending.** ~~On September 15, 2009, CMS approved an amendment to the waiver with an effective date of July 1, 2009. The amendment includes: increased staffing ratios for Day Habilitation Adult Programs; inclusion of selected incidental medical services provided by respite agencies; elimination of triennial review of community care facilities by regional centers; and the addition of voucher transportation services to be funded through the waiver. On December 11, 2009, CMS approved a second amendment to~~

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

Applicable F/Y

C/Y    B/Y

~~the waiver with an effective date of July 1, 2009. This second amendment includes: additional service providers for Behavior Intervention services; extended State Plan services (former optional benefits for persons over 21); and additional daycare services.~~

(PC-17)    X        X  
(OA-45)

B. Multipurpose Senior Services Program – CDA

On June 23, 2009, CMS approved the renewal of the Multipurpose Senior Services Program (MSSP) Waiver for the period of July 1, 2009 through June 30, 2014. Under the waiver, CDA contracts with 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.

The Department pays the MSSP claims. 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.

H 2    (PC-NA)    X        X

In-Home Operations Waiver

CMS approved the IHO Waiver renewal effective January 1, 2010 through December 31, 2014. The IHO Waiver “grandfathered in” Medi-Cal beneficiaries who were continuously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and continue to receive direct-care services primarily rendered by licensed nurses, and whose HCBS costs exceed the Level of Care (LOC) cost cap under the NF/AH Waiver. Each IHO participant’s LOC and waiver costs will remain the same as previously authorized.

H 3    (PC-124)    X        X

Waiver Personal Care Services

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 also not available to backfill the loss of personal care services hours due to restrictions in the eligibility criteria or budget reductions for In-Home Supportive Services (IHSS), Adult Day Health Care (ADHC), or Regional Centers. 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.

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

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 4	(PC-110) (OA-34)	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>The In-Home Supportive Services Plus (IHSS) §1115 Waiver Demonstration and the Independence Plus Waiver (IPW) previously approved for the period of August 1, 2004 through September 30, 2009 converted to a 1915(j) option within the State Plan, effective October 1, 2009. The new Independence Plus Option (IPO) Section 1915(j) waiver absorbed the IPW caseload.</p> <p><del>Savings for the IHSS Anti-Fraud Initiative is included in the Personal Care Services policy change.</del></p>
H 5	(PC-19) (PC-28) <b><u>(PC-21)</u></b>	X	X	<p><u>California Community Transitions (CCT)</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, called California Community Transitions, is effective from January 1, 2007 through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,000 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition to federally-allowed home and community-based settings. The revised award is \$60 million in federal funds.</p> <p>During the 12 months a participant is enrolled in the demonstration, the Department will receive enhanced FFP for the provision of certain HCB services approved by CMS. After 12 months participants are disenrolled from the demonstration but will continue to receive HCBS under the State Plan or via an appropriate HCBS waiver for which they are eligible. Transition work began in September 2008.</p> <p><b><u>On October 28, 2010, the Department established an IA with CDDS to provide enhanced FFP for HCBS provided to CCT participants who have developmental disabilities.</u></b></p>

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

		Applicable F/Y		
		C/Y	B/Y	
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 Disease or AIDS 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 with the Department.</p>
H 7	(OA-35)	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>
H 8	(PC-14) (OA-45)	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 <del>being placed in a nursing home</del> <b>institutionalization</b>. ADHC became an optional Medi-Cal benefit in 1978. ADHC rates are adjusted effective August 1 of each year based on the weighted average NF-A increase.</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 that details the authorized reforms will be submitted to CMS in <del>2012</del> <b>2011</b>.</p> <p>The tightening of the 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, 2012.</p>
H 9	(PC-49)	X	X	<p><u>PACE: Program of All-Inclusive Care for the Elderly</u></p> <p>The Department contracts with five PACE organizations in various counties 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</p>

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

Applicable F/Y  
C/Y B/Y

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 2010 **and 2011** rate setting methodology uses a blend of FFS data on costs incurred by Medi-Cal participants in the MSSP and by the Medi-Cal nursing home resident population historically used for setting PACE rates. FY 2010-11 funding includes projected costs for the 1/01/11 annual rate redetermination. ~~The 2011 rate setting methodology is currently being reviewed.~~ **The 2012 rate setting methodology will use actual cost-based data.** Two new PACE programs **organizations** will become operational in 2011 **FY 2011-12.**

Below is the list of PACE organizations:

<u>PACE program</u>	<u>Organization</u>	<u>County</u>	<u>Operational</u>
On Lok	San Francisco		November 1, 1983
	Alameda		July 1, 2002
	Santa Clara		January 1, 2009
CEI	Alameda		June 1, 1992
Sutter Senior Care	Sacramento		August 1, 1992
Alta Med	Los Angeles		January 1, 1996
CESD	San Diego		February 1, 2008
LA Jewish Homes	Los Angeles		<del>May 1, 2011</del> <b>January 1, 2012</b>
Cal Optima	Orange		April 1, 2012

H 10 (PC-51) X X

Senior Care Action Network

The Senior Care Action Network (SCAN) is a Medicare Advantage Special Needs Plan located in Long Beach and coordinates and provides services 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

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

Applicable F/Y

C/Y    B/Y

services are provided by SCAN. Enrollees who are SNF or ICF certifiable are eligible for additional HCBS. 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. To determine 2009 rates for dually eligible enrollees, SCAN provided the Department with a bid based upon its costs for Medi-Cal services rendered to this population. To determine 2009 rates for nursing home eligible participants, the Department used cost data for MSSP as a point of comparison and made adjustments to SCAN's bid. FY 2009-10 funding includes projected costs for the January 1, 2010 annual rate redetermination. AB 1422 (Chapter 175, Statutes of 2009) imposes an additional tax (MCO) on the total operation revenue of Medi-Cal Managed Care plans. Beginning January 1, 2010, the MCO tax revenue is incorporated into the SCAN rates **retroactive to January 1, 2009**.

Effective January 1, 2008, SCAN began offering Personal Care Services (PCS) to its members, and enrollees are no longer allowed to receive PCS through SCAN while simultaneously receiving IHSS through the county-administered IHSS programs. As of May 1, 2008, SCAN stopped enrolling applicants who receive IHSS through the counties. However, members who were enrolled in SCAN prior to May 1, 2008 are permitted to continue receiving IHSS services through county-administered IHSS programs. ~~Under an agreement with the Department, SCAN will reimburse the Department for the capitation payments received for PCS where IHSS services were instead provided for the period of May 1, 2008-December 31, 2009.~~

H 11 (OA-28)    X    X    Pediatric Palliative Care Waiver

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 approved on December 3, 2008 for three years, beginning April 1, 2009 through March 31, 2012. The waiver was implemented and began enrollment on January 1, 2010.

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 legislation mandates the Department to evaluate the pilot project, and an evaluation of the waiver is also required to meet federal assurances. The evaluation began in July 2010.

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

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 12	(PC-22)	X	X	<p><u>SF Community-Living Support Waiver Pilot Project</u></p> <p>The SF Community Supported Living Waiver implements AB 2968 (Chapter 830, Statutes of 2006), which requires the Department to develop and implement a community-living support benefit for Medi-Cal beneficiaries 22 years of age and older, residing in the City and County of San Francisco who would otherwise be residing in Laguna Honda Hospital, <b><u>San Francisco General Hospital</u></b>, skilled nursing or be rendered homeless. The proposed new waiver is a 1915(c) Home and Community Based Services (HCBS) waiver.</p> <p>Eligible participants will have full-scope Medi-Cal or share-of-cost Medi-Cal for services to be rendered in Residential Care Facilities for the Elderly (RCFEs) or in residency units made available by the Direct Access to Housing Program (DAH).</p> <p>Benefits will include a community supported living benefit in the RCFE or ARF setting and a home health agency-rendered service in a DAH supplied unit. The City and County of San Francisco will pay for the non-federal share of the waiver costs. <b><u>A draft waiver application is pending with CMS. The Department will utilize CPEs to obtain federal funding for this project.</u></b></p>
H 13	(PC-16)		X	<p><u>Additional Services for HCBS Clients</u></p> <p>In December 2009, the Department submitted to CMS a 1915(i) Home and Community-Based Services (HCBS) state plan amendment (SPA) to include certain services provided <b><u>by the State's Regional Center (RC) network of non-profit providers</u></b> to developmentally disabled clients who receive these services through the state's Regional Center (RC) network of non-profit providers. <b><u>persons with developmental disabilities. RC</u></b> clients who have previously received or currently receive certain services will <b><u>continue to</u></b> be eligible for these services <b><u>even if they are not under the HCBS waiver for persons with developmental disabilities.</u></b> Services scheduled for coverage under this SPA include: <b><u>habilitation</u></b>, respite care, personal care services, homemaker services, home health aide services, <b><u>and</u></b> adult day health care, <del>and case management.</del> It is anticipated that the SPA will be approved in <del>late 2010</del> <b><u>FY 2011-12</u></b>, with a retroactive date of October 1, 2009.</p>
H 14	(OA-22)	X	X	<p><u>CCT Enrollment-Administrative Costs</u></p> <p>Pursuant to the Patient Protection and Affordable Care Act, the Department <del>has</del> applied for <b><u>and was awarded</u></b> grant funding to cover administrative costs needed to increase the California Community Transitions (CCT) <del>transitions enrollment</del> <b><u>participation.</u></b> The <b><u>grant requires the</u></b> Department <del>will collaborate with the</del> <b><u>to foster</u></b></p>

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

Applicable F/Y

C/Y    B/Y

**collaborations between the existing** Aging and Disability Resource Connection (ADRC) programs and CCT lead organizations to increase CCT enrollment. The costs ~~will be~~ **incurred for these activities are** 100% federally funded.

H 15 (PC-23)    X    X

Quality of Life (QoL) Surveys for Money Follows the Person Program Participants

CMS requires the Department to conduct QoL surveys with ~~Money Follows the Person (MFP)~~ **CCT** participants within specified timeframes and **follow a specific** methodology. ~~MFP provider agencies~~ **CCT lead organizations**, which are Medi-Cal home and community-based services waiver providers, conduct QoL surveys designed to measure seven domains: living situation, choice and control, access to personal care services, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. The costs of conducting the surveys are 100% federally funded.

H 16 (OA-42)    X    X

Administrative Costs for CCT

In January 2010, CMS announced the availability of 100 percent FFP for certain administrative costs under the Money Follows the Person (MFP) **Rebalancing** Demonstration Grant. The Department requested and was approved for 100 percent federal funding for 34 Regional Center positions that will focus on transitioning beneficiaries from State Developmental Centers to the community via the California Community Transitions (CCT), ~~the MFP Demonstration Grant~~.

The Department ~~has also requested~~ **will be requesting** 100% federal funding for local level positions overseen by the California Department of Aging (CDA) that will focus on transitioning ~~beneficiaries~~ **eligible individuals** from nursing facilities to the community via the ~~California Community Transitions (CCT), MFP Demonstration Grant~~ **CCT**.

**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) Program</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 (assumed to be 13.95% of the Family PACT population through September 30, 2008, 24% of the Family PACT population from October 1, 2008 through July 19, 2009, and 13.95% of the Family PACT population from July 20, 2009 and ongoing) are budgeted at 100% GF. Family PACT Waiver drugs will be included in the Medicaid Drug Rebate Program.</p> <p><del>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. Currently the waiver is approved on short term extensions.</del></p> <p><b><u>A State Plan Amendment to replace the Family PACT waiver in accordance with the Federal Patient Protection and Affordable Care Act was approved on March 24, 2011. Under the SPA, effective retroactively to July 1, 2010, eligible family planning services and supplies formerly reimbursed exclusively with 100% General Funds will receive a 90% federal matching rate, and family planning-related services will receive reimbursement at the State's regular FMAP rate.</u></b></p>
FP 2	(OA-50)	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 new contract to provide data, to monitor and evaluate the Family PACT program was negotiated for a five year term beginning July 1, 2010.</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-55)	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, and direct client outreach; 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>A contract to provide Family PACT support, provider education, and outreach was negotiated for a three-year term beginning April 1, 2009.</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 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>
FP 6	(OA-52)	X	X	<p><u>Family PACT I&amp;E Program and Evaluation</u></p> <p>The Health Trailer Bill of 2003 authorized the Department to require contractors and grantees under the Office of Family Planning, and the Information and Education (I&amp;E) Program 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>

**FAMILY PACT: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.

FP 7 (OA-5)    X    X    Family PACT HIPAA Privacy Practices Beneficiary Notification

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.

FP 8 (PC-139)    X    ✕    Nuvaring Cost Shift

The Department has completed an assessment of the cost accounting 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 for the contraceptive Nuvaring, which is incorrect. Implementation of a correction to the Fiscal Intermediary's system will result in a 90% federal funding match for Nuvaring contraceptives reimbursable through the FPACT Program. Claiming at 90% began in FY 2009-10.

FP 9 (PC-24)    X    X    Increased Federal Matching Funds for FPACT

~~In September 2010, the Department requested that~~ **On March 24, 2011,** CMS ~~approve~~ **approved** an amendment to the State Plan to replace the Family PACT Waiver in accordance with the Federal Patient Protection and Affordable Care Act. Under the State Plan Amendment, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund will receive a 90% federal matching rate, and family planning related services will receive reimbursement at the State's regular FMAP rate, effective retroactively to July 1, 2010.

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

Applicable F/Y  
C/Y    B/Y

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
BC 1 (PC-2)	X	X	<p><u>Breast and Cervical Cancer Treatment Program</u></p> <p>The Budget Act of 2001 includes funding for the creation of the BCCTP effective January 1, 2002, for individuals with a diagnosis of breast and/or cervical cancer who need treatment and have income 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.</p> <p>Enrollment of BCCTP applicants is performed by Centers for Disease Control (CDC)-approved screening providers, which in California are Every Woman Counts and Family PACT Program providers, using an electronic Internet-based application form. Those women who appear to meet federal eligibility requirements receive immediate temporary full-scope no cost Medi-Cal coverage under accelerated enrollment. 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.</p> <p>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.</p> <p>Current managed care rates fully incorporate BCCTP costs.</p>

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
BC 2 (PC-2)	X	X	<p><u>Breast and Cervical Cancer Treatment Program – Premium Payment</u></p> <p>Effective January 1, 2002, under the state funded portion of the Breast and Cervical Cancer Treatment Program funded by the Budget Act of 2001, the Department began payment of the premium cost for individuals with breast and/or cervical cancer who have other health insurance but are underinsured. Eligibility is limited to 18 months for breast cancer and 24 months for cervical cancer. The criteria for participation in the state funded premium payment program include the following:</p> <ul style="list-style-type: none"> <li>• Family income at or below 200% of FPL as determined by the enrolling provider</li> <li>• California resident</li> <li>• Other health coverage with premiums, deductibles and copayments exceeding \$750 in a 12-month period beginning from the month in which the Eligibility Specialist commences the eligibility determination</li> <li>• Diagnosis of breast and/or cervical cancer and in need of treatment</li> <li>• Not eligible for full-scope, no cost Medi-Cal</li> </ul>
BC 3 (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  
C/Y    B/Y

PH 0.1(PC-249)            X    Managed Care Drug Rebates

The Patient Protection and Affordable Care Act (PPACA), H.R. 3590, and the Health Care and Education Reconciliation Act of 2010 (HCERA), extend the federal drug rebate requirement to Medicaid managed care outpatient covered drugs provided by the Geographic Managed Care (GMC) and Two-Plan model plans, and the Health Plan of San Mateo (HPSM), a County Organized Health System (COHS). Previously, with the exception of HPSM, only COHS plans were subject to the rebate requirement.

The Department will invoice for these rebates, retroactive to April 2010, beginning in January 2012.

**PHARMACY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y  
 PH 1 (PC-113) X    X

Part D – Phased-Down Contribution

With the implementation of Medicare Part D, the federal government requires a phased down contribution from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal program. In 2006, the phased-down contribution was 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015. An annual inflation factor is also applied to the phased-down contribution. The phased-down contribution, annual inflation factor and PMPM for the current and previous calendar years (CY) are listed below. In CY 2011 and CY 2012, the contribution rate will be lowered to 81⅓% and 80%, respectively, and a CMS-determined inflation rate will be applied.

CY	Contribution Rate	Inflation Rate	PMPM
2006	90%		\$ 89.02
2007	88⅓%	6.86%	\$ 93.37
2008	86⅔%	1.69%	\$ 93.15
2009	85%	9.26%	\$ 99.82
2010	83⅓%	4.77%	\$102.54
2011	81⅓%	0.28%	\$100.77
2012	80%	3.05 <b>3.34%</b> est.	\$100.71 <b>101.99</b>

PH 2 (PC-33) X    X

Non FFP Drugs

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.~~ **In October 2010, an analysis of the non-FFP drug reports determined that these reports were not accurately capturing non-FFP drug claims. The reports were revised and then re-run for the period FY 2004-05 through FY 2009-10. As a result, a larger number of claims were identified as being not eligible for FFP. The Department will reimburse CMS for the identified non-FFP drug costs, retroactive to FY 2004-05.**

PH 3 (PC-41) X    X

Family PACT Drug Rebates

The Department collects rebates for family planning drugs covered through the Family PACT program.

The Department began invoicing for Family PACT drug rebates on June 7, 2001. These invoices covered all quarters back to December 1, 1999.

**PHARMACY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Beginning October 2008, the Department no longer collects rebates for drugs that are not eligible for FFP.

PH 4 (PC-43)    X        X

State Supplemental Drug Rebates

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.

PH 5 (PC-44)    X        X

Federal Drug Rebate Program

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.

PH 6 (PC-40)    X        X

Medical Supply Rebates

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.

Contracts were renewed in January 2010. The Department instituted product reimbursement based on the contracted Maximum Acquisition Cost (MAC), rather than the AWP previously used. Rebates are calculated as a percent of the MAC, rather than basing the rebate on the Wholesale Acquisition Cost (WAC) previously used. Reimbursement on the MAC has resulted in additional savings to the Department.

PH 7 (PC-42)    X        X  
 (Reworded)

Aged and Disputed Drug Rebates

The Department collects drug rebates as required by federal and state laws. The Department expects to complete the resolution of the oldest aged rebates (1991-96) by the end of FY 2010-11. Upon completion, staff will shift attention to the 1997-2002 time period.

Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Effective FY 2010-11, disputed rebates are defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and to receive rebate payments.

Collection and closure of outstanding disputes has been slowed and workload increased at times due to new disputes with several large

**PHARMACY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

pharmaceutical manufacturers who have hired contractors to dispute payments made during these years.

PH 8 (OA-27)    X        X

Epocrates

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.

PH 9 (PC-38)    X        X

Medi-Cal Pharmacy Reforms

In October 2009, the Department began the implementation of 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 (UBL) requirement on pharmacies and requiring that all 340B entities dispense only 340B purchased drugs to Medi-Cal beneficiaries.

On May 5, 2010, in the case of the *California Pharmacists Association v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the UBL.

PH 10 (PC-39)    X        X

BCCTP Drug Rebates

Enhanced Title XIX Medicaid funds (65% FFP/35% GF) are claimed for drugs under the federal Medicaid BCCTP program. The Department is required by federal law to collect drug rebates whenever there is federal participation. Beginning January 2010, the Department is collecting drug rebates for the federal BCCTP program. Manufacturers were invoiced retroactively to January 1, 2002. By agreement with CMS, rebates for beneficiary drug claims for the federal portion of the BCCTP program (emergency and prenatal services) for those without satisfactory citizenship or immigration status will not be invoiced.

