

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

POLICY CHANGES

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FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 1/1997
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$614,919,000	\$628,775,000
- STATE FUNDS	\$148,746,400	\$152,098,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$614,919,000	\$628,775,000
STATE FUNDS	\$148,746,400	\$152,098,500
FEDERAL FUNDS	\$466,172,600	\$476,676,500

DESCRIPTION

Effective January 1, 1997, family planning services were expanded under the Family PACT program to provide contraceptive services to more persons in need of such services who have incomes under 200% of poverty.

A Section 1115 demonstration project waiver was approved by CMS effective December 1, 1999. Family planning services and testing for sexually transmitted infections (STIs) (about 93% of FPACT costs) are eligible for 90% FFP; treatment of STIs and other family planning companion services (about 5% of costs) are eligible for the Title XIX FMAP; and treatment of other medical conditions, including inpatient care for complications from family planning services (about 2% of costs) are not eligible for FFP. Within these categories, costs for undocumented persons are budgeted at 100% GF. Effective July 20, 2009, costs for undocumented persons are assumed to be 13.95% of the Family PACT population.

On September 30, 2010, in accordance with the Federal Patient Protection and Affordable Care Act, the Department requested that CMS approve an amendment to the State Plan (SPA) to transition the current the Family PACT Waiver into the State Plan. The SPA was approved on March 24, 2011. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund receive a 90% federal matching rate, and family planning-related services receive reimbursement at the State's regular FMAP rate effective retroactively to July 1, 2010.

Drug rebates for Family PACT drugs are included in the Family PACT Drug Rebate Program policy change.

FAMILY PACT PROGRAM
REGULAR POLICY CHANGE NUMBER: 1

Estimate by Service Category (Rounded):

Service Category	FY 2010-11		FY 2011-12	
	TF	GF	TF	GF
Physicians	\$85,367,000	\$20,650,000	\$90,781,000	\$21,960,000
Other Medical	\$364,030,000	\$88,058,000	\$365,899,000	\$88,510,000
County Outpatient	\$3,725,000	\$901,000	\$3,738,000	\$904,000
Community Outpatient	\$4,819,000	\$1,166,000	\$4,958,000	\$1,199,000
Pharmacy	\$156,978,000	\$37,972,000	\$163,399,000	\$39,526,000
TOTAL	\$614,919,000	\$148,747,000	\$628,775,000	\$152,099,000

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 1/2002
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 3

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$127,814,000	\$133,166,000
- STATE FUNDS	\$56,776,150	\$59,335,750
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$127,814,000	\$133,166,000
STATE FUNDS	\$56,776,150	\$59,335,750
FEDERAL FUNDS	\$71,037,850	\$73,830,250

DESCRIPTION

The Budget Act of 2001 (Chapter 106, Statutes of 2001) authorized the Breast and Cervical Cancer Treatment Program (BCCTP) effective January 1, 2002, for women under 200% of the FPL. This policy change budgets for the cost of the BCCTP.

Enhanced Title XIX Medicaid funds (65% FFP/35% GF) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

A State-Only program covers women aged 65 or older regardless of immigration status, individuals who are underinsured, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 24 months for cervical cancer. Estimated State-Only costs include undocumented persons' non-emergency services during cancer treatment.

Screening and diagnosis was discontinued, for the period of January 1, 2010 through November 30, 2010, by the Every Woman Counts (EWC) program. The impact of this change is budgeted in this policy change.

Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

Assumptions:

1. There were 10,372 fee-for-service (FFS) and 2,082 managed care eligibles as of December 2010 (total of 12,454). 2,914 of the FFS eligibles were eligible for State-Only services (Aid Codes 0R, 0T, 0U, and 0V).
2. 428 of the FFS eligibles were in Accelerated Enrollment Aid Code 0N as of December 2010.

BREAST AND CERVICAL CANCER TREATMENT**REGULAR POLICY CHANGE NUMBER: 2**

3. Assume the State will pay Medicare and other health coverage premiums for an average of 207 OR beneficiaries monthly in FY 2010-11 and 207 OR beneficiaries in FY 2011-12. Assume an average monthly premium cost per beneficiary of \$250.10.