PH 11 (PC-34)    X        X  
 (OA-23)

Physician-Administered Drug Reimbursement

The current rate of reimbursement for physician-administered drugs is the Average Wholesale Price (AWP) minus 5%. The Department is ~~proposing legislation that will change the~~ **Health Trailer Bill of 2010 established a new reimbursement rate methodology for** physician-administered drug reimbursement methodology to the lower of the Medi-Cal pharmacy reimbursement rate or the Medicare rate **drugs that will require such drugs to be reimbursed consistent with Medi-**

## PHARMACY: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

**Cal rates of payment for non-physician administered pharmaceuticals** beginning in September 2011. The new methodology is expected to generate savings **beginning in December 2011. To ensure these rates are in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.**

PH 12 (OA-32)	X	<p><b><u>Rate Study for MAIC and AAG AAP</u></b></p> <p>The Welfare and Institutions Code, Section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies' acquisition costs and to update the MAICs at least every three months. Additionally, the Department is proposing legislation to develop a new benchmark, the Average Acquisition Cost (AAC) <b><u>Price (AAP)</u></b>, for pharmacy reimbursement of all drugs once the Average Wholesale Price (AWP) is no longer available beginning September 2011. In order to obtain the information from the providers necessary to establish the MAICs <b><u>and AAP</u></b>, the Department will hire a contractor to survey drug price information from the pharmacies and update it on an ongoing basis. Currently, the Department is under injunction for implementation of the MAIC.</p>
PH 13 (PC-31)	X    X	<p><b><u>UBL and MAIC Injunction</u></b></p> <p>On May 5, 2010, in the case of the <i>California Pharmacists Association v. David Maxwell-Jolly</i>, the court enjoined the Department from continuing to implement the Upper Billing Limitation (UBL), which required pharmacy providers to bill Medi-Cal at a rate that is no higher than the lower of the lowest price reimbursed to pharmacies by other third party payers (excluding Medi-Cal managed care plans and Medicare Part D drug plans) or the lowest price routinely offered to any segment of the general public. The UBL had been implemented in October 2009.</p> <p>The court also enjoined the Department from implementing the Maximum Allowable Ingredient Cost (MAIC), which is an upper payment limit established by the Department that creates a maximum reimbursement for generically equivalent drugs. Implementation of the MAIC was to begin July 1, 2010.</p>
PH 14 (PC-30)	X    X	<p><b><u>Federal Drug Rebate Change</u></b></p> <p>The Patient Protection and Affordable Care Act (PPACA), H.R. 3590, increases the mandated federal rebate to 23.1% of the Average Manufacturer's Price (AMP) from the previous 15.1% for single source drugs and increased the multi-source drug rebate from 11% of AMP to 13%. CMS is claiming one hundred percent of the 8% single source and 2% multi-source differential in the rebate increases. This will result in a cost to the Medi-Cal program because California currently collects</p>

## PHARMACY: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

rebates at the higher percentage for most drugs and retains the GF share at the current FMAP rate, for all rebates collected.

## 1115 WAIVER—MH/UCD & BTR

The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration (MH/UCD) ended on October 31, 2010, and a new demonstration was approved by CMS.

The California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) was approved effective November 1, 2010, for five years. This Demonstration ~~replaces~~ **extends and modifies** the previous Medi-Cal Hospital/Uninsured Care Demonstration. Many of the features of the previous Demonstration have been continued with modifications as noted in the individual assumptions. There is no new funding for the South LA Preservation Fund and the Distressed Hospital Fund. Other significant changes in the new Demonstration are:

- Expansion of the state-only programs that may be federalized up to a maximum of \$400 million in each year of the waiver;
- Creation of a Delivery System Reform Incentive ~~Payment~~ **Pool** fund to support public hospital efforts in enhancing quality of care and health of patients;
- Expansion of the current Health Care Coverage Initiative by creating a separate ~~Medi-Cal~~ **Medicaid** Coverage Expansion program using new funding for those eligibles ~~between 0% and~~ **who have family income at or below** 133% of the Federal Poverty Level.

**1115 WAIVER—MH/UCD & BTR: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

W 0.1 (PC-219)    X        X        BTR—SNCP Designated State Health Programs

The BTR was approved by the Centers for Medicare and Medicaid Services (CMS) effective November 1, 2010. Under the new demonstration, the State may claim up to \$400 million federal funds for certain state-only programs. This claiming has first priority on the Safety Net Care Pool (SNCP) funds.

Certified Public Expenditures (CPEs) from the following programs may be used to draw the federal funds:

- State Only Medical Programs
  - California Children’s Services (CCS)\*
  - Genetically Handicapped Persons Program (GHPP)\*
  - Medically Indigent Adult Long Term Care (MIA-LTC)\*
  - Breast & Cervical Cancer Treatment Program (BCCTP)\*
  - AIDS Drug Assistance Program (ADAP)
  - Expanded Access to Primary Care (EAPC)
  - County Mental Health Services Program
  - Department of Developmental Services (DDS)
  - Every Woman Counts (EWC)
  - Prostate Cancer Treatment Program (PCTP)
- Workforce Development Programs
  - Office of Statewide Health Planning and Development (OSHPD)
    - Song-Brown Healthcare Workforce Training
    - Health Professions Education Foundation Loan Repayment
    - Health Professions Education Foundation Mental Health Loan Assumption Program
  - University of California
  - California State University
  - California Community Colleges
- Miscellaneous programs.

\*Separate assumptions address the federal funds for these programs

W 0.2 (OA-74)    X        X        BTR—Low Income Health Program – Administrative Costs

Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the Low Income Health Program (LIHP). These costs will involve both the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). FFP is available for costs incurred on or after November 1, 2010, through December 31, 2013, that are associated with the start-up, implementation and closeout administration for the LIHP. The federal funding will reimburse

**1115 WAIVER—MH/UCD & BTR: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

the programs an amount equal to 50% of their certified public expenditures for administrative costs.

W 0.3 (PC-240)    X        X        BTR—Low Income Health Program – Inpatient Hospital Services for Inmates

The BTR Demonstration was approved by CMS effective November 1, 2010. The new Demonstration and AB 1628 (Chapter 728, Statutes of 2010) authorize the Department to claim federal funding for inpatient hospital services for certain State inmates in the California Department of Corrections and Rehabilitation correctional facilities. The inpatient hospital services would be those that are provided at hospitals that are off the grounds of the correctional facilities and the inmates would be those determined eligible by the Department for the LIHP program operated by the counties. The Department budgets the FFP based on the counties' CPEs.

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		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 1	(PC-83) (PC-222)	X	X	<u>MH/UCD &amp; BTR—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.

The new BTR effective November 1, 2010, makes several changes to the SNCP funding. **SNCP payments to DPHs are for uncompensated care provided to individuals with no source of third party coverage for the services they received.** Legislation is expected in ~~January~~ **April** 2011 that will detail how the SNCP funding will be distributed. It is assumed that distribution will be continued using current statutes until new legislation is enacted. SNCP funding for the Delivery System Reform Incentive Pool, Designated State Health Programs, and the Low Income Health Program—**Medicaid Coverage Expansion and the Low Income Health Program-Health Care Coverage Initiative** are included in separate new assumptions.

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		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 2	(PC-80)	X	X	<u>MH/UCD &amp; BTR—DSH Payments</u>

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

DPHs 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.

**1115 WAIVER—MH/UCD & BTR: 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 determined in the reconciliation process.

W 3    (PC-81)    X        X        MH/UCD & BTR—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.

W 4    (PC-82)    X        X        MH/UCD & BTR—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.

W 5    (PC-93)    X        X        MH/UCD & BTR—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.

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 6	(PC-86)	X	X	<p><u>MH/UCD &amp; BTR—DPH Physician and Non-Physician Costs</u></p> <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 approved the “Physician and Non-Physician Practitioner Time Study Implementation Plan” on December 15, 2008.</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. <del>Based on discussions with the DPHs, it was agreed to process the payments for 2006-07 and the estimated payments for 2007-08 prior to the payments for 2005-06. Payments for 2006-07 were made in FY 2007-08 and payments for 2007-08 were made in October 2008. Payments for 2005-06 were made in FY 2009-10. Payments for 2008-09 and 2009-10 will be made in FY 2010-11. Payments for 2010-11 will be paid in FY 2011-12.</del> <b><u>Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.</u></b></p>
W 7	(PC-92)	X		<p><u>MH/UCD—Distressed Hospital Fund</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, “distressed hospitals” receive supplemental payments from the Distressed Hospital Fund, Item 4260-601-8033. SB 1100 requires the transfer of 20 percent per year over five years of the balance of the 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"> <li>• The hospital serves a substantial volume of Medi-Cal patients.</li> <li>• The hospital is a critical component of the Medi-Cal program’s health care delivery system.</li> <li>• The hospital is facing a significant financial hardship.</li> </ul> <p><b><u>The final payment will be made in FY 2010-11, depleting any remaining accumulated interest and fund balance.</u></b></p>

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 8	(PC-98)	X	X	<p><u>MH/UCD &amp; BTR—MIA LTC Program– Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded Medically Indigent Adult Long-Term Care program.</p>
W 9	(PC-96)	X	X	<p><u>MH/UCD &amp; BTR—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 and the BTR for the State-only funded portion of the Breast and Cervical Cancer Treatment Program.</p>
W 10	(PC-88)	X	X	<p><u>MH/UCD &amp; BTR—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 and the BTR. 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>
W 11	(PC-90)	X	X	<p><u>MH/UCD—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 <b>payments</b>, 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"> <li>• For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.</li> <li>• For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the</li> </ul>

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

DPH’s computed Medi-cal cost, and the share of cost, third liability and Medi-Cal payments.

The interim reconciliation process of Medi-Cal claims for Demonstration Year 1 2005-06, was completed in February 2008. The final reconciliations for all payments for Year 1 2005-06 and Year 2 2006-07 are expected to be completed in FY 2010-11. The final reconciliation for Year 3 2007-08 is expected to be completed in FY 2011-12.

**Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.**

W 12 (PC-87)    X        X

MH/UCD—Stabilization Funding

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% **applicable** 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

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

distressed hospital stabilization amount. The Department distributes these payments.

W 13 (PC-84)    X        X    MH/UCD—Health Care Coverage Initiative

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.

The federal funds available will reimburse the CI counties an amount equal to the applicable 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.

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.

This initiative ended on October 31, 2010, with the expiration of the MH/UCD. Under the BTR, the CI becomes part of the Low Income Health Program, see the Low Income Health Program assumption.

W 14 (PC-97)    X        X        MH/UCD & BTR—DPH Interim Rate

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 interim per diem rates 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.

W 15 (PC-91)    X        X        MH/UCD & BTR—DPH Interim Rate Growth

Effective July 1, 2005, based on SPA 05-021, DPHs receive interim per diem rates based on the reported hospitals' Medi-Cal costs trended forward annually. 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.

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
W 16 (OA-3)	X	X	<p><u>MH/UCD &amp; BTR—Health Care Coverage Initiative – Administrative Costs</u></p> <p>FFP is available for costs incurred on or after March 29, 2007 through October 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 50% 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.</p> <p>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 <del>will begin</del> <b>began</b> reimbursement to the CI counties in FY 2009-10. The Department <del>will develop and submit to CMS</del> <b>received CMS approval in August 2010 for the</b> 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.</p> <p>Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the Low Income Health Program. <b><u>See assumption BTR-Low Income Health Program – Administrative Costs for more information.</u></b></p>
W 17 (OA-15)	X	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"> <li>• 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.</li> <li>• <del>That DSH payment calculations of hospital specific limits include all payments to DSH hospitals, including supplemental payments. For Demonstration Years 1 and 2 of the Medi-Cal Hospital/ Uninsured Care Demonstration, the Safety Net Care Pool payments to the designated public hospitals will not be considered as revenue when OBRA limits are calculated.</del></li> <li>• <b><u>That hospitals’ DSH payments do not exceed the costs incurred by the hospitals in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital and payments made by uninsured patients.</u></b></li> </ul> <p>CMS <del>has</del> released the final regulation and criteria for the annual independent certified audit. <del>The Department’s methodology and audits</del></p>

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

for ~~Demonstration Years 1, 2 and 3~~ are **Each year’s annual report is due to CMS by December 31, 2010.**

W 18 (PC-89)    X

MH/UCD – South LA Preservation Fund

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. This funding ends October 31, 2010, with the expiration of the Demonstration Project. Under the BTR, no separate funding is allocated to SLAMSP.

W 19 (PC-80)    X    ✕  
 (PC-81)

MH/UCD & BTR—ARRA – DSH Allotment and DSH Replacement Payments

California’s annual allotment of federal funds for the Disproportionate Share Hospital (DSH) temporarily increased for FY 2008-09, **and** FY 2009-10, ~~and FY 2010-11~~ 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.

W 20 (PC-94)    X

MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool ARRA

ARRA temporarily increased California’s FMAP by 11.59% from October 1, 2008 to December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The annual SNCP federal funds allotment will increase accordingly. This increase in federal funds will be claimed **by the State** through the Safety Net Care Pool via certified public expenditures. Effective November 1, 2010, under the BTR, this federal flexibility funding is no longer applicable.

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
W 21 (PC-85)	X		<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool</u></p> <p>The Medi-Cal Hospital/Uninsured Care Demonstration made available \$180 million in federal funds via the SNCP annually. This funding was contingent on the Department meeting specific milestones. In Demonstration Years 1 and 2, this funding was unused. The Department will utilize this funding in FY 2009-10 and FY 2010-11 to claim federal funds via certified public expenditures.</p>
W 22 (PC-95)	X		<p><u>MH/UCD—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 were reduced by 10% for Demonstration Year 2009-10. The Department will increase the amount of CPEs of the four State-only programs to utilize any remaining federal funds in the SNCP.</p>
W 23 (PC-68)	X	X	<p><u>BTR—Mandatory SPD Enrollment into Managed Care</u></p> <p>Beginning June 1, 2011, it will be mandatory for all Medi-Cal Seniors and Persons with Disabilities (SPDs) residing in managed care counties, and not dually eligible for Medicare, to enroll in a managed care plan. Currently, only SPDs in County Organized Health System counties are required to enroll in managed care.</p>
W 24 (PC-218)	X	X	<p><u>BTR—Delivery System Reform Incentive Pool</u></p> <p>The BTR was approved by the Centers for Medicare and Medicaid Services (CMS) effective November 1, 2010. Based on the Special Terms and Conditions of the demonstration, the Safety Net Care Pool (SNCP) includes a Delivery System Reform Incentive Pool (DSRIP). The DSRIP is established to support California public hospitals’ efforts in enhancing the quality of care and the health of the patients and families they serve. Funding is available in four areas:</p> <ol style="list-style-type: none"> <li>1. Infrastructure development</li> <li>2. Innovation and redesign</li> <li>3. Population-focused improvement</li> <li>4. Urgent improvement <b><u>in care</u></b></li> </ol> <p>Intergovernmental transfers (IGTs) will be used <b><u>as the non-federal share</u></b> to claim the federal funding.</p>
W 25 (PC-220) (PC-242)	X	X	<p><u>BTR—Low Income Health Program</u></p> <p>The BTR was approved by the Centers for Medicare and Medicaid Services (CMS) effective November 1, 2010. The new Demonstration modifies the existing Health Care Coverage Initiative <b><u>to expand health</u></b></p>

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**care coverage to low income adults through the Low Income Health Program (LIHP).**

LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). ~~The MCE will cover eligibles from 0% up to 133% of Federal Poverty Levels. The HCCI will cover those above 133% up to 200% of Federal Poverty Levels. These are county-based elective programs. The MCE program will terminate on January 1, 2014, when these individuals will become Medi-Cal eligible~~ **which will terminate on December 31, 2013, when these individuals will become eligible for Medi-Cal, the Health Benefits Exchange, or the Healthy Families program as appropriate** under Health Care Reform.

County program CPEs are used to obtain the federal funding for the LIHP. The MCE program is not subject to a federal funding cap while HCCI funding is subject to a cap each demonstration year.

The current HCCI program under the previous demonstration will continue unchanged until the program detailed designs has been agreed upon with CMS for both the MCE and the HCCI. Once the designs are approved, counties will have to make an election to participate. **The counties will use certified public expenditures or intergovernmental transfers to obtain federal funding for the LIHP. If counties that participate in the HCCI under the MH/UCD elect not to participate in the LIHP, they can elect to continue to provide health care services for existing enrollees and receive federal funding for these services.**

- a. **MCE will cover individuals who have family incomes at or below 133% FPL. The MCE program is not subject to a federal funding cap.**
- b. **HCCI will cover individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to a cap of \$180 million for the first three demonstration years and \$90 million for the last year ending December 31, 2013.**

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## MANAGED CARE

### Medi-Cal Managed Care Rates

Base Rates are developed through encounter and claims data available for each plan for the most recent 12 months (December 31, ~~2008~~ **2009**) and plans' self reported utilization and encounters by category of service (i.e. Inpatient, ER, Pharmacy, PCP, Specialist, FQHC, etc) for each rate category for the same period. Medi-Cal eligibility and paid claims data are used to identify all births occurring in each county and health plan. The expenditures associated with labor and delivery services are then removed from the base expenditure data. The ~~determined birth counts~~ **delivery events and associated** maternity costs are carved out of the Family/Adult, and ~~Disabled~~ **Seniors and Persons with Disabilities (SPDs) Medi-Cal Only aid** categories to establish a budget neutral county specific maternity supplemental payment.

Trend studies are performed and policy changes are incorporated into the rates. Medi-Cal specific financial statements are gathered for each plan for the last five quarters. Administrative loads are developed based upon a Two-Plan program average. Plan specific rates are established based upon all of the aforementioned steps.

A financial experience model is developed by trending plan specific financial data to the mid-point of the prospective rate year. The financial experience is then compared to the rate results established through the rate development model. If the result is reasonable, the rates are established from the rate development model. If the result is not reasonable, additional research is performed and the rates are adjusted based upon the research and actuarial judgment.

For rate years beginning in 2009-10, for plans contracting in Two Plan Model and Geographic Managed Care counties, the Department implemented maternity supplemental payments and risk adjusted capitation rates.

The maternity supplemental payments are in addition to the health plan's monthly capitation payment and are paid based on the plan's reporting of a delivery event. Maternity supplemental payment amounts are done in a budget neutral manner so that the cost of the expected deliveries does not exceed the total dollars removed from the Adult/Family and Disabled Medi-Cal Only capitation rates.

Capitation rates are risk adjusted to better reflect the match of a plan's expected costs to the plan's risk. Capitation rates were risk adjusted in the Family/Adult and Aged /Disabled/Medi-Cal Only COAs.

Risk Adjustment and County Averaging is prepared with plan specific pharmacy data (with NDC Codes) gathered for Managed Care and FFS enrollment data for the most recent 12 month period. A cut-off date is established for the enrollment look-back. If a beneficiary is enrolled for 6 of the 12 months (not consecutively), then he is counted in the plan's risk scoring calculation.

Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 10 age bands, gender, and 45 disease categories. Each member in the Family/Adult or ~~ABD~~ **(SPD)** Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the ~~ABD~~ **SPD** Medi-Cal only rate. A county specific rate is then developed for the Family/Adult rate and the ~~ABD~~ **SPD** Medi-Cal only rate. The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the 2010-11 rates, 20 percent of this county specific rate was taken and multiplied by each plan's respective risk score and 80 percent of each plan's plan specific rate was retained and added to the 20 percent risk adjusted rate to establish a risk adjusted plan specific rate. This percentage blend was chosen in order to prevent rate shock and allow the managed care plans to adjust their operations and demonstrates the Department's move towards using a greater percentage of the risk adjusted county average rates.