FY 2010-11: $207 \times \$250.10 \times 12 \text{ months} = \$620,000$ TF (\$620,000 GF)

FY 2011-12: $207 \times \$250.10 \times 12 \text{ months} = \$620,000$ TF (\$620,000 GF)

4. FFS costs are estimated as follows:

	FY 2010-11		FY 2011-12	
	TF	GF	TF	GF
Full Scope Costs	\$109,289,000	\$38,251,000	\$113,585,000	\$39,755,000
State-Only Costs				
Services	\$17,905,000	\$17,904,000	\$18,961,000	\$18,961,000
Premiums	\$620,000	\$620,000	\$620,000	\$620,000
Total	\$127,814,000	\$56,775,000	\$133,166,000	\$59,336,000

5. All BCCTP costs are budgeted in policy changes. BCCTP managed care costs are budgeted in managed care policy changes.
6. Federal reimbursement for a portion of State-Only BCCTP costs based on the certification of public expenditures is budgeted in the policy change MH/UCD – BCCTP.

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 3
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 8

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$15,711,000	\$15,711,000
- STATE FUNDS	\$5,598,300	\$5,598,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,711,000	\$15,711,000
STATE FUNDS	\$5,598,300	\$5,598,300
FEDERAL FUNDS	\$10,112,700	\$10,112,700

DESCRIPTION

The CHDP Gateway program was implemented July 1, 2003. Children who receive a CHDP screen are pre-enrolled (PE) into Medi-Cal or the Healthy Families Program (HFP). PE provides a minimum of 2 months of full-scope coverage, during which the family may apply for ongoing Medi-Cal or HFP coverage. The state-funded CHDP program continues to provide screens to children eligible for limited-scope Medi-Cal.

Assumptions:

- In FY 2010-11, it is estimated 539,197 children will be screened through the Gateway. Medi-Cal: 449,887 (83%), HFP: 53,982 (10%), CHDP State-Only 35,328 (7%).
- The estimated FY 2010-11 average monthly Medi-Cal and HFP PE eligibles and annual costs are as follows:

	<u>ave. mthly eligibles</u>	<u>TF</u>	<u>GF</u>
Medi-Cal PE	37,491	\$120,202,000	(\$42,070,000 SF) **
HFP PE	4,499	\$15,711,000	(\$5,498,850 GF)
Total	41,990	\$135,913,000	(\$47,568,850 SF)

- CHDP State-Only costs are budgeted in the Family Health Estimate.
- The federal funds for HFP Gateway PE costs are budgeted in Title XXI, Item 4260-113 funding. The federal funds for Medi-Cal PE claims are budgeted in Title XIX, Item 4260-101 funding.
- It is assumed that the average monthly eligibles/annual costs will be similar for FY 2011-12.

CHDP GATEWAY - PREENROLLMENT**REGULAR POLICY CHANGE NUMBER: 3**

6. All costs for Medi-Cal Gateway PE are 100% in the base. FY 2010-11 and FY 2011-12 costs for HFP Gateway PE eligibles are not included in the base and are shown below:

FY 2010-11 HFP: \$15,711,000 (\$5,498,850 GF)

FY 2011-12 HFP: \$15,711,000 (\$5,498,850 GF)

7. Based on information provided by the Children's Medi-Cal Services Branch, assume that \$663,000 SF will be Childhood Lead Poisoning Prevention (CLPP) funding in FY 2010-11 and FY 2011-12.

** \$663,000 SF CLPP

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 11/1998
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 5

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$13,540,000	\$12,776,000
- STATE FUNDS	\$4,739,000	\$4,471,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$13,540,000	\$12,776,000
STATE FUNDS	\$4,739,000	\$4,471,600
FEDERAL FUNDS	\$8,801,000	\$8,304,400

DESCRIPTION

In order to allow time to apply for Healthy Families, AB 2780 (Chapter 310, Statutes of 1998) provides one month additional Medi-Cal eligibility as a bridge for children who become ineligible for Medi-Cal without a share-of-cost or are eligible for Medi-Cal with a share-of-cost and have income less than 250% of poverty (aid code 7X).

The costs for this program are not included in the Medi-Cal base estimate. They are added through this policy change.

Assumptions:

- Based on current Medi-Cal data, 123,251 children in FY 2010-11 and FY 2011-12 are expected to receive one-month bridge (aid code 7X). The average monthly number of beneficiaries will be 10,271 in FY 2010-11 and FY 2011-12.
- Based on cost data from January 2010 through December 2010 and eligible data from October 2009 through September 2010, assume the cost of benefits is \$68.56 per month for fee-for-service children.
- The fee-for-service eligible-months are expected to be 36,624 in FY 2010-11 and 35,157 in FY 2011-12. It is assumed total FFS expenditures for aid code 7X will be \$2,511,000 in FY 2010-11 and \$2,410,000 in FY 2011-12.

$$\text{FY 2010-11: } \$68.56 \times 36,624 = \$2,511,000$$

$$\text{FY 2011-12: } \$68.56 \times 35,157 = \$2,410,000$$

- The managed care eligible-months are expected to be 86,626 in FY 2010-11 and 88,093 in FY 2011-12. It is assumed total managed care capitation and carve-out expenditures for aid code 7X will be \$11,029,000 in FY 2010-11 and \$11,402,000 in FY 2011-12.

BRIDGE TO HFP**REGULAR POLICY CHANGE NUMBER: 4**

5. Total expenditures for aid code 7X are expected to be \$13,540,00 in FY 2010-11 and \$13,812,000 in FY 2011-12.

FY 2010-11: $\$2,511,000 + \$11,029,000 = \$13,540,000$

FY 2011-12: $\$2,410,000 + \$11,402,000 = \$13,812,000$

6. Beginning January 1, 2012, HFP eligibles with income above 100% and up to and including 250% of the federal poverty level (FPL) will transition from the HFP to Medi-Cal over a six-month period. Assume 15% of beneficiaries in aid code 7X have income over 250% of the FPL and will not be eligible for Medi-Cal.

$\$13,812,000 / 12 \text{ months} \times 6 \text{ months} = \$6,906,000 \times 15\% = \$1,036,000$

$\$13,812,000 - \$1,036,000 = \$12,776,000$ FY 2011-12

7. This is a Title XXI program with enhanced FFP of 65.00% in FY 2010-11 and FY 2011-12. These costs are budgeted in 4260-113-0001/0890.

FY 2010-11: $\$13,540,000 \times 65.00\% = \$8,801,000$ FFP

FY 2011-12: $\$12,776,000 \times 65.00\% = \$8,304,000$ FFP

LOW-INCOME SUBSIDY APPS. TREATED AS M/C APPS.

REGULAR POLICY CHANGE NUMBER: 5
 IMPLEMENTATION DATE: 1/2010
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1387

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$16,437,000	\$20,700,000
- STATE FUNDS	\$10,386,500	\$12,777,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	85.20 %	82.80 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,432,700	\$3,560,400
STATE FUNDS	\$1,537,200	\$2,197,730
FEDERAL FUNDS	\$895,470	\$1,362,670

DESCRIPTION

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. Counties have been instructed to also treat the LIS application as an application for Medi-Cal. The date the SSA receives a LIS application is to 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. Based on SSA data, there is an average of 5,800 LIS applications received per month.

Assumptions:

1. Assume an average of 5,800 LIS applications will be received each month. Assume 30% already have Medi-Cal coverage and of the remaining 70% only 50% will apply for Medi-Cal. Of these, 15% will be found eligible for Medi-Cal each month.
2. Of those found eligible for Medi-Cal, assume that 25% will be eligible for the MN-SOC program and 75% for the Aged and Disabled FPL program.
3. Of those enrolled in the MN-SOC program, assume that 84% will not meet their SOC and 16% will meet their SOC. Those who do not meet their SOC will not become certified eligibles and will not receive Medi-Cal services.
4. There will be a total of 241 new eligibles each month, 95% in A & D FPL and 5% in MN-SOC. Assuming a 12-month phase-in of costs, there will be a total of 31,089 eligible months in FY 2010-11 and 34,704 in FY 2011-12.
5. Assume that 20% will enroll in managed care and 80% will remain in fee-for-service.
6. The average monthly cost for those in the FFS MN-SOC program is \$1,693.74 and \$295.10 for the A & D FPL program. The cost for those enrolled in managed care is \$404.95 (\$44.50 carve-out and \$360.45 capitation rate).

LOW-INCOME SUBSIDY APPS. TREATED AS M/C APPS.