## MANAGED CARE

For County Organized Health Systems, rates continue to be based on the plans' reported expenditures trended in the same manner as for the Two Plan and GMC models.

### Fee-for-Service Expenditures for Managed Care Beneficiaries

Managed care capitation payments totaled \$7.4 billion in calendar year 2009, and FFS "carve-outs" and "wrap-around" payments totaled an additional \$1.8 billion for managed care enrollees. Managed care contracts require health plans to provide specific services to Medi-Cal enrolled beneficiaries. Medi-Cal services that are not delegated to contracting health plans remain the responsibility of the Medi-Cal FFS program. When a beneficiary who is enrolled in a Medi-Cal managed care plan is rendered a Medi-Cal service that has been explicitly excluded from their plan's respective managed care contract, providers must seek payment through the FFS Medi-Cal program. The services rendered in the above scenario are commonly referred to as "carved out" services. "Carved-out" services and their associated expenditures are excluded from the capitation payments and are reflected in the Medi-Cal FFS paid claims data.

In addition to managed care carve-outs, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to FQHC/RHC providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as "wrap-around" payments.

FQHC "wrap-around" payments and California Children's Services "carve-out" expenditures account for roughly 70% of all FFS expenditures generated by Medi-Cal beneficiaries enrolled in managed care plans.

Fee-for-Service Expenditures for Non-Capitated Services Made on Behalf of Beneficiaries Enrolled in Medi-Cal Managed Care Health Plans; FY 2009-10				
Vendor Code	Non CCS	CCS	GRAND TOTAL	PERCENT
77-Rural Health Clinic/Federally Qualified Health Center/Indian Health Clinic	\$ 458,420,684	\$ 2,846,570	\$ 461,267,254	25.4%
60-Community Hospital-Acute Inpatient	\$ 24,191,518	\$ 426,322,007	\$ 450,513,524	24.8%
26-Pharmacist	\$ 238,835,353	\$ 144,326,619	\$ 383,161,971	21.1%
80-Nursing Facility (formerly known as Skilled Nursing Facility)	\$ 103,481,234	\$ 110,970	\$ 103,592,203	5.7%
22-Physician Group	\$ 6,782,541	\$ 79,422,083	\$ 86,204,623	4.7%
55-Local Education Agency	\$ 70,336,569	\$ -	\$ 70,336,569	3.9%
62-Community Hospital-Outpatient	\$ 4,990,139	\$ 57,652,707	\$ 62,642,846	3.4%
44-Home Health Agency	\$ 6,039,116	\$ 37,565,563	\$ 43,604,679	2.4%
01-Adult Day Health Care Center	\$ 36,475,779	\$ -	\$ 36,475,779	2.0%
50-County Hospital-Acute Inpatient	\$ 1,410,050	\$ 29,467,660	\$ 30,877,710	1.7%
Other	\$ 52,139,351	\$ 37,127,297	\$ 89,266,649	4.9%
<b>Grand Total</b>	<b>\$ 1,003,102,332</b>	<b>\$ 814,841,476</b>	<b>\$ 1,817,943,808</b>	<b>100.0%</b>
<b>Percent</b>	<b>55.2%</b>	<b>44.8%</b>	<b>100.0%</b>	

### 2010-11 and 2011-12 Rates

Overall, the rates represent a ~~4.65%~~ **3.8%** increase **in FY 2010-11 and 2.71% increase in FY 2011-12** over the previous rates (based on a fiscal year comparison). The ~~4.65%~~ increase includes pharmacy pricing reductions of 0.71% and a 2% non-general fund impact related to IGTs. A portion of the increase is due to the net positive (upward) impact of the program changes contributing 0.2%. This 0.2% was driven by an increase from the provider payment reduction adjustment of 0.7% which was partially offset by a 0.5% decrease coming from the post stabilization and SB94 rollback impacts. Claim cost trends are also up approximately 0.9% per year, led by increases seen recently for several Two Plan model plans. One large Two Plan Model plan also shifted from last year's extremely low 1% to a more reasonable 4.3%

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## MANAGED CARE

trend. Given their size, this has a significant impact on the overall trend. These items have overpowered a 0.5% administration decrease at the mid-point, 0.4% decrease at the lower bound. **The lower level increase was related to aggregate annual trends which were 4.3% in FY 2010-11 dropping down to 3.5% for FY 2011-12 for the Two Plan Model and Geographic Managed Care plans (GMC). The 2.71% increase includes a slightly lower administrative load than the prior fiscal year. The updated program changes produce a 0.23% increase in the overall rates, mainly due to the current provider payment reduction adjustments. The pharmacy MAC adjustment created a 1% decrease in the lower bound rate range, while the reduction in pharmacy rebates created a 1.3% increase.**

Inpatient costs' impact in the Two Plan is up roughly 6.25% when comparing the current rates to prior. The County Organized Health System plan (COHS) claim cost trends and administration PMPMs developed for 7/1/10-6/30/11 have helped significantly in moderating capitation increases for the total Medi-Cal managed care program. Also of note for COHS plans is the increase in scope of services for the Health Plan of San Mateo. In February 2010, HPSM added long term care services to their scope of coverage, added additional coverage for CHDP and mental health laboratory and pharmacy services effective July 1, 2010.

These **The FY 2011-12** rates do not reflect potential **the** savings achieved once **when** DHCS assumes **assumed** the authority for rate setting for Geographic Managed Care **GMC** contract **contracts** from the California Medical Assistance Commission. This change occurred July 1, 2010 and is budgeted as a line item change in the Estimate. **with the passage of SB 853 in October 2010. Rates for GMC plans will be set by the Department at the lower bound of the rate range beginning January 1, 2011.**

Rates for FY 2011-12 have not yet been determined; however, a placeholder of 3.9% has been **was** included in the November Estimate.

**MANAGED CARE: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 0.1 (PC-252)		X	<p><u>Managed Care Public Hospital IGTs</u></p> <p>Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage will be assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. In conjunction with this, SB 208 (Chapter 714, Statutes of 2010) allows public entities, such as Designated Public Hospitals (DPH), to transfer funds under Intergovernmental Transfers (IGT) to the Department. The funds will be used as the non-federal share of capitation rate increases. This will enable plans to compensate DPHs in amounts that are no less than what they would have received for providing services to these beneficiaries under the FFS model, including supplemental payments, CPEs and any additional federally permissible amounts, which are available only under FFS. On an annual basis, it is anticipated this will result in an estimated \$554 million in total funds that will be paid in the form of capitation rate increases. . Because this enrollment transition will occur over a period of time beginning June 1, 2011, the initial IGT will be \$346 million for the period June 1, 2011 through June 30, 2012.</p>
M 0.2 (PC-250)	X	X	<p><u>Transfer of MCO Tax Funds to the General Fund</u></p> <p>AB 1422 (Chapter 157, Statutes of 2009) imposed an additional tax on the total operating revenue of Medi-Cal Managed Care Organizations (MCOs). The taxes are then placed in a special MCO Tax fund and are used to increase the capitation rates to reimburse the cost of the tax to the plans.</p> <p>Capitation rate increases due to the MCO tax are initially paid from the General Fund. The General Fund is then reimbursed through a transfer from the MCO Tax Fund on a quarterly basis. A reimbursement of \$89.9 million is expected in FY 2010-11 for FY 2009-10 capitation payments.</p>
M 0.3 (PC-261)		X	<p><u>Managed Care IGT Administrative and Processing Fee</u></p> <p>Counties may transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds are used for the nonfederal share of capitation rate increases. Beginning July 1, 2011, the Department will charge counties an administrative and processing fee for their IGTs. The fee will be 20% of each IGT and will offset the cost of medical services provided under the Medi-Cal program.</p>
M 0.4 (PC-265)		X	<p><u>General Fund Reimbursements from DPHs</u></p> <p>Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage will be assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. For Medi-Cal beneficiaries under the FFS program, payments to Designated Public Hospitals (DPHs) are comprised of CPEs</p>

### MANAGED CARE: NEW ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

matched with federal funds. For Medi-Cal beneficiaries under managed care, payments to DPHs are comprised of General Fund and federal funds. Therefore, as SPDs are transitioned into managed care, GF expenditures will increase for DPH services.

Beginning in FY 2011-12, DPHs will reimburse the GF for costs that are built into the managed care capitation rates that would not have been incurred had the SPDs remained in FFS.

M 0.5 (PC-266)  
(PC-FI)

X    One Year Lock-In for Managed Care Enrollees

The Department will propose legislation to restrict beneficiaries in Two-Plan and GMC counties from switching managed care plans more than once a year, effective October 1, 2011.

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 1	(PC-45)	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, fourteen counties are fully operational under the Two-Plan Model.</p> <p>A regional Two-Plan Model, including Fresno (an existing managed care county), Kings and Madera Counties is set for implementation in February <del>February</del> <b>March</b> 2011.</p> <p>2010-11 <del>2010-11</del> <b>2011-12</b> capitation rates include:</p> <ul style="list-style-type: none"> <li>• Rate redetermination effective <del>10/1/10</del> <b>10/1/11</b>.</li> <li>• <del>H1N1 vaccine</del></li> <li>• <del>Cal Pharmacy injunction impact</del></li> <li>• <del>Elimination of nine optional benefits</del></li> <li>• <del>Optometry services reinstatement</del></li> </ul> <p>Title XXI payments for the June 2010 capitation were paid in FY 2010-11 due to an insufficient Title XXI Appropriation.</p>				
M 2	(PC-58)	X		<u>PHP</u>
<p>Kaiser is the only remaining Prepaid Health Plan (PHP) and has a contract in Marin County. It is expected that Marin County will transition to a COHS plan effective July 2011.</p> <p>2010-11 capitation rates include:</p> <ul style="list-style-type: none"> <li>• Rate redetermination effective 10/1/10.</li> </ul>				
M 3	(PC-46) (PC-66)	X	X	<u>County Organized Health Systems</u>
<p>Five County Organized Health Systems (COHSs) are operational in eleven counties. Effective February 1, 2010, Health Plan of San Mateo added long term care services to their contract. Currently, all COHS plans <del>provide</del> <b>have assumed risk for</b> long term care services <del>to their enrollees</del>. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries. PHC is negotiating with the Department to remove undocumented beneficiaries from their contract effective July 1, 2011. <del>The rate year for COHS plans begins July 1<sup>st</sup> and ends June 30<sup>th</sup>.</del></p>				

**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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 (October 2009)  
 Marin County (July 2011)  
 Mendocino County (July 2011)

Central California Alliance for Health (CCAH)  
 Santa Cruz County  
 Monterey County  
 Merced County (October 2009)

Ventura County plans to start up a new COHS with a target date of ~~February~~ **July** 2011.

2010-11 **2011-12** capitation rates include:

- Rate redetermination effective ~~07/01/10~~ **07/01/11**.
- ~~H1N1 vaccine~~
- ~~Cal Pharmacy injunction impact~~
- ~~Elimination of nine optional benefits~~
- ~~Optometry services reinstatement~~

Title XXI payments for the June 2010 capitation were paid in FY 2010-11 due to an insufficient Title XXI Appropriation.

M 4    (PC-55)    X    X

AIDS Healthcare Centers

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) prior to January 1, 2002 are included in the plan's contracted scope of services except for new drugs which do not fit into one of the current therapeutic classes and for which the Department

**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

does not have sufficient utilization data to determine the financial impact of the use of those drugs will have on the managed care plan<sup>4</sup>. New rates developed effective January 1, 2010 include all drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) prior to January 1, 2007.

Savings Sharing/Incentive Distributions: Prior obligations exist for AIDS Healthcare Centers. These are obligations that are owed to the contractor 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 take up to one year. Because of the long period of time needed to make the final determinations, savings-sharing has not been determined for calendar year 2009 and beyond.

The current contract was not converted to full risk and has been extended with new rates through December 31, ~~2010~~ **2011**. ~~Once all approvals are received a full risk contract will be implemented.~~

M 5    (PC-47)    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., Anthem Blue Cross Partnership Plan, KP Cal, LLC, and Molina Healthcare of California Partner Plan, Inc.

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 1<sup>st</sup> Partnership Plan, LLC, and Community Health Group Partnership Plan.

Capitation rates for GMC contracts ~~are currently~~ **were previously** negotiated by the California Medical Assistance Commission (**CMAC**). **However, Senate Bill 853 (Chapter 717, Statutes of 2010)** provided ~~The the~~ Department has proposed legislation to transfer the authority for negotiating the capitation **exclusive authority to set the** rates, to the Department, which is expected to achieve a savings **terms, and conditions of GMC contract amendments**.

2010-11 ~~2011-12~~ capitation rates include:

- Rate redetermination effective 1/1/11.
- ~~H1N1 vaccine~~
- ~~Cal Pharmacy injunction impact~~
- ~~Elimination of nine optional benefits~~
- ~~Optometry services reinstatement~~

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y																																		
		<u>C/Y</u>	<u>B/Y</u>																																	
M 6	(PC-57)	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. 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 contract with the Department is effective January 1, 2008 through December 31, 2012.</p>																																
M 7	(OA-17)	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.</p>																																
M 8	(PC-48)	X	X	<p><u>Managed Care Intergovernmental Transfers</u></p> <p>Counties will transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds will be used for the nonfederal share of capitation rate increases. The following counties' IGT will continue on an ongoing basis:</p> <table border="0" style="margin-left: 40px;"> <thead> <tr> <th><u>COHS</u></th> <th><u>Effective Date</u></th> </tr> </thead> <tbody> <tr> <td>San Mateo</td> <td>July 1, 2005</td> </tr> <tr> <td>Santa Barbara</td> <td>July 1, 2009 (<del>Pending CMS approval</del>)</td> </tr> <tr> <td>Santa Cruz</td> <td>July 1, 2009 (Pending CMS approval)</td> </tr> <tr> <td>Solano</td> <td>July 1, 2009 (Pending CMS approval)</td> </tr> <tr> <td>Monterey</td> <td>July 1, 2009 (Pending CMS approval)</td> </tr> <tr> <td>Sonoma</td> <td><del>July</del> <b>October</b> 1, 2009 (Pending CMS approval)</td> </tr> <tr> <td>Merced</td> <td>October 1, 2009 (Pending CMS approval)</td> </tr> <tr> <td>Orange</td> <td>July 1, 2010 (Pending CMS approval)</td> </tr> <tr> <td><b><u>Yolo</u></b></td> <td><b><u>July 1, 2010 (Pending CMS approval)</u></b></td> </tr> <tr> <td><b><u>Marin</u></b></td> <td><b><u>July 1, 2011 (Pending CMS approval)</u></b></td> </tr> </tbody> </table> <table border="0" style="margin-left: 40px;"> <thead> <tr> <th><u>Two Plan Model</u></th> <th><u>Effective Date</u></th> </tr> </thead> <tbody> <tr> <td>Los Angeles</td> <td>October 1, 2006</td> </tr> <tr> <td>Alameda</td> <td>October 1, 2008</td> </tr> <tr> <td>Contra Costa</td> <td>October 1, 2008</td> </tr> <tr> <td>Kern</td> <td>October 1, 2008</td> </tr> </tbody> </table>	<u>COHS</u>	<u>Effective Date</u>	San Mateo	July 1, 2005	Santa Barbara	July 1, 2009 ( <del>Pending CMS approval</del> )	Santa Cruz	July 1, 2009 (Pending CMS approval)	Solano	July 1, 2009 (Pending CMS approval)	Monterey	July 1, 2009 (Pending CMS approval)	Sonoma	<del>July</del> <b>October</b> 1, 2009 (Pending CMS approval)	Merced	October 1, 2009 (Pending CMS approval)	Orange	July 1, 2010 (Pending CMS approval)	<b><u>Yolo</u></b>	<b><u>July 1, 2010 (Pending CMS approval)</u></b>	<b><u>Marin</u></b>	<b><u>July 1, 2011 (Pending CMS approval)</u></b>	<u>Two Plan Model</u>	<u>Effective Date</u>	Los Angeles	October 1, 2006	Alameda	October 1, 2008	Contra Costa	October 1, 2008	Kern	October 1, 2008
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**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Riverside	October 1, 2008
San Bernardino	October 1, 2008
San Francisco	October 1, 2008
San Joaquin	October 1, 2008
Santa Clara	October 1, 2008

M 9    (PC-65)    X    X

FFS Costs for Managed Care Enrollees

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.

M 10    (PC-64 N/A)    X

Annual Redetermination of Capitation Rates

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.

~~Capitation rates for Geographic Managed Care contracts are currently negotiated by the California Medical Assistance Commission. The Department has proposed legislation to transfer the authority for negotiating capitation rates to the Department effective July 1, 2010.~~

M 11    (OA-21)    X

SPD Education and Outreach Material

~~To target barriers to enrollment of seniors and persons with disabilities (SPDs) into managed care, the~~ **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. **Because SPDs will be required to enroll in managed care plans, including in GMC and Two-Plan counties,** UC Berkeley is ~~currently developing~~ **has developed** the education and outreach material that will be used for the Medi-Cal SPDs' conversion to mandatory enrollment status.

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 12	(PC-67)	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. Agnews closed in March 2009 and all consumers have been transitioned to the community.</p> <p>The Department has developed agreements with three health plans, regional centers and CDDS 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, 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 <u>a managed care plan</u>. The Department <del>has</del> established a mechanism whereby the plans <del>are</del> <u>were</u> paid a supplemental payment in addition to the capitation rate for these individuals, followed by periodic reconciliations to reimburse the plans for reasonable costs. <del>In December 2010, The the Department will implement</del> <u>implemented</u> new full risk rates retroactively to July 1, 2008 for the Health Plan of San Mateo and January 1, 2008 for Santa Clara, Family Health Plan <del>once the plan contracts are amended to include the new full risk rates. The full risk rates are anticipated to be implemented in 2010. The interim rate will be eliminated once the full risk capitation rate is implemented. The Alameda Alliance for Health has not yet agreed to accept a full risk capitation rate.</del> <u>contract was amended, effective July 1, 2010, to reduce the previous interim rate until a full risk capitation rate is agreed upon.</u></p>
M 13	(PC-54) (PC-52) (PC-62) (PC-63)	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 October 2009, Medi-Cal managed care has completed expansion into San Luis Obispo County (COHS), Sonoma County (COHS), and Merced County (COHS).</p> <p><del>The next phase is for</del> Ventura County (COHS), <del>is</del> targeted for implementation in <del>February</del> <u>July</u> 2011. In addition, a regional Two-Plan Model, including Fresno (an existing managed care county), Kings and Madera Counties is set for implementation in <del>February</del> <u>March</u> 2011. Mendocino County (COHS) and Marin County (COHS) are targeted for implementation in July 2011.</p>
M 14	(PC-56)	X		<p><u>Court-Ordered Managed Care Rate Adjustments</u></p> <p>In the case of <i>Health Net of California v. Department of Health Services</i>, the Third District Court of Appeal ruled that the Department must pay <del>\$17,427,000</del> <u>\$17,590,000</u>, including post-judgment interest, to Health Net for a dispute over Two Plan Model capitation rates for years ranging from 1997 to 2002. <del>To date In FY 2009-10, \$14.6 million has been</del> <u>was</u> paid to Health Net and the remaining <del>\$2.83</del> <u>2.99</u> million <del>will be</del> <u>was</u> paid to the health plan in FY 2010-11 <u>December 2010</u>.</p>

**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

M 15 (PC-53)    X

Maternity Supplemental Payment

The Department implemented a new maternity services reimbursement structure for Two Plan model managed care plans effective October 1, 2009, and for several GMC model managed care plans effective January 1, 2010. With this new payment structure, maternity services are not part of the Family and Adult rates. Instead, the health plans are paid a pre-determined amount based upon the maternity costs and other actuarial information for each delivery event. The plans are given up to 15 months to report deliveries before forfeiting the supplemental payment.

The Family and Adult capitation rates have been adjusted and are reflected in the model policy changes, but only the Two Plan model plans and some GMC model plans have a contracted maternity supplemental payment rate and have been paid. The Department ~~is continuing to negotiate~~ **has finalized** rates with ~~Kaiser Sacramento and Kaiser San Diego~~, of the **remaining** GMC model plans. ~~Once the GMC model maternity supplemental payment rates have been finalized, payments will be retroactive to~~ **Retroactive payments for the period of** January 1, 2010 through June 30, 2010 ~~and are expected to be~~ **were** made in FY 2010-11.

M 16 (PC-64)    X

Managed Care Family Planning Increased Federal Matching Funds

The Department has completed an assessment of the cost accounting 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~~ **Previously**, a 50% federal funding match ~~is was~~ drawn down. Implementation of a new cost accounting methodology ~~will result~~ **resulted** in a 90% federal funding match for family planning services. The Department consulted with CMS on the validity of the methodology and retroactive claiming. CMS approved the methodology and the Department implemented the new cost accounting methodology to claim enhanced funding retroactively for a 24-month period and on an ongoing basis. Claiming at 90% began in FY 2009-10.

M 17 (PC-60)    X        X  
 (PC-45)  
 (PC-46)  
 (PC-47)  
 (PC-51)  
 (PC-55)

Increase in Capitation Rates for MCO Tax

AB 1422 (Chapter 157, Statutes of 2009) has imposed an additional tax on the total operating revenue of Medi-Cal Managed Care plans. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. The provision pertaining to this tax is effective retroactively to January 1, 2009 and will sunset June 30, 2011. The Department is proposing legislation to

## MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

extend the tax through ~~June 30, 2012~~ **December 30, 2013**. Managed Care plans affected by this new legislation are:

- Two Plan Model
- County Organization Health Systems
- Geographic Managed Care
- AIDS Healthcare Centers
- SCAN

**PROVIDER RATES: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PR 0.1 (PC-29)	X	X	<p><u>Hospital Inpatient Rate Freeze Litigation</u></p> <p><i>California Hospital Association v. David Maxwell-Jolly, et al.</i> was filed in the United States District Court on December 27, 2010. The lawsuit challenged implementation of the hospital inpatient rate freeze. On January 28, 2011, the court granted a Temporary Restraining Order (TRO) against the Department. On March 4, 2011, the court issued a ruling granting the preliminary injunction and enjoining the Department's implementation of the rate freeze. Because of the court action, the hospital inpatient rate freeze will not be applied to inpatient services provided on or after January 28, 2011.</p>
PR 0.2 (PC-259)		X	<p><u>Non-AB 1629 LTC Rate Freeze</u></p> <p>The Health Trailer Bill of 2011 requires the Department to freeze rates at the 2008-09 levels for long term care facilities not subject to the rate-setting methodology mandated under AB 1629.</p>

**PROVIDER RATES: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
PR 1	(PC-78) (PC-72)	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. ABX4 5 (Chapter 5, Statutes of 2009), lowered the allowable overall rate increase from five percent to zero percent for rate years 2009-10 and 2010-11.</p> <p>The QA fee is capped at 5.5% of gross revenue (including Medicare) through July 31, 2011. The rate methodology and QA fee provisions sunset on July 31, 2012.</p> <p>The Health Trailer Bill of 2010</p> <ul style="list-style-type: none"> <li>• Extended the reimbursement methodology and QA fee provisions through July 31, 2012</li> <li>• Provided a rate increase through an additional QA fee, which will be GF neutral.</li> <li>• Implemented a quality and accountability payments program for NF-Bs, with the first phase beginning in rate year 2010-11. Payments made under the program will begin in rate year 2011-12 as supplemental to the rates and will be paid through a special fund. The special fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, one percent of the weighted average rate increase for 2011-12 and the savings achieved from setting the professional liability insurance cost category at the 75th percentile.</li> </ul> <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 was applied to the rate effective August 1, 2009 and will be retroactive to July 12, 2006.</p> <p><b><u>CMS mandated that freestanding skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training and increased staff time to input data, resulting in an add-on to the reimbursement rates for these facilities. The rate increase will be effective August 1, 2011, and be retroactive to August 1, 2010.</u></b></p>

**PROVIDER RATES: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

There is no expected cost of living rate increase for the fiscal year 2010-11 or 2011-12.

PR 2 (PC-74)    X    X

Annual MEI Increase for FQHCs and RHCs

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 1<sup>st</sup> of each year.

PR 3 (PC-71)    X    X

LTC Rate Adjustments

Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of the annual rate study. However, ABX4 5 (Chapter 5, Statutes of 2009), froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels.

Pursuant to ABX4 9, beginning in FY 2009-10, the Uniform Holiday Schedule increased the number of days that the adult day services facilities are closed. The closures impact staffing at Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Habilitative and Nursing. These facilities increased staffing to accommodate the additional four days that residents will be on-site. Because the closure of adult day services is a state-mandated cost to facilities, a reimbursement rate add-on was effective for the 2009-10 rate year and for each additional rate year that the freeze is in effect. Due to this add-on, only ICF/DD, ICF/DD Habilitative and Nursing facilities receive State Plan LTC adjustments.

The following facilities are included in this assumption:

- 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~~

**PROVIDER RATES: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

~~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. **Effective October 1, 2011, the federal government will allow states to cap the QA fee at 6% of the facilities total gross revenue.**

PR 4 (PC-77)    X    X

Hospice Rate Increases

Pursuant to state regulations, Medicaid hospice rates are established in accordance with 1902(a)(13), (42 USC 1396a(a)(13)) of the federal Social Security Act. This act requires annual increases in payment rates for hospice care services based on corresponding Medicare rates. New hospice rates are effective October 1<sup>st</sup> of each year.

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.

PR 5 (PC-BA)    X    X

Alternative Birthing Centers

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.

PR 6 (PC-79)    X    X

Reduction to Radiology Rates

The Budget Act of 2010 reduced Medi-Cal rates for radiology services to 80 percent of Medicare rates, effective October 1, 2010. **Rate reductions will be implemented, retroactive to October 1, 2010, following assessment of the impact of the reduction.**

PR 7 (PC-69)    X    X

AB 1629 Rate Adjustments Due to QA Fee Increase

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. The State uses a portion of the fee to draw down FFP and to fund the rate increases.

The Budget Act of 2010 requires the Department to expand the amount of revenues upon which the QA fee is assessed by including revenue

**PROVIDER RATES: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

from Multi-Level Retirement Communities (MLRCs) and revising the QA Fee trending methodology. This will result in rate increases to the facilities. The rate increases are expected to be cost neutral to the General Fund.

The Department of Public Health lowered the licensing fees for skilled nursing facilities in FY 2010-11. This will allow the Department to increase the quality assurance portion of the fee, up to the 5.5% cap, resulting in an increase in rates to these facilities. The rate increases are expected to be cost neutral to the General Fund.

FY 2011-12 will also include an additional rate increase due to the increase in the QA fee safe harbor limit from 5.5% to 6%, scheduled to take effect on ~~August 1~~ **October 1**, 2011.

PR 8 (PC-29)    X    X

Hospital Inpatient Rate Freeze

The Health Trailer Bill of 2010 froze Medi-Cal inpatient services rates paid to all hospitals except Designated Public Hospitals (DPH) at the lesser of the rate that was in effect on January 1 or July 1, 2010. The rate freeze would apply to both non-contract and contract hospitals. Any negotiated rate increases for contract hospitals would be nullified upon implementation of this legislation. The DPHs are reimbursed utilizing certified public expenditures (CPE) as the State’s share of costs. Therefore, DPHs are excluded from this hospital inpatient rate freeze.

PR 9 (PC-243)    ✕    X  
 (Reworded)

10% Provider Payment Reduction

The Health Trailer Bill of 2011 requires the Department to implement a 10% provider payment reduction to specified providers. This reduction will be implemented in both the FFS and managed care settings.

PR 10 (PC-245)    ✕    X

10% Payment Reduction for ~~1629~~ Long Term Care Facilities

~~Legislation will be proposed to implement~~ **The Health Trailer Bill of 2011 implements** a 10% payment reduction to nursing and subacute facilities reimbursed under the AB 1629 reimbursement methodology. **to long term care facilities. This reduction will be implemented in both the FFS and managed care settings.**

**The payment reduction is applicable to the following facilities:**

- **Freestanding Skilled Nursing Facilities – (SNF-B) and Subacute Facilities (AB 1629 Facilities)**
- **Distinct – Part (Hospital-Based) Skilled Nursing Facilities – (DP/SNF-B), Adult Subacute**
- **Intermediate Care Facilities for the Developmentally Disabled (ICF-DD)**
- **Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) - Habilitative**

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) – Nursing
- Freestanding Skilled Nursing Facilities – (SNF-B), Pediatric Subacute
- Distinct – Part (Hospital-Based) Skilled Nursing Facilities – (DP/SNF-B), Pediatric Subacute

**SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

SP 0.1 (PC-260)	X	X	<u>NDPH IGT Supplemental Payments</u>	AB 113 (Chapter 20, Statutes of 2011) establishes a supplemental payment program for Non-Designated Public Hospitals (NDPHs). These payments are funded with Intergovernmental Transfers (IGTs) and are distributed to the NDPHs based upon a formula in the statute. The State retains nine percent of the IGTs to fund administrative costs and Medi-Cal children’s health programs.
SP 0.2			<u>SB 90 Hospital Inpatient Reimbursement</u>	SB 90 (Chapter 19, Statutes of 2011), an urgency bill signed April 13, 2011, made a number of changes to the Medi-Cal program:
(PC-263)		X	<u>FY 2011-12 Hospital QAF – Children’s Health Care</u>	SB 90 allows an acute care hospital building that is classified as a Structural Performance Category-1 (SPC-1) building to be used for nonacute care hospital purposes after January 1, 2010, contingent upon a hospital QAF program being established in FY 2011-12 that results in \$320 million in fee revenue for health care coverage for children. It is assumed that legislation will be enacted to establish such a program in FY 2011-12.
(PC-29)	X	X	<u>Hospital Inpatient Rate Freeze</u>	The hospital inpatient rate freeze imposed by SB 853, the Health Trailer Bill of 2010, was annulled by SB 90. Any payment reductions because of the rate freeze will be refunded to hospitals.
(PC-81)	X	X	<u>MH/UCD &amp; BTR—Private Hospital DSH Replacement</u>	SB 90 reduced Medi-Cal DSH replacement payments to private hospitals by \$30 million GF in FY 2010-11 and \$75 million GF in FY 2011-12.
(PC-99) (PC-137)	X		<u>Hospital QAF – Hospital Payments</u>	SB 90 extended the Hospital QAF program for the period January to June 2011. The bill modified the amount of payments to hospitals and also increased the amount available for children’s health to \$105 million per quarter during the extension from the previous \$80 million per quarter.

**SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
(PC-267)			X	<u>Preserving Contract Hospitals</u>
				SB 90 includes a provision that requires a reduction in amount of any QAF supplemental payment for a contract hospital that converts to non-contract status. This reduction is equal to the amount by which the hospital's overall payment for Medi-Cal services was increased during the program period by reason of it becoming a noncontract hospital.
(PC-264)	X		X	<u>Non-Contract Hospital Rate Changes</u>
				SB 90 repealed a number of rate reductions for non-contract hospital inpatient services. These include:
				<ul style="list-style-type: none"> <li>• ABX3 5 (Chapter 3, Statutes of 2008) 10% reduction of non-contract hospital inpatient payments;</li> <li>• AB 1183 (Chapter 758, Statutes of 2008), the Budget Trailer Bill required additional rate reductions for non-contract hospitals; and</li> <li>• AB 97 (Chapter 3, Statutes of 2011) imposed 10% reductions on those non-contract hospitals that were previously exempt.</li> </ul>

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

SP 1 (PC-100) X                    AB 1653 Supplemental Payments to DPHs

AB 1653 (Chapter 218, Statutes of 2010) revises the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 (Chapter 627, Statutes of 2009). AB 1653 also allows the State to retain up to \$420 million from the portion of the Hospital Quality Assurance Revenue Fund (Item 4260-610-3158) set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department ~~would claim~~ **claimed** these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and ~~would distribute~~ **distributed** those funds in conformity with the QAF Hospital payment schedule.

SP 2 (PC-105) X            X            Capital Project Debt Reimbursement

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.

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. Two DP facilities are expected to begin submitting claims in FY 2010-11.

SP 3 (PC-102) X            X            Hospital Outpatient Supplemental Payments

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 share 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 every year in June. Interim payment adjustments are made upon receipt and review of amended claims.

The reconciliation mandated by AB 915 of FY 2002-03 against audited cost reports is scheduled to begin in FY 2010-11. Adjustments to interim payments, or recoupment of overpaid funds, are expected during FY

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

2010-11. Reconciliation of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.

SP 4	(PC-103)	X	X	<p><u>IGTs for Non-SB 1100 Hospitals</u></p> <p>W&amp;I Code, Section 14164, provides general authority for the Department to accept IGTs from a governmental entity in the State in support of the Medi-Cal program. The IGT will be used as the non-federal share of cost in order to draw down FFP, which will then be distributed to the hospitals designated by the county or health care district.</p>
SP 5	(PC-106)	X	X	<p><u>FFP for Local Trauma Centers</u></p> <p>The Budget Act of 2003 provided authority for Los Angeles County and Alameda County to submit IGTs to the Medi-Cal program to be used as the non-federal share of costs in order to draw down federal funds. The combined funds will be used to reimburse specified hospitals for costs of trauma care provided to Medi-Cal beneficiaries.</p>
SP 6	(PC-107)	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 7	(PC-108)	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 8	(PC-109)	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		
		<u>C/Y</u>	<u>B/Y</u>	
SP 9	(PC-101)	X	X	<p><u>Freestanding Outpatient Clinics and State Veterans' Homes Supplemental Payments</u></p> <p>AB 959 (Chapter 162, Statutes of 2006) adds eligible freestanding outpatient clinics and state veterans' homes to the current Medi-Cal outpatient supplemental program. Under this program, clinics that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. State veterans' homes that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, or health care district are also eligible to receive supplemental payments.</p> <p>The non-federal match is paid from public funds of the participating facilities.</p> <p>Supplemental payments to state veterans' homes will be effective retroactively beginning with the rate year starting August 1, 2006, <del>pending an approved State Plan Amendment.</del> Supplemental payments to freestanding outpatient clinics will be effective retroactively beginning July 1, 2006 pending an approved State Plan Amendment. The SPA is expected to be approved in FY 2010-11, <del>and payments</del> <b>Payments for FY 2006-07 through FY 2009-10 for both programs <u>State's Veterans Homes</u> are expected to be made beginning in FY 2010-11. <u>Payments for FY 2006-7 through 2009-10 for Freestanding Outpatient Clinics are expected to be made beginning in FY 2011-12.</u></b></p>
SP 10	(PC-104)	X	X	<p><u>Specialty Mental Health Services Supplemental Reimbursement</u></p> <p>ABX4 5 (Chapter 5, Statutes of 2009) creates a provision to allow an eligible public agency receiving reimbursement for specialty mental health services provided to Medi-Cal beneficiaries to also receive supplemental Medi-Cal reimbursement up to 100% of actual allowable costs.</p> <p>The supplemental payment 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. The non-federal share of costs used to draw down FFP for the supplemental payments will be expended from the public agency, and will not involve General Fund dollars.</p> <p>The Department submitted a SPA to CMS to obtain approval for the new supplemental payment program. The Department and CDMH are providing additional information to CMS. Upon approval, supplemental payments will be authorized retroactive to January 2009, with payments expected to be made beginning FY <del>2010-11</del> <b>2011-12.</b></p> <p>The Supplemental Payment Program will be included in the SMH Waiver.</p>

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

Applicable F/Y  
C/Y    B/Y

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

Applicable F/Y  
C/Y    B/Y

A 1	(PC-131) <u>Lawsuits / Claims*</u>	Applicable F/Y <u>C/Y</u> <u>B/Y</u>	
	a. <u>Attorney Fees of \$5,000 or Less</u>		
	Fund Balance	\$50,000	\$50,000
	b. <u>Provider Settlements of \$75,000 or Less</u>		
	1. <i>Daughters of Charity Health Systems</i>	\$3,538	
	2. <i>Cedars-Sinai Medical Center</i>	\$1,002	
	3. <i>Daughters of Charity Health Systems</i>	\$15,600	
	4. <i>Cedars-Sinai Medical Center</i>	\$4,521	
	5. <i>Catholic Healthcare West Southern CA</i>	\$6,105	
	6. <i>Cedars-Sinai Medical Center</i>	\$6,665	
	7. <i>Catholic Healthcare West Southern CA</i>	\$1,296	
	8. <i>Jupiter Bellflower Doctors Hospital</i>	\$13,339	
	9. <i>Catholic Healthcare West Southern CA</i>	\$7,713	
	10. <i>Alta Los Angeles Hospitals Inc.</i>	\$3,777	
	11. <i>Catholic Healthcare West Southern CA</i>	\$5,043	New
	12. <i>Catholic Healthcare West</i>	\$31,166	New
	13. <i>East Los Angeles Doctors Hospital, Inc.</i>	\$7,983	New
	14. <i>Daughters of Charity Health Systems</i>	\$9,773	New
	15. <i>Anaheim Memorial Medical Center</i>	\$18,594	New
	16. <i>Good Samaritan Hospital</i>	\$309	New
	17. <i>Catholic Healthcare West</i>	\$13,038	New
	18. <i>Pacific Health Corporation</i>	<u>\$13,933</u>	New
	Total	\$163,395	
	Fund Balance	\$1,436,605	\$1,600,000
	c. <u>Beneficiary Settlements of \$2,000 or Less</u>		
	Fund Balance	\$15,000	\$15,000
	d. <u>Small Claims Court Judgments of \$5,000 or Less</u>		
	Fund Balance	\$200,000	\$200,000
	e. <u>Other Attorney Fees</u>		
	1. <i>Alejandro C.</i>	\$14,477	
	2. <i>Kevin Conlan v. Diana Bonta et al.</i>	\$242,485	New
	3. <i>Emily Q, et al. v. Diana Bonta, et al.</i>	\$313,210	New
	f. <u>Other Provider Settlements / Judgments</u>		
	1. <i>Daughters of Charity Health Systems</i>	\$163,962	
	2. <i>Good Samaritan Hospital</i>	\$121,888	
	3. <i>Providence Health System</i>	\$370,177	New
	4. <i>Country Hills Health Care Inc.</i>	\$58,254	New
	g. <u>Other Beneficiary Settlements</u>		

Amounts may exclude interest payments.

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

Applicable F/Y  
C/Y    B/Y

A 2    (PC-130)    X

Audit Settlements

Federal audit A-09-07-00039 determined that the Department reimbursed providers for terminated drug products. These drug products were not eligible for Medicaid coverage because they were terminated drugs and their termination dates were listed on the CMS quarterly drug tapes before the drugs were dispensed. The Department will return the federal portion of the terminated drug expenditures to CMS in FY 2010-11 for drugs paid from October 1, 2003 through September 30, 2005.

During the conversion of the LEA Program coding to national coding, coding errors were made which caused multiple claiming issues and prolonged the timeline for completing the necessary FI systems changes. Because of the delay, when the claims were processed some were beyond the two-year claiming limit. CMS has issued a disallowance of \$732,000 for these claims.