REGULAR POLICY CHANGE NUMBER: 5

7. Assume monthly payments for Medicare Part B premiums, estimated to be \$110.50 for CY 2010 and \$115.40 for CY 2011, are made for those in the A & D FPL program and those in MN SOC, for the month their Medi-Cal SOC is met.
8. It is assumed 70% of those in the A & D FPL are also QMB eligible for which FFP may be claimed for their Part B premiums.
9. Assume a monthly clawback payment for those who are in the A & D FPL program and those in MN-SOC, for the month SOC is met. The clawback rate is estimated to be \$102.54 for CY 2010, \$100.77 for CY 2011, and \$101.71 for CY 2012.
10. Assume a monthly capitation payment of \$6.70 for all newly eligible for dental services.

(rounded)	FY 2010-11		FY 2011-12	
	TF	GF	TF	GF
FFS:				
MN SOC	\$ 1,639,000	\$ 819,500	\$ 2,342,000	\$ 1,171,000
A & D FPL	\$ 5,427,000	\$2,713,500	\$ 7,757,000	\$ 3,878,500
	\$ 7,066,000	\$3,533,000	\$10,099,000	\$ 5,049,500
Managed Care:				
Capitation Rate	\$ 2,272,000	\$ 1,136,000	\$ 2,536,000	\$ 1,268,000
Carve-Out	\$ 220,000	\$ 110,000	\$ 314,000	\$ 157,000
	\$ 2,492,000	\$ 1,246,000	\$ 2,850,000	\$ 1,425,000
Part B	\$ 3,511,000	\$ 2,343,500	\$ 4,005,000	\$ 2,673,500
Clawback	\$ 3,160,000	\$ 3,160,000	\$ 3,513,000	\$ 3,513,000
Dental Capitation	\$ 208,000	\$ 104,000	\$ 233,000	\$ 116,500
Total	\$ 16,437,000	\$10,386,500	\$20,700,000	\$ 12,777,500

REFUGEES

REGULAR POLICY CHANGE NUMBER: 6
 IMPLEMENTATION DATE: 7/1980
 ANALYST: Jade Li
 FISCAL REFERENCE NUMBER: 14

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$6,531,000	\$6,491,000
- STATE FUNDS	\$6,531,000	\$6,491,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,531,000	\$6,491,000
STATE FUNDS	\$6,531,000	\$6,491,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Full federal funding is available through the Refugee Resettlement Program (RRP) for medical services to refugees receiving Refugee Cash Assistance (Aid Codes 01, 08, and 0A) and for Refugee Medical Assistance refugees (Aid Code 02) during their first 8 months in the United States.

The RRP federal grant is administered by the California Department of Public Health (CDPH), which has program responsibility through the Refugee Health Assessment Program. The federal Office of Refugee Resettlement allows only one grant award for refugee health services in the state. The Department of Health Care Services invoices the CDPH for the reimbursement of refugee expenditures, which are originally funded with General Fund. Total refugee expenditures to be reimbursed by CDPH are estimated to be \$6,531,000 in FY 2010-11 and \$6,491,000 in FY 2011-12.

The General Fund reimbursement for these refugee expenditures is included on the 4260-610-0995 Reimbursement line in the Management Summary.

LANTERMAN DEVELOPMENTAL CENTER CLOSURE

REGULAR POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 1/2011
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1560

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$1,150,000	\$7,793,000
- STATE FUNDS	\$575,000	\$3,896,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,150,000	\$7,793,000
STATE FUNDS	\$575,000	\$3,896,500
FEDERAL FUNDS	\$575,000	\$3,896,500

DESCRIPTION

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. 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 receive services through the Medi-Cal fee-for-service system.

Assumptions:

- Under CDDS' Plan for Closure of Lanterman Developmental Center, the individual planning process will be the basis for ensuring that each resident's needs and choices are identified and appropriately addressed in the community. Therefore, the costs of the services to be provided through the Medi-Cal program once the residents transition to the community are unknown at this time.
- Placeholder costs of \$1,150,000 (\$575,000 GF) for FY 2010-11, and \$7,793,000 (\$3,897,000 GF) for FY 2011-12 have been included in the May 2011 Medi-Cal Estimate.

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 8/2011
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1558

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$188,000
- STATE FUNDS	\$0	\$132,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$188,000
STATE FUNDS	\$0	\$132,500
FEDERAL FUNDS	\$0	\$55,500

DESCRIPTION

The Working Disabled Program (WDP) allows for employed individuals with disabilities to earn up to 250% of the federal poverty level and receive full scope Medi-Cal benefits. All eligibles in this program are required to pay a monthly premium based on their countable income.