Federal audit A-09-08-00034 determined that FFP was improperly claimed for compound drug ingredients that were not eligible for Medicaid coverage. The Department will return the federal portion of the improperly claimed compound drug ingredient expenditures to CMS in FY 2010-11 for claims paid from October 1, 2003 through September 30, 2005.

A 3    (PC-133)    X

X

Notices of Dispute / Administrative Appeals – Settlements

Settlement agreements for disputes between the Department and the ~~Two-Plan model~~ managed care plans are estimated to be \$1,000,000 **\$2,000,000** for possible settlements for each fiscal year.

A 4    (PC-127)    X

X

Minor Consent Settlement

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.

A 5    (OA-6)    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.

Ongoing litigation filed by managed care plans against the Department regarding their capitation rates has resulted in increased work and costs for

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

Applicable F/Y  
C/Y    B/Y

the Department's consulting actuaries to comply with the requirements of the court rulings.

A 6    (PC-150)    X

Litigation Settlements

The Department continues to work collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks and overcharging Medicaid. Settlements are expected to be received in FY 2010-11 from Westcliff Medical Laboratories; **Seacliff Diagnostics Medical Group**; Teva; Alpharma; AstraZeneca; and Novartis; **Dey Pharma, L.P.**; **Allergan**; **Forest Pharmaceuticals, Inc.**; **Eisai/Elan**; **GlaxosmithKlein Pharmaceutical Corp.**; **KOS Pharmaceuticals, Inc.**; **Ortho-McNeil-Janssen Pharmaceutical, Inc.**; **Schwarz Pharma**; **Serono**; and **CVS Caremark, Inc.**

**OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

**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 September 30, 2009.

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.

On August 10, 2010, the President signed the Education, Jobs and Medicaid Assistance Act of 2010 that includes a six-month extension through June 2011 of Medicaid's temporary enhanced FMAP for the states. California will receive an 8.77% FMAP increase for January 1, 2011 through March 31, 2011 and a 6.88% FMAP increase for April 1, 2011 through June 30, 2011.

R 2	(PC-115)	X	X	<u>Dental Contract</u>
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Pursuant to ABX3 5 (Chapter 20, Statutes of 2009), effective July 1, 2009, the Department no longer provides specified dental services for adults 21 years of age or older with the following exclusions: individuals residing in Skilled Nursing Facilities (SNFs) or Intermediate Care Facilities (ICFs), pregnant women, and Federally Required Adult Dental Services (FRADs).

The dental rates for the period August 1, 2009 through July 31, 2010 are:

Refugees	All Others
\$9.50	\$6.76

Effective March 2, 2010, reimbursement rates for certain dental anesthesia procedures have been reduced. These changes are reflected in the 2010-11 capitation rates.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The dental rates for the period August 1, 2010 through July 31, 2011 are:

Refugees	All Others
<del>\$9.50</del>	<del>\$6.76</del>
<b><u>\$7.06</u></b>	<b><u>\$6.70</u></b>

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

R 3    (PC-50)    X    X  
       (PC-149)

Dental Geographic Managed Care

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 several dental plans. ~~As of July 1, 2008~~ **Currently**, there are five dental GMC plans.

The five GMC contracts are in effect through December 31, 2012.

R 4    (PC-50)    X    X  
       (PC-149)

Dental Managed Care within Medi-Cal Two-Plan Model Counties

The 1997-98 Budget Act made a 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.

The Department has contracted with eight dental plans that are providing services as voluntary PHPs in Los Angeles County. These contracts ended June 30, 2009. Amendments have been executed extending the contracts through June 30, 2011. Contract amendments extending the PHP contracts are in process.

R 5    (PC-145)    X    X

FI Cost Containment Projects – Program Savings

The Department has approved implementation of proposals developed by the Fiscal Intermediary 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.

R 6    (OA-9)    X    X

MIS/DSS Contract

The Management Information System and Decision Support System (MIS/DSS) ~~gathers houses~~ data from provider, financial, eligibility and managed care/fee-for-service encounter and claims ~~data~~ **and incorporates it** 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.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Ongoing operation and maintenance of the MIS/DSS is accomplished through a multi-year contract with Integris, Inc. DBA Ingenix, which is effective through February 14, ~~2011~~ **2014**. ~~Current contract provisions allow for an option to extend the contract for an additional three years. The Department anticipates exercising this option for the first additional year commencing February 15, 2011 through February 14, 2012.~~

Effective July 1, 2008, the Department reduced the funding for the MIS/DSS contract ongoing operations costs by 25%. **Additional funding is required to meet the increased operational service and data volume demands, while ensuring compliance with new security and OTECH standards.**

R 7    (PC-142)    X        X

Indian Health Services

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.

Recent changes posted in the Federal Register increased the per visit rate payable to Indian Health Clinics effective January 2010.

R 8    (OA-49)    X        X

Kit for New Parents

Beginning in November 2001, Title XIX FFP has been claimed for the "Welcome Kits" distributed by the California Children and Families Commission (Proposition 10) to parents of Medi-Cal eligible newborns.

R 9    (PC-116)    X        X

Developmental Centers/State Operated Small Facilities

The Medi-Cal budget includes the estimated federal fund cost of the CDDS Developmental Centers (DCs) and two State-operated small facilities.

R 10    (OA-37)    X        X

CDDS Administrative Costs

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.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 11	(PC-112) (OA-36)	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 July 21, 2010, CMS granted a second year waiver renewal starting October 1, 2010 through June 30, 2011 for the current Specialty Mental Health Waiver. <b><u>On March 30, 2011, a waiver renewal request was submitted to CMS for approval.</u></b></p> <p>On July 1, 2010, HPSM began providing laboratory and pharmacy services to mental health patients enrolled in the plan.</p> <p>As a result of the settlement of litigation filed by a number of specialty mental health providers subcontracted to Los Angeles County, payments for certain denied or unprocessed claims under the waiver for FYs 2003-04, 2004-05 and 2005-06 will be paid in FY 2010-11.</p>
R 12	(PC-126)	X	X	<p><u>Healthy Families – CDMH</u></p> <p>Title XXI FFP will be claimed for the cost of providing additional mental health services to Severely Emotionally Disturbed children who have exhausted Healthy Families mental health benefits.</p>
R 13	(PC-120) (OA-43)	X	X	<p><u>Mental Health Drug Medi-Cal – CDADP</u></p> <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 14	(PC-132) (OA-44)	X	X	<p><u>CLPP Case Management Services</u></p> <p>The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments, which provide case management services. To the extent that local governments provide case management to Medi-Cal eligibles, federal matching funds can be claimed.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 15	(PC-141) (Reworded)	X	X	<p><u>Cigarette and Tobacco Products Surtax Funds</u></p> <p>Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the <i>Orthopaedic Hospital</i> settlement via the Hospital Services Account and the Unallocated Account.</p> <p>Additional CTPS/Proposition 99 funds have also been allocated to aid in the funding of Medi-Cal hospital outpatient services for FY 2010-11 and FY 2011-12. The amounts available to Medi-Cal vary from year to year.</p>
R 16	(OA-54)	X	X	<p><u>California Health and Human Services Agency HIPAA Funding</u></p> <p><del>In order to meet HIPAA requirements and ensure that its provisions are applied in a uniform manner to ensure there are no disruptions to the ongoing reimbursement of healthcare programs,</del> a <b>A</b> HIPAA office has been established at the California Health and Human Services Agency <b>to coordinate implementation and set policy regulations for departments utilizing Title XIX programs.</b> Title XIX FFP is available for <u>qualifying</u> HIPAA activities related to Medi-Cal.</p>
R 17	(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 18	(OA-2) (OA-30)	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. 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>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.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 19	(PC-140)	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), was entirely state-funded. As of 2008, this cost is now county-funded per Welfare and Institutions Code, Section 14053.3.</p>
R 20	(OA-18)	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 21	(OA-31)	X	X	<p><u>TAR Postage</u></p> <p>Postage costs related to mailing treatment authorization request-related documents are budgeted in local assistance.</p>
R 22	(PC-129)	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. On January 1, 2008, the State Plan was amended to remove HIV/AIDS as an automatic HIPP-eligible condition. Effective March 1, 2010, the Department discontinued payments for beneficiaries with HIV/AIDS whose premiums exceeded Medi-Cal cost avoidance thresholds.</p>
R 23	(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. The premiums for Calendar Year 2010 are \$461 for Part A and \$110.50 for Part B. The premiums for Calendar Year 2011 are \$450 for Part A and \$115.40 for Part B. The estimated premiums for Calendar Year 2012 are \$450 and \$115.40, respectively.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 24	(OA-61)	X	X	<u>PIA Eyewear Courier Service</u>  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 Sacramento Overnight, Incorporated expires on June 30, 2011.
R 25	(OA-40)	X	X	<u>FFP for Department of Public Health Support Costs</u>  Title XIX federal Medicaid funding for Medi-Cal-related CDPH support costs are budgeted in the Medi-Cal local assistance budget and are shown as a reimbursement in the CDPH budget.
R 26	(PC-117)	X	X	<u>ICF-DD Transportation and Day Care Costs - CDDS</u>  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.  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.
R 27	(PC-128)	X	X	<u>Non-Contract Hospital Inpatient Cost Settlements</u>  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.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 28	(PC-70)	X	X	<u>FQHC/RHC/CBRC Reconciliation Process</u>
<p>The Medi-Cal reimbursement policy for Federally Qualified Health Centers/Rural Health Clinics and Cost-Based Reimbursement Clinics (FQHC/RHC/CBRCs) 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 &amp; I Code § 14170, a final audit is performed and either a final settlement or recovery invoice is prepared.</p> <p>W &amp; I Code § 14105.24 requires the Department to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. An interim rate, adjusted after each audit report is final, is paid to the clinics. The CBRCs are then required to submit an annual cost report no later than 150 days after the close of their fiscal year. The Department audits each CBRC's cost report and completes a cost settlement which results in a payment to the CBRC or a recoupment from the CBRC. The Department expects to complete the audits for FY 2006-07 in FY 2010-11 and for FY 2007-08 in FY 2011-12. Interim rates will be adjusted to the FY 2005-06 audited levels beginning in FY 2010-11, and to the FY 2006-07 audited levels in FY 2011-12.</p>				
R 29	(OA-14)	X	<b>X</b>	<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 to current standards.</p>				

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

On January 16, 2009, the Federal Register identified new HIPAA transaction requirements (5010), which must be implemented by December 31, 2011.

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.

R 30    (PC-136) X        X  
           (PC-118)

ARRA – Additional FFP for DHCS

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.

R 31    (OA-13) X        X  
           (PC-123)  
           (PC-FI)

ARRA HITECH Incentive Program

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 \$45 billion over ten years between 2011 and 2021 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.

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. It is estimated that approximately 10,000 providers and 435 hospitals will be eligible for incentive payments over the life of the program. Provider payments are paid with 100% federal funds.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

On November 19, 2009, CMS approved California’s Health Information Technology Planning – Advanced Planning Document (HIT PAPD) for the purpose of creating the initial landscape assessment, campaign plan and strategic and implementation plan, which were completed in May 2010. ~~The Department has submitted an updated HIT PAPD to request funding for additional planning and policy work necessary to complete the CMS required State Medicaid Health Information Technology Plan and the Implementation Advanced Planning Document (HIT IAPD).~~ **In September 2010 CMS approved an updated HIT PAPD (HIT PAPDU) to fund additional planning and policy work necessary to complete the CMS required State Medicaid Health Information Technology Plan (SMHP) and the Implementation Advance Planning Document (HIT IAPD). Implementation of the provider incentive program is pending CMS approval. It is anticipated that implementation will begin May 2011.**

The Fiscal Intermediary (FI) will design, develop and implement systems necessary to enroll, pay and audit providers and hospitals who participate in the Medi-Cal EHR Incentive Payments Program.

HITECH establishes a 90% federal funding match specific to the state for this work. The 10% General Fund match will be covered by the California Healthcare Foundation. Therefore, there will be no impact to the General Fund.

R 32 (PC-148) ✕      X

Reduction in IMD Ancillary Services Costs

The W&I Code requires that any state and federal Medi-Cal funds paid for the cost of ancillary services for Medi-Cal eligibles who have not attained 65 years of age and who are residents of Institutions for Mental Diseases (IMDs) be recovered from counties by the California Department of Mental Health (CDMH) . The Department is developing processes in collaboration with CDMH to stop and to collect inappropriate billing for ancillary services.

R 33 (OA-25) X      X

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

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

resolving the outstanding issues. The Department continues to be responsible for paying for the special master. **The federal district court recently ordered that jurisdiction will end on May 6, 2011.**

R 34    (OA-29)    X        X        Katie A. v. Diana Bontá – Special Master

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 engage in further meetings with the court appointed Special Master. These meetings ~~are currently scheduled to end ended~~ in November 2010; however, it is anticipated that the judge will extend the **order a new series of** meetings **that will extend** into FY 2011-12. The Special Master is being funded by the Department and CDSS.

R 35    (PC-152)    X               Delay Checkwrite June 2011 to July 2011

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 2010-11, an additional checkwrite for institutional providers whose claims are processed by the fiscal intermediary will be delayed and paid during the next fiscal year. **The Department will no longer delay the June 23, 2011 checkwrite in order to maximize FFP.**

R 36    (OA-19)    X        X        Encryption of PHI Data

The Department acquired hardware, supplies and associated maintenance and support services that are necessary to encrypt electronic data stored on backup tapes. The data on these tapes contain Medi-Cal beneficiary information that is considered confidential and/or protected health information (PHI) by federal and state mandates.

The encryption of these tapes will:

- Secure and protect Department information assets from unauthorized disclosure;
- Protect the privacy of Medi-Cal beneficiaries;

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- Prevent lawsuits from citizens for privacy violations;
- Avoid costs to notify millions of people if a large breach does occur; and
- Maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.

R 37 (PC-118) X  
(PC-136)

Extension of ARRA FMAP Increase

On August 10, 2010, the President signed the Education, Jobs and Medicaid Assistance Act (P.L. 111-226) which includes a six-month extension through June 2011 of Medicaid’s temporary enhanced FMAP for the states. California will receive an 8.77% FMAP increase for January 1, 2011 through March 31, 2011 and a 6.88% FMAP increase for April 1, 2011 through June 30, 2011.

R 38 (PC-NA) X        X  
(PC-154)

Federal Flexibility and Stabilization—Additional Federal Reimbursement

The Department will request federal reimbursement for: (1) Health care costs for disabled individuals who were actually eligible for Medicare; (2) recalculation of the rate at which California pays for Medicare Part D drug coverage and (3) applying the enhanced ARRA FMAP ratio to the Medicare Part D drug coverage payments. The impact of these federal funding increases is included in a separate budget control section with the exception of (3) applying the enhanced ARRA FMAP ratio to the Medicare Part D drug coverage payments.

R 39 (PC-125) X        X

ICF-DD Administrative and QA Fee Reimbursement - CDDS

The Department of Developmental Services (DDS) will make supplemental payments to Medi-Cal providers that are licensed as Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), ICD-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center consumers. The services and transportation are arranged for and paid by the local Regional Centers, which will bill DDS on behalf of the ICF-DDs. When the State Plan Amendment (SPA) is approved, DDS will provide payment, retroactive to July 1, 2007, to the ICF-DDs for the cost of reimbursing the Regional Centers for the cost of arranging the services plus a coordination fee (administration fee and the increase in the QA fee).

The Department will enter into an interagency agreement with DDS for the reimbursement of the increased administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 40	(PC-143)	X	X	<p><u>Discontinue Part B Premium for Unmet Share of Cost Beneficiaries</u></p> <p>Effective April 2011, the Budget Act of 2010 included the elimination of payment of the Medicare Part B premiums for beneficiaries with an unmet share of cost (SOC) of \$500 or less. Payment of the premiums for those with unmet SOCs greater than \$500 was eliminated effective December 1, 2008.</p>
R 41	(PC-138)	X	X	<p><u>Medi-Cal Cost Containment Strategies</u></p> <p>The Department will implement strategies to reduce Medi-Cal costs. These strategies may include a combination of limits on services and utilization controls, increased cost sharing through copayments and/or premiums, and other programmatic changes.</p>
R 42	(PC-99) (PC-137)	X	X	<p><u>Hospital QAF</u></p> <p>AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 2009 through December 2010. AB 1653 (Chapter 218, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 (Chapter 627, Statutes of 2009). AB 1653 alters the methodology, timing, and frequency of supplemental payments, increases capitation payments <b><u>to Medi-Cal managed health care plans</u></b>, and increases payments to mental health plans. <del>AB 1653 allows the Department to proceed with implementing the Quality Assurance Fee (QAF) once a letter indicating likely federal approval has been received. Legislation has been proposed to extend the fee to June 30, 2011.</del></p> <p>The fee will be deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158) created by AB 188 (Chapter 645, Statutes of 2009). This fund will be used to provide supplemental payments to private, and non-designated public hospitals, grants to designated public hospitals, and increased capitation payments to managed health care and increased payments to mental health plans. Managed care capitation rates <del>will be</del> <b><u>were</u></b> adjusted to reflect the increased payments that are required to be made to hospitals for hospital services provided to Medi-Cal enrollees of the plan. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program. <del>A "likely federal approval" letter was received from CMS on September 27, 2010, allowing DHCS to make fee-for-service payments. Two of the three approvals for managed care plan contracts have also been received, and payments to those managed care plans covered by the approved contracts were made before January 1, 2011.</del> <b><u>Final federal approval for the fee-for-service payments has been received. CMS has also</u></b></p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**approved the managed care contract amendments with the rate adjustments.**

R 43 (PC-241)    X    X    Accelerated Payments

In FY 2010-11, the Department will accelerate budgeted payments to maximize federal funds under ARRA. The increased FMAP for July 2010 through December 2010 available under ARRA is 11.59%. While the Education, Jobs and Medicaid Assistance Act of 2010 extended the increased FMAP, it phased it out over six months. The increased FMAP available for January 2011 through March 2011 is 8.77%, and the increased FMAP for April 2011 through June 2011 is 6.88%. For FY 2011-12, the FMAP will return to the base rate of 50%.

The Department will temporarily suspend the one-week hold at the end of December 2010, March 2011 and June 2011, thereby advancing payments one week. In addition, the Department will pay the last two checkwrites in June 2011, which were budgeted in the 2010 Budget Act to be paid in FY 2011-12. The Department will also accelerate **COHS** managed care payments in December 2010 and March 2011, and accelerate some Safety Net payments in December 2010.

**OTHER: RECOVERIES: NEW ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
RC 0.1 (PC-251) (OA-75)	X		<p><u>Medicare Buy-In Quality Review Project</u></p> <p>On October 1, 2010, the Department entered into a three-year contract with the University of Massachusetts (UMASS) to identify potential overpayments to CMS or Medicare providers related to the buy-in process for Medicare/Medi-Cal dual eligibles. UMASS will assist the Department in auditing the invoices received from CMS to pay the Medicare premiums. The Department anticipates it will begin realizing savings in FY 2011-12. Payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers.</p>
RC 0.2 (PC-255)	X		<p><u>Recoupment of Medicare Provider Overpayments</u></p> <p>The Department will recoup overpayments made to Medi-Cal/Medicare providers for services that have both a professional and technical billing component. Prior to October 2005, claims were billed on paper which included both the professional and technical billing component. In October 2005, billable services transitioned to electronic claims but claims with both professional and technical components were processed in error. The system was corrected in May 2009 to bill for each service if the claim had both components. In April 2011, the Department plans to install the Erroneous Payment Correction (EPC) to reprocess previously paid claims from October 2005 through May 2009.</p>

**OTHER: RECOVERIES: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
RC 1 (PC-153)	X		X	<u>Base Recoveries</u>  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.
RC 2 (PC-146)	X		X	<u>Anti-Fraud Initiative</u>  Effective July 1, 2010, the Department expanded its anti-fraud activities for physician services. Savings <del>will begin</del> <b>began</b> in <del>November 2010</del> <b>January 2011</b> .
RC 3 (PC-147)	X		X	<u>FQHC/RHC Audit Staffing</u>  The Department will receive positions to perform audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines. In the past five years, the number of FQHC/RHC providers has increased from 460 to 907, while the number of audit staff has remained the same. It is anticipated that the new positions will generate increased cost savings.
RC 4 (OA-8)	X		X	<u>Medi-Cal Safety Net Recovery Contract</u>  The Department contracts with vendors to identify third party health insurance and workers compensation insurance. When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries. <del>The current contract began in January 2009.</del>
RC 5 (PC-221)	X		X	<u>Anti-fraud Activities for Pharmacy and Physicians</u>  In FY <del>2010-11</del> <b>2011-12</b> , the Department <del>proposes to</del> <b>will</b> expand its anti-fraud activities. The activities will focus on pharmacy services and physician services.

**FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u> <u>B/Y</u>	
FI 0.1 (PC-FI)	X	<p><u>Point of Service Refresh</u></p> <p>Medi-Cal providers are currently able to use the Point of Service (POS) devices to verify Medi-Cal recipients' eligibility, and perform claims-related transactions including: decrement Share of Cost (SOC), submit pharmacy transactions for immediate on-line adjudication, access the Child Health and Disability Prevention Gateway, and submit Family Planning, Access, Care and Treatment transactions.</p> <p>The devices that support the POS network are out-of-date and need to be replaced to comply with the new HIPAA transactions standards. Implementation of the POS refresh is scheduled for June 2011.</p>
FI 0.2 (PC-FI)	X	<p><u>FI Assumption of Operations Delay Reimbursement</u></p> <p>In May 2010, the Department awarded the medical fiscal intermediary contract to Affiliated Computer Services (ACS) to assume the responsibilities for Medi-Cal claims processing functions as well as to replace the current California Medicaid Management Information System (CA-MMIS). The Assumption of Operations (AOO) by ACS was scheduled for February 1, 2011, but delayed to June 13, 2011. ACS has agreed to reimburse the Department for costs related to this delay.</p> <p>In January 2011, ACS delayed the AOO from June 13, 2011 to September 30, 2011. The Department and ACS are in the process of determining ACS' liability due to the second AOO delay.</p>
FI 0.3 (PC-FI)	X	<p><u>Additional Resources to Support CSU Operations</u></p> <p>Additional funding is required to support operations of the Correspondence Specialist Unit (CSU) due to the implementation of SDN 09041 Optional Benefits Exclusions (OBE) Phase Three. A post payment audit of OBE claims generated by the implementation of SDN 09041 will be performed on a sample basis.</p>
FI 0.4 (PC-FI)	X	<p><u>Family PACT Retroactive Eligibility Claim Process</u></p> <p>Effective April 1, 2011, the Department implemented a manual retroactive eligibility process for newly-enrolled qualified Family PACT beneficiaries. The manual process will include procedures to allow qualifying Family PACT clients to be reimbursed for qualifying out of pocket expenses for the prior three months before eligibility determination, requiring HP to update all affected systems necessary to ensure proper payment of these Family PACT claims.</p>

**FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

FI 0.5 (PC-FI)

X

Additional Costs associated with Delay in Assumption of Operations (AOO)

Due to the delay in AOO by ACS, there will be additional anticipated costs associated with HP for the following: incremental turnover support beyond the contract required 12 months, increases in short term lease payment for buildings, increases in short term hardware and software maintenance agreements, and potential increases in leases to replace failing equipment.

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 1	(PC-FI) (PC-145)	X	X	<p><u>Cost Containment Proposals – Savings Sharing</u></p> <p>The Department continues to review and approve the Fiscal Intermediary-initiated cost containment proposals, implementing as appropriate to contain Medi-Cal costs. Savings are achieved, with the Fiscal Intermediary continuing to receive a share of the savings.</p> <p>Additionally, the Contractor continues the process of identifying fraudulent claims activity in two areas – outpatient (physician, DME, lab, pharmacy, etc.) and prepayment review. As other areas are identified, they will be further developed. The savings methodology is linked to actual cost avoidance and/or realized recovery of fraudulent payments to providers. The Contractor has developed a program to formalize the identification of fraudulent claims activity, facilitate appropriate intervention with various audit organizations, recommend system or policy modifications, if appropriate, and support regulation development, if necessary, to support efforts by the Department to expeditiously stop illegal and inappropriate payment activity. The staffing is provided by the Contractor.</p>
FI 2	(PC-FI)	X	X	<p><u>HIPAA – Provider Relations</u></p> <p>Provider relations are an essential component of the activities relating to HIPAA. Additional Fiscal Intermediary 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>Fiscal Intermediary 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. The Fiscal Intermediary also continues work on implementing the National Provider Identifier.</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 3	(PC-FI)	X	X	<p><u>HIPAA UPN Exception Request</u></p> <p>Implementation of the original scope of the Universal Product Number (UPN) pilot project was cancelled in March of 2006 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.</p> <p>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 were implemented on April 1, 2009; however, medical supply providers were given an additional 90-day grace period in order to make the changes to their systems. Effective July 1, 2009, all medical supplies were billed with a national HCPCS code along with a UPN for products that have been contracted with the Department. <del>All HIPAA UPN system costs will be paid in FY 2009-10 and FY 2010-11.</del> CMS is requiring a two-year evaluation of the project to substantiate the possible adoption of the UPN as a HIPAA standard. <del>Work continues to be done in this area</del> <b><u>The two-year UPN evaluation period extends through FY 2010-11 and FY 2011-12. During this time, State and contract staff will continue</u></b> to administer research tools, collect and analyze data and develop evaluation reports on the study findings.</p>
FI 4	(PC-FI)	X	X	<p><u>HIPAA – CA-MMIS</u></p> <p>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.</p> <p>The work necessary is associated with the following HIPAA regulations:</p> <ul style="list-style-type: none"> <li>• Privacy (April 14, 2003 compliance deadline)</li> </ul>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- 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 (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. 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.

FI 5    (PC-NA)    X        X        Extension of the HP Contract

The Department currently holds a contract with HP for the operation of CA-MMIS. Operations under the base contract continued through June 30, 2007. Through the provisions of the contract, the Department exercised all three one-year bid extensions, which extended the contract until June 30, 2010.

The Department has opted to exercise an extended operations period, and will work with the Department of General Services and HP to continue uninterrupted support of ongoing operations until a successful Assumption of Operations (AOO) by the new FI contractor.

FI 6    (OA-24)    X        X        Medicaid Information Technology Architecture (MITA)

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

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

various systems. CMS will not approve APDs or provide federal funding to the Department without adherence to MITA.

The Department completed the CMS-required MITA State Self-Assessment (SS-A) of business processes to determine the current and long-term business requirements. The Department must now complete a MITA Transition and Implementation plan by ~~February 28~~ **December 31**, 2011, to retain the enhanced funding for the SS-A. The Department is currently developing Enterprise Architecture (EA) at the Agency level to address MITA EA activities.

FI 7    (OA-12)    X    X    CA-MMIS Replacement and Oversight Contractors

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. The Department ~~will contract~~ **contracts** with various vendors to assist with FI oversight activities, documentation of business rules, IT evaluation assistance, project management assistance during transition and IV&V assistance for the replacement system.

FI 8    (PC-FI)    X    X    Medi-Cal Fiscal Intermediary Contract Turnover

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 Department opted to exercise an extended operations period and will work with the Department of General Services to continue uninterrupted support of ongoing operations until a successful AOO by the new FI contractor. Turnover activities began January 1, 2008.

FI 9    (PC-FI)    X    X    CA-MMIS Takeover by New FI Contractor

CA-MMIS is the 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 Department has opted to exercise an extended operations period of the current medical FI contract and will work with the Department of General Services to continue uninterrupted support of ongoing operations until a successful AOO by the new FI contractor. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published on December 8, 2009. **The Takeover activities of the new FI contractor began on May 3, 2010.** In the Takeover Phase, upon

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

~~award of a new Medi-Cal FI contract~~, the new FI is required to complete contractually required activities necessary for the ~~assumption of operations~~ **AOO** from the current contractor. These activities include the following expansion items: On-line and Computer-Based Interactive Training, Post-Service Prepayment Audit, Contingency Payments, Caller Satisfaction Evaluation Tool, Encounter Data Processing, Geographic Mapping, Contract Management, CA-MMIS Enterprise Project Management Office, Project and Portfolio Management, **Additional Software Licenses**, Additional Office Space, Security for Data "At Rest", Additional 32-Bit Processors, Payment Methodology Modification, and Sensitive Information Redaction.

FI 10 (OA-59)    X

Case Management Information and Payrolling System II (CMIPS II)

The Department entered into an interagency agreement (IA) with CDSS to be reimbursed for the cost of one-time programming and system changes necessary to interface the CA-MMIS with the CMIPS II. The system changes that establish the interface between systems to enable the CDSS In-Home Supportive Services (IHSS) program to access clinical data necessary for effective case management were implemented in June 2009.

FI 11 (OA-10)    X        X

CA-MMIS Takeover Other State Transition Costs

CA-MMIS is the claims processing system used for Medi-Cal. The current FI contract ~~was~~ **is** scheduled to end on June 30, ~~2010~~ **2011**. The Department ~~has opted~~ **plans** to ~~exercise an extended operations period of the current medical FI contract and will work with the Department of General Services to continue uninterrupted support of ongoing operations until a successful AOO by the new FI contractor.~~ **extend the term of the current contract past the June 30, 2011 expiration date through a contract amendment utilizing a non-competitive bid justification.** CA-MMIS Takeover activities include interfacing with other DHCS mission critical systems such as MEDS, EMBER, SCO, MIS/DSS and PCES applications that will require coordination and resources with other DHCS Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system and parallel), support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. Therefore, additional costs will be incurred to support two environments during the Takeover of the existing system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these new environments in support of transition activities during the Takeover phase. CA-MMIS is a mission critical system that must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during Takeover.

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

FI 12 (PC-FI)    X        X        Business Rules Extraction Enhancement

The objective of the Business Rules Extraction (BRE) Enhancement is to define a new rules base for the legacy MMIS and store the rules, once confirmed, in a requirements traceability tool for tracking future testing management and updating. The existing business rules for CA-MMIS are not well documented and may not fully represent current Medi-Cal policy. It is the Department’s intent to implement the Replacement System with the current business rules and program policy, to support validation of the Replacement System functionality, and then update the system through policy directives to the Contractor, based on the Contractor’s report of the BRE. The Confirmed Legacy System business rules will also be incorporated into the Replacement System design. The Contractor will develop this policy base through analysis of business rules embedded in the legacy CA-MMIS and compare the policy base with published DHCS policy manuals. The Contractor will identify discrepancies between the system embedded rules and current DHCS policy and recommend a course of action. DHCS will determine the appropriate course of action and direct the Contractor on this course. DHCS will verify and validate the business rules only after the Contractor has completed its detailed analysis.

FI 13 (PC-FI)    X        X        CA-MMIS Re-Procurement – HIPAA ICD-10 Legacy Enhancement

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding. Medi-Cal currently uses ICD-9 coding, as does the majority of the national health care industry, as critical data for claims processing, prior authorization, fraud investigation, and other program operations. The Final Rule for ICD-10 indicates an expectation that efforts to begin addressing these requirements begin no later than January 2011; the compliance deadline is October 1, 2013.

**The procurement of a new contract for the CA-MMIS was awarded to Affiliated Computer Services (ACS), and new contract for CA-MMIS includes an enhancement of the existing system to address ICD-10 requirements. The eventual replacement system will not be in place in time to meet the federal requirements, which would put all federal Medi-Cal IT funding at risk for deferral or denial due to violation of HIPAA requirements. Planning, analysis, development and implementation of the CA-MMIS ICD-10 enhancement is in process.**

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 14	(PC-FI)	X	X	<p><u>CA-MMIS Re-Procurement – 5010/D.0 Legacy Enhancement</u></p> <p>As part of the HIPAA, the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt new versions of the standards for electronically exchanging critical administrative health care transactions, including health care claims, eligibility information, prior authorizations, and payment information. These changes will impact the vast majority of Medi-Cal providers and managed care plans. These new versions are maintained by two national standards organizations; X12 and the National Council for Prescription Drug Programs (NCPDP). X12's transactions are part of standard called "5010," while NCPDP's standard is called "D.0". <del>A new transaction for Medicaid Pharmacy Subrogation (i.e., "pay and chase") is also required and is known as NCPDP Version 3.0.</del> The compliance deadline is January 1, 2012.</p> <p>The procurement of a new contract for CA-MMIS <b><u>new contract for the CA-MMIS was awarded to ACS, and</u></b> includes an enhancement of the existing system to address the <del>5010/D.0/3.0</del> <b>5010/D.0</b> transaction requirements. <del>The eventual replacement system will not be in place in time to meet the federal requirements, which would put all federal Medi-Cal IT funding at risk for deferral or denial due to violation of HIPAA requirements. Providers would also experience difficulty submitting claims electronically to Medi-Cal for payment.</del> <b><u>Planning, analysis, development and implementation of the CA-MMIS 5010/D.0 enhancement are in process.</u></b></p>
FI 15	(PC-FI)	✗	X	<p><u>TAR/SAR System Replacement</u></p> <p>The Department will replace the existing Treatment Authorization Request (TAR) System, establish two TAR Processing Centers and consolidate existing Medi-Cal Field Office, Field Office Automation Group (FOAG) activities. The CMS-Net and Service Authorization Request (SAR) functionality, including the help desk, will also be replaced by the new TAR system. TAR/SAR replacement DD&amp;I will begin January <del>2011</del> <b>2012</b>, and implementation of the system will begin within two years of assumption of operations by the new FI.</p>
FI 16	(PC-FI)	✗	X	<p><u>Pharmacy Claims/DUR/Rebate Accounting</u></p> <p>The Department will implement a new pharmacy claims system that will include three major components: real-time Point-of-Service (POS) and batch claims processing; the rebate collection and tracking system; and drug utilization review (both prospective and retrospective). Work on the system will begin in January <del>2011</del> <b>2012</b>, and implementation of the system will begin within two years of assumption of operations by the new FI.</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
FI 17	(PC-FI)	X	<p><u>Rebate Accounting and Information System Hardware and Software Refresh</u></p> <p>The Rebate Accounting and Information System (RAIS) support invoicing of pharmaceutical drugs, physician-administered drugs, and medical supply rebates.</p> <p>RAIS is built upon technology that is client server oriented. Since the hardware technology is constantly changing and expanding, the hardware has a limited life span. In order to avoid memory storage reaching maximum capacity and hardware components failing due to the age of the equipment, the FI Contractor is required to evaluate RAIS hardware and software every five years. The last refresh of the RAIS platforms was completed in 2005. The FI Contractor's review of RAIS determined that the RAIS hardware will reach its end of life by the beginning of 2011. <del>Procurement of new hardware and software will begin in February 2011 and payments will begin in FY 2011-12.</del> <b><u>The refresh is expected to take place in FY 2011-12.</u></b></p>
FI 18	(PC-FI)	X	<p><u>Provider Enrollment Automation Project</u></p> <p>Beginning in FY 2011-12, the Department will implement an Optional Contractual Service (OCS) under the FI contractor to enhance the current CA-MMIS Health Enterprise Provider Enrollment functionality. This will provide Medi-Cal providers with web-based, high-speed access to fully automated e-forms; imaging; communications; and workflow management, as well as reporting features to support timely, accurate, and efficient receipt and processing of provider enrollment and re-enrollment applications.</p>

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 0.1 (OA-76)		X	<u>Health Care Options Consultant Costs</u>  The Department will contract with a health care consultant to identify the best practices used in other states with enrollment broker contracts, determine the impact of Health Care Reform on the HCO program, and assist in evaluating all options regarding enrollment.  Operations for the current enrollment broker contacts ends on September 30, 2012, with three one-year extension options.

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 1 (PC-FI)	X	X	<p><u>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 were determined in consultation with health plans and stakeholders. The pilot project began on February 27, 2009 and will continue for a period of two years. At the end of the pilot project period (March 2011), 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 2 (PC-FI)	X	X	<p><u>Additional Contractual Service (ACS) – Initial Health Screen Questionnaire</u></p> <p>The HCO contract includes an Additional Contractual Service (ACS). The Department will implement the Initial Health Screen Questionnaire ACS beginning in FY 2010-11. 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>
HO 3 (PC-FI)	X		<p><u>Managed Care Expansion</u></p> <p>The Budget Act of 2005 included the geographic expansion of managed care into 13 additional counties. A regional Two-Plan Model, including Fresno (an existing managed care county), Kings and Madera Counties is expected to be implemented in February <b>on March 1, 2011</b>. <b>Notices Mailing of notices</b> to the beneficiaries <b>were mailed began</b> in June 2010. These counties followed the Two-Plan model consisting of one-local initiative plan and one commercial plan or two commercial plans. The Department has developed new informing materials specific to these counties. Presentation sites opened in the expansion counties in August 2010. This expansion has resulted in increased costs to the Department</p>

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

Applicable F/Y  
C/Y    B/Y

for expanded mailings and the additional enrollment service representatives needed at the new county presentation sites.

HO 4 (PC-FI)    X    X

**SPD Mandatory Enrollment into Managed Care HCO Costs**

Beginning June 1, 2011, it will be mandatory for all Medi-Cal Only Seniors and Persons with Disabilities (SPDs) residing in managed care counties to enroll in a managed care plan. As a result, MAXIMUS, the HCO enrollment broker, will be required to send informing materials to each SPD beneficiary upon transitioning to a mandatory status for enrollment.

To meet the Department's outreach and education goals, MAXIMUS will hire additional staff to aid the beneficiaries in this transition and to handle ongoing outreach and education.

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
DD 0.1 (PC-FI)		X	<u>CD-MMIS Takeover by New Dental FI Contractor</u>  The CD-MMIS is the Medi-Cal dental claims processing system operated by the dental FI. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. An RFP is in development to establish a new FI contract. In the Takeover Phase, the new FI is required to complete contractually required activities necessary to ensure a timely and accurate takeover of the existing MMIS. The takeover activities for the new dental FI contractor are expected to begin on October 1, 2011.

**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)
- 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 (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 require CD-MMIS changes in order to incorporate updated transactions for dental claims by the federal compliance date of January 1, 2012.

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
DD 2 (PC-FI)	X	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 data and documentation are included in the Office of Medi-Cal Procurement's data library. Turnover support services and all activities in accordance with the contract requirements commenced on January 4, 2010 and will continue through June 30, 2012.