AB 1269 (Chapter 282, Statutes of 2009) requires the Department to implement changes to the WDP 30 days after ARRA ends on June 30, 2011. However, under the Patient Protection and Affordable Care Act (PPACA) of 2010, Maintenance of Effort (MOE) requirements are imposed upon states until January 1, 2014. These requirements prevent states from implementing more restrictive Medicaid eligibility policies, procedures or methodologies without jeopardizing federal funding.

The changes made by AB 1269 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.

Change #4 concerning monthly premiums will not be implemented due to the MOE provisions of PPACA.

Assumptions:

1. The changes to the WDP will be implemented August 1, 2011.
2. The provisions of the bill concerning retained income exemption and 26 weeks of eligibility while unemployed have an indeterminate impact.

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 8

3. The exemption of disability income that converts to retirement income will create an increase in the number of WDP participants resulting in additional costs to Medi-Cal.
4. Those affected by the exemption of disability income that converts to retirement income are age 65 and older.
5. The full increase in eligibles will be phased-in over 12 months
6. There are currently 483 average monthly eligibles with Aid Code 6G who are over 65.
7. The current growth rate of over 65 year olds in Aid Code 6G is 5 per month or 1.1% monthly.
8. The change to the WDP will result in an additional 64 eligibles per year.
9. The average monthly Fee-for-Service cost per eligible in 6G is \$544.92.
10. Dental capitation per 6G eligible is \$6.70 per month.
11. Medicare Part B premiums are \$115.40 per month.
12. Medicare Clawback costs are \$100.77 in CY 2011 and \$101.71 in CY 2012 per eligible per month.

FY 2011-12	TF	GF
FFS Costs (lagged)	\$109,000	\$54,500
Dental	\$2,000	\$1,000
Medicare Part B	\$41,000	\$41,000
Clawback	\$36,000	\$36,000
Total	\$188,000	\$132,500

MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

REGULAR POLICY CHANGE NUMBER: 9
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1569

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,678,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,678,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$1,678,000

DESCRIPTION

This policy change budgets the FFP match, at the Medi-Cal rate, for the cost of inpatient services for inmates who are deemed eligible for Medi-Cal. 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 adult inmates in State correctional facilities when these services are provided off the grounds of the State correctional facility, and the inmates are determined eligible for either the Medi-Cal program or the Low Income Health Program (LIHP) run by counties.

The CDCR will utilize the Medi-Cal applications currently used by counties, and the Department will review these applications to make an eligibility determination according to current standard eligibility rules. Healthcare costs of state inmates are currently paid by the State General Fund. Federal Medicaid regulations and federal guidance provided to states allow for coverage of inpatient services to eligible inmates when provided in off-site facilities.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional federal funding due to ARRA is \$120,000 in FY 2010-11 and is included in this policy change.

Assumptions:

1. Implementation began April 1, 2011 and reimbursements will begin July 2011.
2. Claims may be filed retroactively to January 1, 2011. It is assumed that the cost of retroactive claims from January 1, 2011 through March 31, 2011, will be insignificant and therefore will not be budgeted for in this policy change.

MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

REGULAR POLICY CHANGE NUMBER: 9

3. California Prison Health Care Services estimates 13,460 inmate inpatient admissions annually.
4. Applications for Medi-Cal will be processed by the Department if the applicant received off-site inpatient related services. Costs for inmates eligible for LIHP are budgeted in the Policy Change LIHP Inpatient Hosp. Costs for CDCR Inmates.
5. It is assumed the Department will process an estimated 400 applications per month.
6. Of the estimated 400 monthly applications it is assumed 5 percent are age 65 or older, 3 percent are disabled, and 2 percent are for pregnancy events.

400 x 5% Aged = 20 applications
 400 x 3% Disabled = 12 applications
 400 x 2% Pregnancy Event = 8 applications

7. Based on CDCR data, 13 percent of the inmates are undocumented and will not be eligible for Medi-Cal coverage, except in the case of pregnancy events.

20 Aged – 13% undocumented = 3
 12 Disabled – 13% undocumented = 2

8. Assume 90 percent of applicants will be Medi-Cal eligible, resulting in 31 eligibles monthly.

90% eligible x 17 Aged = 15 eligible
 90% eligible x 10 Disabled = 9 eligible
 90% eligible x 8 Pregnancy Events = 7 eligible

9. Assume 48 percent of pregnancy events will be cesarean and 51 percent will be vaginal.

10. Assume the average Medi-Cal cost per event for an inpatient admission is \$9,506 for the aged, \$10,833 for disabled, \$5,931 for a cesarean pregnancy and \$3,759 for a vaginal pregnancy.