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**GENERAL FUND REVENUES**

1. Quality Assurance/Improvement Fees

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

FY 2009-10:	\$ 18,929,000		ICF-DD Quality Assurance Fee
	\$ 65,867,000		Managed Care Quality Improvement Assessment Fee
	\$ 300,641,000		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 45,841,000		Additional Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 178,740,000		Managed Care Organization Tax (AB 1422)
	\$1,760,000,000		Hospital Quality Assurance Revenue Fund (Item 4260-601-3158)
	\$2,370,018,000		Total
FY 2010-11:	\$ 23,168,000		ICF-DD Quality Assurance Fee
	\$ <del>306,304,000</del> <b><u>304,432,000</u></b>		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 426,699,000	<b><u>126,165,000</u></b>	Additional Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 492,314,000	<b><u>198,315,000</u></b>	Managed Care Organization Tax (AB 1422)
	\$ 1,760,000,000		Hospital Quality Assurance Revenue Fund (Item 4260-601-3158)
	\$ 2,408,485,000	<b><u>2,412,080,000</u></b>	Total
FY 2011-12:	\$ 23,168,000	<b><u>25,187,000</u></b>	ICF-DD Quality Assurance Fee
	\$ 318,947,000		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 188,418,000		Additional Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 494,452,000	<b><u>206,581,000</u></b>	Managed Care Organization Tax (AB 1422)
	<b><u>\$ 320,000,000</u></b>		<b><u>Hospital Quality Assurance Revenue Fund (Item 4260-601-3158)</u></b>
	\$ 724,985,000	<b><u>1,059,133,000</u></b>	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 ended in October 2009.

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

AB 1422 (Chapter 157, Statutes of 2009) has imposed an additional tax on the total operating revenue of all Medi-Cal managed care plans. The provision pertaining to this tax will be effective retroactive to January 1, 2009 and will end on ~~January 1~~ **June 30**, 2011. The Department is proposing legislation that will extend the tax ~~through June 30, 2011~~. The amount for FY 09-10 includes revenue retroactive to January 1, 2009. This new tax will generate additional General Fund revenue.

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AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee on applicable general acute care hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). This fund will be used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and enhanced payments to managed health care and mental health plans. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program. **SB 90 (Chapter 19, Statutes of 2011) extended the hospital QAF through June 30, 2011. SB 90 also ties changes in hospital seismic safety standards to enactment of a new hospital QAF that results in FY 2011-12 revenue for children's services of at least \$320 million.**

The California Department of Public Health has proposed lowering Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions would allow the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected.

**2. Redevelopment Agency and Local Government Funds**

The amended 2009 Budget Act included a \$3.6 billion expenditure transfer of Redevelopment Agency and local government funds to the General Fund to offset General Fund expenditures. Of the \$3.6 billion transfer, \$572,638,000 has been attributed to the Medi-Cal program for accounting purposes. The transfer provides funds directly to the General Fund, and cash does not flow through the Department of Health Care Services. The transfer does not affect Medi-Cal payments or the estimate.

**ELIGIBILITY****1. 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. ARRA has extended the QI-1 program through June 30, 2011. **The current sunset date has been extended to December 31, 2011 by the Medicare and Medicaid Extenders Act of 2010, Public Law No: 111-309.**

**2. 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 has been extended to ~~June 30, 2011~~ by ARRA **December 31, 2011 by the Medicare and Medicaid Extenders Act of 2010, Public Law No: 111-309.**

**3. 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

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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 allows the Department to improve the identification of veterans enrolled in the Medi-Cal program. Improved veteran identification enhances 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 implemented a Veterans Match Pilot Program that filters the PARIS match results and focuses outreach efforts on veteran Medi-Cal beneficiaries receiving long term care services in three counties. The Department is referring 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 began July 1, 2009, and the workload is being absorbed by existing Department staff. Potential savings cannot be determined at this time.

The Department also implemented 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.

**4. Lomeli, et al., v. Shewry**

**On January 20, 2011, The Department is currently negotiating finalized a settlement of the Lomeli, et al., v. Shewry lawsuit. The petitioners in Lomeli allege alleged that the Department does not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage and demand demanded the Department to provide those applicants a meaningful opportunity to apply for retroactive Medi-Cal coverage. If a settlement is reached It requires the Department will to send notices to all new SSI applicants who have not had Medi-Cal eligibility in all of the three consecutive months before applying for SSI. The Department will also send notices to new SSI beneficiaries informing them of the availability of retroactive coverage. The Department is required to implement the notification change within six months of the settlement date. Final settlement documents are in circulation between parties. Attorneys’ fees are not subject to the settlement and remain an open issue.**

**5. 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 eligible 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 2010-11 and FY 2011-12 due to the spending limit.

**INFORMATION ONLY:****6. The Enterprise Enrollment Portal (EEP) Project**

The Department, along with other departments and the California Health and Human Service Agency, is working on the EEP Project, which will establish a portal for initial screening and application for 11 CHHS programs that will provide a one-time only entry of the applicant's data for Medi-Cal, HFP, AIM, CHDP, WIC, Family PACT, Every Woman Counts, BCCTP, CalWORKS, ~~Food Stamps~~ **CalFresh**, County Medical Services Program, Newborn Hospital, Prenatal Gateway, and WIC Gateway applications. The planning and development stages of the EEP Project, which include an FSR, IAPD, Information Technology Procurement Plan (ITPP), and RFP, are funded by the California Health Care Foundation. The EEP Project is currently on hold until the State receives federal guidance regarding enrollment simplification and **the there is further development of the** State's health insurance exchange.

**7. Centralized Eligibility**

ABX4 7 (Chapter 7, Statutes of 2009) requires the Department and CDSS to develop a statewide eligibility and enrollment determination process for Medi-Cal, CalWORKS and the Supplemental Nutrition Assistance Program (SNAP) based on a comprehensive plan with stakeholder steering committee involvement. It is intended to facilitate better access to services and aid for eligible clients, improve consistency of eligibility determinations statewide, employ state-of-the-art technology, and create an efficient process that eliminates redundancies and inefficiencies. The Legislature must receive the comprehensive plan at least 45 days prior to a request for an appropriation. Upon legislative approval of the plan, the Department and CDSS would proceed with the procurement of a performance-based contract, consistent with the approved plan, to implement a statewide eligibility and enrollment determination process. Stakeholder work efforts have been suspended until the federal Patient Protection and Affordable Care Act (PPACA) requirements regarding enrollment simplification are clarified. Comprehensive plan development will be discussed when efforts resume.

**8. Limitation of IHSS Services**

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.

Effective November 1, 2009, CDSS will limit the provision of IHSS domestic and related services to individuals with a functional index score of 4.0, and eliminated all services for individuals with a functional index score of 2.0 and below, with the exceptions of paramedical services, protective supervision, and services for recipients receiving more than 120 overall hours per month.

On October 19, 2009, the federal court issued a preliminary injunction against the reduction.

**9. Reduction of IHSS Hours**

**The Department provides the Title XIX FFP to CDSS, via interagency agreements, for the federal share of IHSS personal care services provided to Medi-Cal beneficiaries.**

**Effective February 1, 2011, CDSS will reduce the hours of all IHSS services to individuals by 2.3 percent per month.**

**10. Ledezma v. Shewry Lawsuit**

**The Department is currently negotiating a settlement of the Ledezma v. Shewry lawsuit. The suit resulted from a system programming error that discontinued Qualified Medicare Beneficiaries (QMB) at annual re-determination. Eligibility for Medicare Part A has been restored and affected**

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**beneficiaries have been reimbursed for the cost of their premiums. The Department remains responsible for the cost of reimbursing out-of-pocket medical expenses for qualified claims. Settlement costs are not expected to be significant; however, the cost for establishing a beneficiary reimbursement process to evaluate claims is anticipated to be significant if the plaintiffs do not accept the Department's proposed methodology. Beneficiary reimbursements and costs associated with the beneficiary reimbursement process are not eligible for federal matching funds.**

**BENEFITS****1. California Children's Services (CCS) Program Pilots**

The Department will develop and implement four organized health care delivery models to serve CCS eligible children in at least four geographical locations within the State. This effort is a major component of the DHCS 1115-Waiver renewal **the BTR** with CMS and will result in securing additional federal financial participation for the five year life of the Waiver. The four organized health care delivery systems to be tested during the course of the Waiver are: an enhanced primary care case management model; an accountable care organization model; an existing Medi-Cal managed care organization; and a specialty health care plan. **In the pilot counties, administrative work traditionally performed by counties for these children will be performed by the pilot contractor. As a result of this shift, administrative funding provided to the counties will shift to the pilot contractor.** ~~They~~ **The pilots** are anticipated to become operational (enrollment begins) January 2012. It may be necessary to phase in operations for these models over a period of time.

**2. State-Only Anti-Rejection Medicine Benefit Extension**

**Assembly Bill 2352 (Chapter 676, Statutes of 2010) requires Medi-Cal beneficiaries to remain eligible for State-Only Medi-Cal coverage for anti-rejection medication for up to two years following an organ transplant unless, during that time, the beneficiary becomes eligible for Medicare or private health insurance that would cover the medication. Currently, some patients qualify for Medi-Cal under a federal rule allowing coverage for anti-rejection medication for one year post organ transplant. After this eligibility ends, the Department will no longer receive FFP. Therefore, the costs for extending this benefit will be 100% General Fund. The fiscal impact is indeterminate.**

**3. CDSS IHSS Share-of-Cost Buyout**

**The CDSS and the Department implemented a process that enabled Medi-Cal IHSS recipients who had 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 exceeded his/her IHSS SOC was required to meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.**

**An Interagency Agreement between CDSS and CDHS established the process for the transfer of CDSS funds to prepay the Medi-Cal SOC for IHSS recipients.**

**Effective October 2009, the SOC Buy-Out provision ended, however the reconciliation process of outstanding claims will continue up to the allowable claiming period.**

**INFORMATION ONLY:****HOME & COMMUNITY BASED-SERVICES**1. AB 398--Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department 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. There is currently no appropriation to initiate and sustain this pilot project.

2. Adult Day Health Care Reforms

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.
- 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.

Unbundling of the all-inclusive procedure code, post-payment reviews of participant charts, and a new rate methodology are scheduled for August 1, 2012.

Tightening medical necessity criteria and clarifying the role of the patient's personal care doctor and assist in establishing a personal care doctor for the patient have been fully implemented.

3. Medicare and Medi-Cal Dual Eligibles Pilot Projects to Improve Access to HCBS

As part of California's effort to provide organized systems of care for vulnerable populations under an 1115 Waiver, the Department is planning to identify pilot projects to test integration of Medicare and Medicaid services including long-term services and supports for dual eligible beneficiaries in up to four counties through both county organized health system and two-plan managed care models.

The goals of the pilot projects include:

- Coordinating Medi-Cal and Medicare benefits across health care settings improving continuity and access to acute care, long-term care, and HCBS;
- Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services;
- Increasing the availability of and access to home and community-based alternatives.

The Department will expects to identify pilot projects by April 2011 and begin pilot implementation January in October 2012.

**INFORMATION ONLY:**4. Self-Directed Services Waiver - CDDS

The Health Trailer Bill of 2005 authorized the implementation of the Self-Directed Services (SDS) program in FY 2006-07. The Department submitted the SDS Waiver to CMS on April 2, 2008. Approval of the SDS Waiver is pending further discussion with the federal administration.

5. Assisted Living Waiver Expansion

AB 499 (Chapter 557, Statutes of 2000) required the Department to submit an HCBS waiver to CMS to test the efficacy of providing assisted living as a Medi-Cal benefit for elderly and disabled persons in two settings, Residential Care Facilities for the Elderly (RCFEs), and Publicly Subsidized Housing (PSH). In June 2005, CMS approved the Assisted Living Waiver Pilot Project (ALWPP) application. Currently the waiver serves 1,300 persons in the pilot counties of Los Angeles, Sacramento and San Joaquin.

The Department has received CMS approval for a five year renewal of the waiver, renamed the Assisted Living Waiver, to increase the number of slots in each participating county. The Department will expand in Sonoma, Fresno, San Bernardino, Riverside, Los Angeles, Sacramento, and San Joaquin Counties beginning in FY 2011-12 by 390 slots or 56 slots per county. The expansion is expected to be cost-neutral based on a cost analysis of ALW enrollees.

6. Developmentally Disabled/Continuous Nursing Care Waiver Expansion

AB 359 (Chapter 845, Statutes of 1999) required the Department to establish a pilot program to provide continuous 24-hour nursing care to medically fragile infants, children and adults with developmental disabilities in home-like community settings. CMS approved a renewal of the Section 1915(b) freedom of choice waiver for the period of October 1, 2007 through September 30, 2009. To be eligible for this waiver, participants must have Medi-Cal eligibility, certification by a regional center as developmentally disabled, eligibility for special treatment programs and medical necessity for continuous skilled nursing care needs, and be enrolled in a regional center.

The Department converted this waiver into a 1915(c) HCBS waiver, effective October 1, 2009 through September 30, 2012. Nursing care services are currently available in seven regional centers. The Department will expand to two additional regional centers adding 12 slots beginning in FY 2011-12. The expansion is expected to be cost-neutral based on a cost analysis of DD/CNC waiver enrollees.

7. Community First Choice Option

Section 2401 of the Patient Protection and Affordable Care Act (PPACA) establishes a new State option to provide home and community-based attendant services and supports. These services and supports may be offered through the federal Community First Choice State plan Option (CFCO). The CFCO, available October 1, 2011, allows States to receive a six percent increase in federal match for expenditures related to this option.

It is expected that most of the current IHSS program and some current services in existing home and community-based waivers services would fall under CFCO. Therefore, they would be eligible for the increased federal match. Draft federal regulations for CFCO were released in February 2011. The Federal Centers for Medicare & Medicaid Services release date of final regulations is unknown.

**FAMILY PACT**

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**INFORMATION ONLY:****BREAST AND CERVICAL CANCER TREATMENT****PHARMACY**1. New Pricing Benchmark for Medi-Cal Drug Reimbursement

Average Wholesale Price (AWP) is currently the pricing benchmark used to reimburse drug claims to Medi-Cal FFS pharmacy providers. In September 2011, AWP will cease to be available from First Data Bank, the Department's pharmacy data source. The Department is proposing a statutory change that will provide the authority to establish a new pricing benchmark for Medi-Cal, which will enable the Department to continue to reimburse pharmacy providers in alignment with the requirements set forth in federal statute. The Department will incorporate adequate flexibility into the statute so that if CMS provides guidelines for an alternative national benchmark, such a benchmark could be used under the statute.

2. Federal Upper Limit

The Deficit Reduction Act (DRA) of 2005 requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states has put the AMP and FUL changes on hold. CMS continues to release FULs using the methodology in place prior to the 2005 DRA. These FULs have created lower net costs for some generically available products beginning October 1, 2008. **The Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175% of the weighted average (based on utilization) of the AMP. It also redefined how AMP is calculated. These changes will result in an indeterminate change in the amount the Department reimburses for generic drugs.**

3. Medication Dispensing Machine Pilot Project

**The Human Services Budget Trailer Bill of 2011 requires the Department to implement the Home and Community Based Medication Dispensing Machine Pilot Project (MM Pilot). Under the pilot, the Department will identify Medi-Cal beneficiaries who are at risk of hospitalization or nursing home placement due to lack of medication adherence, and evaluate whether the placement of automated medication dispensing machines in the beneficiaries' homes increases medication adherence and decreases related hospitalizations. Implementation will begin in FY 2011-12. The Department will provide quarterly progress reports to the Legislature, and by July 1, 2012, a determination, based on the quarterly reports, will be made as to whether the expected savings have been achieved. At that time, recommendations will be made to the Legislature to amend or terminate the pilot. A report with the results of the pilot's evaluation will be sent to the Legislature by December 2013. The implementation costs and the expected savings are included in a separate budget control section.**

**HOSPITAL FINANCING****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, and Sonoma and Merced Counties on October 1, 2009 as County Organized Health Systems (COHS). The Department is

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planning to also implement the Two-Plan model in some expansion counties. The Department has determined that the environment and timing do not appear optimal to continue expansion efforts in four of the counties originally targeted for expansion (i.e., San Benito, El Dorado, Imperial, and Placer), and has removed them from the list below. The Department continues to work with the stakeholders in the remaining expansion counties.

Below is the proposed list of expansion counties:

<u>County</u>	<u>Plan Type</u>
Sonoma	COHS (Completed in October 2009)
San Luis Obispo	COHS (Completed in March 2008)
Mendocino	COHS (July 2011)
Kings	Two Plan ( <del>October 2010</del> <b>March 2011</b> )
Madera	Two Plan ( <del>October 2010</del> <b>March 2011</b> )
Merced	COHS (Completed in October 2009)
Ventura	COHS ( <del>February</del> <b>July</b> 2011)
Marin	COHS (July 2011)

2. 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.

3. Court-Ordered Managed Care Rate Adjustments Prejudgment Interest

In the case of *Health Net of California v. Department of Health Services*, the Third District Court of Appeal ruled that **ordered** the Department ~~must pay approximately \$17.4 million to Health Net for a dispute over~~ **to recalculate** Two Plan Model capitation rates for years ranging from 1997 to 2002 **and the court remanded the case to the Superior Court for further proceedings. Once the rates were recalculated, the superior court determined that the Department owed additional monies to Health Net, plus prejudgment interest.** An additional amount of **Prejudgment interest is estimated to be** \$12.8 million ~~is estimated for prejudgment interest.~~ The Department has filed an appeal ~~to~~ **with** the Third District Court of Appeal (~~Sacramento~~) for the portion of the judgment which awarded **challenging the award of** prejudgment interest. Interest will be budgeted if necessary depending upon the outcome of the appeal.

**INFORMATION ONLY:****4. Risk Adjustment Percentages for the Two-Plan and Geographic Managed Care Models**

The Department implemented risk adjustment to the Medi-Cal managed care capitation rates for the Two-Plan and GMC model plans during the 2009-10 rate year. The risk adjustment methodology uses Medicaid RX, a pharmacy encounter-based software program developed by UC San Diego and involved developing a county-specific and a plan-specific rate for the Adult-Family rate category and the Aged, Blind, and Disabled Medi-Cal only rate category. This was done for each county and plan in the Two-Plan and GMC model counties. 20% of the county-specific rate was then risk adjusted using a plan-specific risk score produced through Medicaid RX and then added to 80% of the plan-specific rate to establish a risk adjusted plan specific rate. The county-specific and plan-specific rate percentages were held constant during the 2010-11 rate year, due to the Health Trailer Bill of 2010. This provision will sunset on October 1, 2011. The Department intends to increase the county-specific risk adjustment percentage for the 2011-12 rate year and ongoing.

**PROVIDER RATES****1. Air Ambulance Medical Transportation**

AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 upon every conviction involving a vehicle violation, effective January 1, 2011. The bill requires the county treasurers to transfer the money collected after payment of county administrative costs, to the State Controller's Emergency Air Medical Transportation Act Fund quarterly.

Upon legislative appropriation, 20% of the fund, after the payment of the Department's administrative costs, will be allocated to the General Fund, and 80% will be used to increase the rates for medical emergency Medi-Cal air transportation services. The Department will determine the timing and method of the payments so there will be no GF cost for the rate increases. The bill requires the Department to seek federal matching funds for the money collected in the fund.

**SUPPLEMENTAL PAYMENTS****1. Designated Public Hospitals – Seismic Safety Requirements**

AB 303 (Chapter 428, Statutes of 2009) authorizes Medi-Cal supplemental reimbursement to Designated Public Hospitals for debt service incurred for the financing of eligible capital construction projects to meet seismic safety requirements.

Eligible projects will be limited to meeting seismic safety deadlines, and will include those new capital projects funded by new debt for which final plans have been submitted to the Office of Statewide Health Planning and Development after January 1, 2007, and prior to December 31, 2011.

There will be no expenditures from the State General Fund for the nonfederal share of the supplemental reimbursement. The nonfederal share will be comprised of either certified public expenditures or intergovernmental transfers.

The Department is assessing federal approval requirements for implementation of this supplemental payment program. Implementation will occur only if federal approvals are obtained and federal financial participation is available.