184 Aged Eligible Mos.	x \$9,506	= \$1,749,000 (\$874,500 FF)
110 Disabled Eligible Mos.	x \$10,833	= \$1,192,000 (\$596,000 FF)
41 Annual Vaginal Deliveries	x \$3,759	= \$154,000 (\$77,000 FF)
44 Annual Cesarean Deliveries	x \$5,932	= \$261,000 (\$130,500 FF)

11. The total cost will be \$3,356,000 (\$1,678,000 FF) in FY 2011-12 and annually.

$\$1,749,000 + \$1,192,000 + \$154,000 + \$261,000 = \mathbf{\$3,356,000 (\$1,678,000 FF)}$

NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 10
 IMPLEMENTATION DATE: 12/1997
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 15

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$102,359,500	\$120,791,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$102,359,500	\$120,791,000
FEDERAL FUNDS	-\$102,359,500	-\$120,791,000

DESCRIPTION

HR 3734, the Welfare Reform Bill, specified that FFP is not available for full-scope Medi-Cal services for nonexempt qualified aliens who enter the country after August 1996, for the first 5 years they are in the country. They are eligible for FFP for emergency services only. As California law requires that legal immigrants receive the same services as citizens, the nonemergency services are only State funded. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of New Qualified Aliens from January 2006 through December 2010, current year and budget year were projected. Based on the historical pattern of FFS versus managed care nonemergency service expenditures for the period of April 2009 through March 2010 (17.35%), the managed care totals for current year and budget year were projected.

The impact of SCHIP funding for prenatal care for new qualified aliens is included in the SCHIP Funding for Prenatal Care policy change.

The impact of CHIPRA funding for 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, is budgeted in the CHIPRA Medi-Cal for Children and Pregnant Women policy change.

(rounded)	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FFS	\$ 174,458,000	\$ 205,872,000
Managed Care	\$ 30,261,000	\$ 35,710,000
Total	\$ 204,719,000	\$ 241,582,000
FFP Repayment	\$ 102,360,000	\$ 120,791,000

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 11
 IMPLEMENTATION DATE: 12/1998
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 13

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$47,360,850	-\$50,727,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$47,360,850	-\$50,727,300
FEDERAL FUNDS	\$47,360,850	\$50,727,300

DESCRIPTION

This policy change shifts funding from Title XIX fifty-percent FFP to Title XXI sixty-five percent FFP. 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 family income within Percentage Program limits.

Assumptions:

1. Aid codes (8N, 8P, 8R, and 8T) that identify children eligible for Medi-Cal due to disregarding assets were implemented in December 1998.
2. Average monthly fee-for-service eligibles, which are included in the base, are estimated to be 57,657 in FY 2010-11 and 65,327 in FY 2011-12. It is assumed total FFS expenditures will be \$35,673,000 in FY 2010-11 and \$40,380,000 in FY 2011-12.
3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 144,927 in FY 2010-11 and 162,667 in FY 2011-12. It is assumed total Managed Care expenditures will be \$280,066,000 in FY 2010-11 and \$297,802,000 in FY 2011-12.
4. Enhanced federal funding under Title XXI (MCHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2010-11 and will be 65.00% in FY 2011-12.
5. Beginning in FY 2000-01, these costs are being budgeted in 4260-113. Only the FFP in excess of the regular Medi-Cal FMAP is budgeted here.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
Total	\$315,739,000	\$338,182,000
FFP	\$205,230,000	\$219,818,000
General Fund	\$110,509,000	\$118,364,000
Enhanced FFP (rounded)	\$47,361,000	\$50,727,000

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 12
 IMPLEMENTATION DATE: 1/2011
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1371

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$19,874,650	-\$8,833,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$19,874,650	-\$8,833,000
FEDERAL FUNDS	\$19,874,650	\$8,833,000

DESCRIPTION

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 50% 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 US for less than five years and pays for nonemergency services with 100% State funds if federal financial participation (FFP) is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services.) CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children or pregnant women even if they have been in the U.S. for less than five years, effective April 1, 2009. Enhanced Title XXI funding is available for children eighteen years of age and younger.