**INFORMATION ONLY:****OTHER: AUDITS AND LAWSUITS**

1. *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. 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. This petition was denied. On June 19, 2009, the trial court issued an order with respect to the plaintiff hospitals that require the Department to (1) cease applying the SB 1103 reimbursement limit when conducting audits and issuing final cost settlements, (2) cease collection of any overpayments that resulted from applying the SB 1103 limit, (3) recalculate and reissue final cost settlements without applying the SB 1103 limit, and (4) refund any overpayments resulting from the SB 1103 limit that was previously recouped. The Department appealed the order on August 14, 2009. The appellate briefing has been completed, and the parties are waiting for the Court of Appeal to schedule oral arguments.

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

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 completed a rate review and concluded that rates were consistent with section 1396(1)(30)(A). After the rate review was filed with the court, petitioners objected. On September 25, 2009 the trial court held that the Department did not perform a proper rate review in light of the standard set forth in *Orthopaedic Hospital v Belshe*. The court ordered the Department to perform a further rate review. The Department has appealed the trial court's ruling. ~~No briefing schedule has been set.~~  
**Appellate argument has not been scheduled.**

3. *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

**INFORMATION ONLY:**

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. 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 appealed. The Court of Appeals heard oral arguments on June 22, 2010. The parties are awaiting a decision.

**4. 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. **Based on claims data for ineligible *Craig v. Bontá* beneficiaries, the Department estimates that if it owes FFP to CMS, for the period prior to December 31, 2003, it should be no more than \$12 million.** CMS estimated that the Department owes approximately \$17.6 million in FFP for the period prior to December 31, 2003. **CMS has agreed to the Department's estimate; however,** 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 continues to challenge this deferral but** may be required to pay back the FFP, depending on how the deferral is resolved.

**5. City and County of San Francisco, County of Santa Clara v. Shewry**

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.~~ In April 2010, the Superior Court ruled in favor of San Francisco and Santa Clara on one of the issues in the lawsuit, and issued a writ of mandate requiring the Department to include inpatient psychiatric hospital services to individuals under age 21 as a Medi-Cal covered health service. In June 2010, the Department filed a notice of appeal with the First Appellate District Court of Appeal. ~~The Department awaits the briefing schedule for that appeal.~~ **A current CMS guidance to other states indicates that FFP is available for inpatient hospital services offsite; therefore, the Department is seeking to dismiss the appeal. The fiscal impact is indeterminate, but there will be no GF impact.**

**INFORMATION ONLY:**6. *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 that the 10% reduction in Medi-Cal reimbursement for non-contract hospital inpatient services, which was enacted by ABX3 5, violated 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. On November 18, 2009, the district court issued a preliminary injunction with respect to the 10% reduction for the 17 hospitals. The Department appealed, and on May 27, 2010 the United States Court of Appeals affirmed the preliminary injunction. **On January 18, 2011, the United States Supreme Court granted the Department's petition for certiorari (request to the court to accept a discretionary appeal). The court is likely to schedule a hearing for Fall of 2011.**

7. *Independent Living Center of Southern California Inc. et al. v. David Maxwell-Jolly*

On August 18, 2008, the federal district court issued a preliminary injunction against the 10% reduction in Medi-Cal payments mandated by Assembly Bill 5, with respect to payments for physicians, dentists, optometrists, adult day health centers, clinics and prescription drugs for dates of service on or after August 18, 2008. On November 17, 2008, the same federal district court issued a preliminary injunction against the 10% reduction in Medi-Cal payments for home health services and non-emergency medical transportation services for dates of service on or after November 17, 2008. The Department appealed these preliminary injunctions.

On July 9, 2009, the United States Court of Appeals issued a decision affirming the August 18, 2008 preliminary injunction and further held that the injunction applied to dates of service back to July 1, 2008. On August 7, 2009, the Court of Appeals issued a decision affirming the November 17, 2008 preliminary injunction but that it only applied to services on or after November 17, 2008, as the district court ruled. The Department filed petitions for rehearing with the Court of Appeals concerning the Court's July 9, 2009 and August 7, 2009 decisions. The petitions were denied. The Department petitioned the United States Supreme Court in February 2010.

On January 29, 2010, the court ordered the Department to repay Medi-Cal rate reductions to physician, dental, optometry, ADHC, clinic, and pharmacy services for the period of July 1, 2008 through August 17, 2008.

The Department filed a petition for certiorari, which is a request for a discretionary appeal, with the United States Supreme Court in March 2010. ~~On May 23, 2010, the Supreme Court issued an order inviting the Solicitor General to file an amicus brief on behalf of the United States.~~ **On January 18, 2011, the United States Supreme Court granted the Department's petition for certiorari. The court is likely to schedule a hearing for Fall of 2011.**

8. *Yoo, Chang Ho dba PCH Medical Pharmacy, et al v. Sandra Shewry*

The Department temporarily withholds reimbursement payments to Medi-Cal providers upon whom it has reliable evidence of fraud or abuse of the Medi-Cal Program. Petitioners allege the Department has violated State and federal authorities, because the Department does not pay interest on amounts subject to temporary withhold.

On November 26, 2008, the trial court found that implied authority exists to require the Department to pay interest if funds are temporarily withheld more than 150 days.

**INFORMATION ONLY:**

This ruling could significantly impact the Department's implementation of temporary withholds to protect the Medi-Cal Program against fraud and abuse. The Department appealed the decision and the appellate court reversed it. ~~The plaintiff has filed an appeal to the California Supreme Court~~ **The Department will be submitting a request to the appellate court to seek clarification of its published decision in favor of the Department.**

9. AB 1183 Litigation

Two lawsuits challenged provider payment reductions that were mandated by Assembly Bill (AB) 1183 (Chapter 758, Statutes of 2008) effective October 1, 2008 for non-contract hospital inpatient services, and March 1, 2009 for prescription drugs and adult day health care center (ADHC) services.

- In the *Independent Living Center of Southern California (formerly Managed Care Pharmacy) v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on February 26, 2009 against the 5% payment reduction for prescription drugs.
- In the *California Pharmacists Association, et al. v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on March 6, 2009 against the 5% payment reduction for ADHCs services. The district court denied a preliminary injunction against the AB 1183 payment reductions for hospitals. On April 6, 2009, the United States Court of Appeal for the Ninth Circuit granted the plaintiffs' motion for a stay of the district court's denial of a preliminary injunction concerning the hospital payment reductions, pending their appeal of that ruling, which effectively enjoined the AB 1183 payment reductions for hospitals beginning April 6, 2009.

On March 3, 2010, the Court of Appeals issued three decisions affirming the injunctions concerning the AB 1183 payment reductions for prescription drugs, ADHCs, and hospitals. On March 23, 2010, the Department filed a petition for certiorari, which is a petition to accept a discretionary appeal, with the United States Supreme Court concerning these court decisions. **On January 18, 2011, the Supreme Court granted the Department's petition for certiorari (request to the court to accept a discretionary appeal). The Court will likely schedule a hearing for Fall 2011.**

10. CHA v. David Maxwell-Jolly

On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for Distinct Part Nursing Facilities (DP/NF) Level B and DP/NF adult and pediatric subacute providers. The court also enjoined the Department from continuing the 10% reduction for some non-contract small and rural hospitals. The injunctions are effective as of February 24, 2010. The Department appealed. The Court of Appeals has stayed appellate proceedings pending a decision by the United States Supreme Court on the Department's petition for certiorari (request to the court to accept a discretionary appeal) in the case of *Independent Living Center of Southern California v. Maxwell-Jolly*.

11. Audits of Medi-Cal TCM and LEA Medi-Cal Billing Option Programs

The LEA Medi-Cal Billing Option Program provides the federal share of reimbursement for health assessment and treatment for Medi-Cal eligible children and family members within the school environment. A LEA provider employs or contracts with qualified medical practitioners to render certain health services and is reimbursed for actual direct costs incurred with a small add-on factor for indirect expenses. LEA providers are paid an interim rate based on pre-established billing allowances by treatment code. The LEAs file a Cost Reimbursement and Comparison Schedule (CRCS), reporting services and actual costs incurred in the fiscal year. The Department will perform audits to reconcile the cost reports with payments for FY 2006-07 through FY 2008-09.

**INFORMATION ONLY:**

The TCM Program provides comprehensive case management services to Medi-Cal eligible individuals within a specified target population to gain access to needed medical, social, educational, and other services. TCM services are provided by counties and chartered cities/local government agencies (LGAs). LGAs receive payments for TCM services based on a prospective rate that is established based on prior year reported costs from their fiscal year end cost reports.

The Department will perform audits to reconcile the cost reports with payments for FY 2002-03 through FY 2007-08.

**12. California Association of Rural Health Clinics, et al. v. Maxwell-Jolly**

In the case of *California Association of Rural Health Clinics, et al. v. Maxwell-Jolly*, the plaintiffs filed a lawsuit on behalf of RHC and FQHC providers against the Department challenging the exclusion of adult dental, chiropractic, and podiatry services from Medi-Cal coverage. Plaintiffs contend that adult dental, chiropractic, and podiatry services are among those federally mandated services that are required to be provided by RHCs and FQHCs. Medi-Cal coverage of those services, along with other Medi-Cal optional benefits, were eliminated pursuant to AB X3 5 (Chapter 20, Statutes of 2009), effective July 1, 2009.

On October 18, 2010, the United States District Court issued an injunction ordering the Department to provide the reimbursement of adult dental, chiropractic, and podiatry services as Medi-Cal covered benefits when provided in an RHC/FQHC setting. The Court ruling states that the optional benefits exclusion cannot be implemented until the Department receives federal approval. **The Department appealed the court order. The plaintiffs appealed the portion of the court's decision that held that federal law does not require states to cover these services when rendered by RHCs and FQHCs.** The Department is currently working with the CMS to obtain approval of the SPA and anticipates a resolution of all outstanding issues in the near future. Estimated costs of this injunction are indeterminate at this time.

**13. Managed Care Potential Legal Damages**

**Four health plans (Santa Clara County Authority, Health Net, Blue Cross and Molina Healthcare) have filed litigation against the Department challenging the Medi-Cal managed care rate setting methodology for the rate years from 2002 through 2005. The four separate litigation matters are pending in Sacramento Superior Court or Department of Health Care Services Office of Administrative Hearing and Appeals. The health plans claim that the legislation requiring the Department to use reduction factors to reduce provider reimbursements or overall plan payments due to the State's budgetary issues is invalid. There are four possible legal outcomes with respect to the cases, all with significant differences in the payment of monetary awards: 1) Health plans' claims are dismissed, no monetary award; 2) Health plans' litigation claims are successful and State must pay monetary awards limited to the 5 percent provider reduction; 3) Health plans' litigation claims are successful and State must pay monetary awards only for the budget factor; and 4) Health plans' litigation claims are successful and State must pay monetary awards for both the provider reduction and the budget factor.**

**Because the litigation filed by the health plans is not complete and final decisions have not been rendered, the expected financial cost of monetary awards and any potential of prejudgment interest are unknown at this time. Nevertheless, monetary awards could potentially be in the hundreds of millions of dollars. The Department will exhaust all legal remedies before paying monetary awards to the health plans.**

**INFORMATION ONLY:****OTHER: REIMBURSEMENTS**1. 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.

2. 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 Waiver which is ~~set to expire on August 31, 2010. The Department is currently developing a new comprehensive 1115 Waiver, and the new Waiver will include the continuation of the SPCP~~ **ended on October 31, 2010. The BTR Waiver was approved November 1, 2010 for five years and includes continuation of the SPCP.**

3. 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 2009-10), the June 30, 2010 Medi-Cal accrual amounts were estimated to be \$1.2 billion state General Fund and \$6.2 billion federal funds, for a total of \$7.4 billion.

4. 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 obtained approval from CMS to amend the State Plan to establish a cost-based reimbursement methodology for the freestanding clinic beginning April 1, 2009.

**INFORMATION ONLY:**

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. Other Healthcare Coverage - Exception to Timely Filing Rule

Effective January 2010, the Department is prohibited from disclosing SPCP hospital provider rates to commercial health insurers. As a result, the Department changed the claims recovery process for SPCP hospitals. Prior to January 2010, the Department had three years to bill commercial health insurers for payment recovery for services provided to Medi-Cal beneficiaries who were found to have commercial health insurance. Under the new process, the Department bills the providers directly and, based on the contracts with the insurers, the providers have between 30 and 180 days to bill for payment recovery. After that time, the insurers may reject the claims as not filed timely. Under the provider billing time limits, it is estimated that the Department will lose 80% of recoverable claims.

The Department is proposing legislation to allow Medi-Cal providers three years to bill commercial health insurers. This will ensure that the Department continues to recover the maximum amount of claims due to the Department.

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**

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**DISCONTINUED ASSUMPTIONS****Fully Incorporated Into Base Data/Ongoing****ELIGIBILITY****BENEFITS****HOME & COMMUNITY-BASED SERVICES****FAMILY PACT****BREAST AND CERVICAL CANCER****PHARMACY**1. Pharmacy TAR Auto-Adjudication

Due to an increase in pharmacy TARs, the Department uses an auto-adjudication process on National Drug Codes (NDCs) submitted on TARs with a high approval rate and low cost risk in order to meet the State and Federal mandated TAR processing timelines. A higher number of NDCs are approved through auto-adjudication than when Department pharmacists review the NDCs for medical necessity. The Department hired nine new pharmacists as of June 30, 2009, under the fiscal intermediary (FI) contract to review TARs. In FY 2009-10, the Department reduced its use of auto-adjudication from FY 2008-09.

**HOSPITAL FINANCING****MANAGED CARE**1. Addition of LTC, Mental Health Lab and Pharmacy, and CHDP – Health Plan of San Mateo

The Health Plan of San Mateo (HPSM) added long term care (LTC) services to its contract effective February 1, 2010. HPSM added mental health lab and pharmacy, and Child Health and Disability Prevention (CHDP) to its scope of services effective July 1, 2010. These services were previously provided under the fee-for-service system.

**PROVIDER RATES**1. Santa Rosa Memorial Hospital Injunction

On November 18, 2009, in the case of *Santa Rosa Memorial Hospital, et al v. David Maxwell-Jolly*, the U.S. District Court issued a preliminary injunction with respect to the 10% reduction for non-contract hospital inpatient services enacted by ABX3 5 (Chapter 3, Statutes of 2008). The injunction only applied to the 17 plaintiff hospitals, and was effective November 18, 2009. The Department appealed. On May 27, 2010, the United States Court of Appeals for the Ninth Circuit affirmed the preliminary injunction.

2. CHA v. David Maxwell-Jolly Injunction

On February 25, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for Distinct Part Nursing Facilities (DP/NF) Level B and DP/NF adult and pediatric subacute providers. The court also enjoined the Department from continuing the 10% reduction for some non-contract small and rural

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated Into Base Data/Ongoing

hospitals. The injunctions are effective as of February 24, 2010. The Department appealed. The Court of Appeals has stayed appellate proceedings pending a decision by the United States Supreme Court on the Department's petition for certiorari (request to the court to accept a discretionary appeal) in the case of *Independent Living Center of Southern California v. Maxwell-Jolly*.

#### SUPPLEMENTAL PAYMENTS

#### OTHER: AUDITS AND LAWSUITS

#### OTHER: REIMBURSEMENTS

##### 1. SSI/SSP Retroactive Medicare Premiums

The Social Security Administration determined that 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 has required states to pay retroactive premiums for these beneficiaries where the states also have a buy-in agreement. California currently has a buy-in agreement for Medicare Part B premiums and has paid retroactive premiums despite the inability to obtain Medicare reimbursement for Medi-Cal services provided to these beneficiaries. CMS discontinued this practice beginning with the March 2010 payment.

#### OTHER: RECOVERIES

#### FISCAL INTERMEDIARY: MEDICAL

#### FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

#### FISCAL INTERMEDIARY: DENTAL

## DISCONTINUED ASSUMPTIONS

### Time Limited/No Longer Applicable

#### ELIGIBILITY

#### BENEFITS

1. CDSS IHSS Share-of-Cost Buyout

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.

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.

#### HOME & COMMUNITY-BASED SERVICES

#### FAMILY PACT

#### BREAST AND CERVICAL CANCER

#### PHARMACY

#### HOSPITAL FINANCING

#### MANAGED CARE

#### PROVIDER RATES

1. Independent Living Center Injunction

On January 29, 2010, in the case of *Independent Living Center of Southern California v. David Maxwell-Jolly*, the court ordered the Department to restore payment reductions for the period of July 1, 2008 through August 17, 2008 for physician, dental, optometry, ADHC, clinic and pharmacy services.

#### SUPPLEMENTAL PAYMENTS

#### OTHER: AUDITS AND LAWSUITS

#### OTHER: REIMBURSEMENTS

#### OTHER: RECOVERIES

#### FISCAL INTERMEDIARY: MEDICAL

## **DISCONTINUED ASSUMPTIONS**

### **Time Limited/No Longer Applicable**

#### **FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

1. SPD Education and Outreach Guide Implementation

To target barriers to enrollment of Medi-Cal/Medicare beneficiaries seniors and persons with disabilities (SPD) into managed care, the Department has developed a SPD specific tri-fold brochure to mail to SPDs in fee-for-service (FFS) in Two-Plan and GMC managed care counties. When this direct mailing results in a request for more health plan information, a detailed, county-specific SPD Guide will be mailed to the beneficiary. The SPD guide is a result of collaborative efforts between the Department and UC Berkeley as part of education and outreach activities to SPDs in order to increase their voluntary enrollment into Medi-Cal managed care.

The SPD Tri-fold brochure and Guide implementation, expected to begin August 1, 2011, will increase packet mailings, translations, printing, and postage costs.

#### **FISCAL INTERMEDIARY: DELTA DENTAL**

## DISCONTINUED ASSUMPTIONS

### Withdrawn

#### ELIGIBILITY

#### BENEFITS

#### HOME & COMMUNITY-BASED SERVICES

#### FAMILY PACT

#### BREAST AND CERVICAL CANCER

#### PHARMACY

#### HOSPITAL FINANCING

#### MANAGED CARE

#### PROVIDER RATES

#### SUPPLEMENTAL PAYMENTS

#### OTHER: AUDITS AND LAWSUITS

#### OTHER: REIMBURSEMENTS

1. Public Health Monitoring System

The Department is entering into an interagency agreement with CDPH to provide FFP for the Public Health Monitoring System (PHMS). The PHMS will be a secure extranet site available to business partners for the exchange of vital records data with CDPH. The PHMS will deliver vital records data to CA-MMIS and related systems to automate processes for disenrolling beneficiaries and providers, and to manage estate recoveries. The PHMS will be developed and implemented by CDPH from July 2011 through June 2015. The matching General Fund will be provided by CDPH.

2. First 5 California Funding

In FY 2011-12, \$1 billion of Proposition 10, First 5 California funding, will be allocated to Medi-Cal to offset the GF cost of Medi-Cal services for children 0-5 years old.

3. SPD Transition to Managed Care - CDDS

The Department will provide FFP to CDDS for 13 positions that will be liaisons between the regional centers and managed care plans on the SPD transition.

#### OTHER: RECOVERIES

1. Provider Overpayment Repayments

Effective March 23, 2010, Section 6506 of the Health Care Reform Act, H.R. 3590, amends Section 1903 (d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) to allow states a period of one year,

## DISCONTINUED ASSUMPTIONS

### Withdrawn

instead of 60 days, to repay the federal portion of overpayments to providers. There will be a one-time GF savings due to a 10-month reduction in FFP repayments in FY 2010-11.

In July 2010, CMS clarified that states must report collections made on provider overpayments when collections are made. Based on this clarification, the Department will be required to accelerate its reporting. This will result in a one-time cost to the Department to correct the prior year underpayment in FY 2011-12.

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DELTA DENTAL**