This policy change budgets for the retroactive period, April 1, 2009 through June 30, 2010, in FY 2010-11.

Assumptions:

- Based on cost data for FY 2009-10, assume the total annual expenditures for NQA children are \$29,175,000 TF (\$14,588,000 GF), of this amount \$11,309,000 TF (\$4,154,000 GF) are for non-emergency services. Of the non-emergency expenditures, \$4,367,000 TF (\$1,645,000 GF) is for FFS, including managed care carve-out costs, and \$6,941,000 TF (\$2,510,000 GF) is for managed care capitation rates.
- Based on cost data for FY 2009-10, assume the FFS expenditures for NQA pregnant women are \$41,041,000, including managed care carve-out costs. 93.36% of these costs are related to pregnancy, which are currently eligible for FFP. Assume the remainder of the costs, 6.64%, will be eligible for FFP under CHIPRA.

$$\begin{aligned}
 \$39,145,497 \text{ FFS} \times 6.64\% &= \$2,599,000 \\
 \$1,896,000 \text{ Carve-Out} \times 6.64\% &= \$126,000 \\
 \$2,599,000 + \$126,000 &= \$2,725,000 \text{ } (\$1,363,000 \text{ GF})
 \end{aligned}$$

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN**REGULAR POLICY CHANGE NUMBER: 12**

3. Assume the Managed Care costs for NQA pregnant women are now eligible for FFP under CHIPRA. Assume the annual cost for these beneficiaries is \$632,000 TF (\$316,000 GF).
4. Assume the total expenditures for non-pregnancy related services for NQA pregnant women are 3,357,000 TF (\$1,679,000 GF) annually.

$\$2,725,000 + \$632,000 = \$3,357,000$ (\$1,679,000 GF) Annually

5. Assume a savings to the General Fund since the non-emergency expenditures for NQA children and pregnant women were previously budgeted at 100% GF, but are now eligible for FFP.
6. Total non-emergency costs for NQA children under the age of 19 years and non-pregnancy related services for NQA pregnant women are as follows:

FY 2010-11	TF	GF	FFP
Retro Children	\$14,136,000	\$5,193,000	\$8,943,000
Retro Pregnant Women	\$4,197,000	\$2,098,000	\$2,099,000
Children	\$11,309,000	\$4,154,000	\$7,155,000
Pregnant Women	\$3,357,000	\$1,679,000	\$1,679,000
Total (Rounded)	\$32,999,000	\$13,124,000	\$19,876,000

FY 2011-12	TF	GF	FFP
Children	\$11,309,000	\$4,154,000	\$7,155,000
Pregnant Women	\$3,357,000	\$1,679,000	\$1,679,000
Total (Rounded)	\$14,666,000	\$5,833,000	\$8,834,000

PROGRAM INTEGRITY AND ELIGIBILITY VERIFICATION

REGULAR POLICY CHANGE NUMBER: 13
 IMPLEMENTATION DATE: 10/2009
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1357

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,918,000	-\$6,208,000
- STATE FUNDS	-\$959,000	-\$3,104,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	58.69 %	20.60 %
APPLIED TO BASE		
TOTAL FUNDS	-\$792,300	-\$4,929,200
STATE FUNDS	-\$396,160	-\$2,464,580
FEDERAL FUNDS	-\$396,160	-\$2,464,580

DESCRIPTION

The Department implemented 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.

PARIS

The Department implemented a PARIS Interstate and Federal match pilot program in FY 2009-10. The pilot program allows the Department to test the viability of long-term savings prior to incurring costs that would be associated with statewide implementation.

PARIS is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS system includes three different data matches. The PARIS-Veterans match allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs. The PARIS-Federal match allows states to compare their beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management to identify federal pension income or health benefits. The PARIS-Interstate match allows states to compare their beneficiary information with other states to identify beneficiary changes in residence and public assistance benefits in other states.

Since the launch of the pilot program Medi-Cal savings have been achieved through improved verification and identification capabilities. Currently, PARIS-Interstate is implemented in 15 counties. The Department plans to expand PARIS-Interstate to 20 counties in FY 2011-12. Estimated savings from PARIS-Interstate on a cash basis is \$1,918,000 (\$959,000 GF) for FY 2010-11 and \$6,208,000 (\$3,104,000 GF) for FY 2011-12.

PROGRAM INTEGRITY AND ELIGIBILITY VERIFICATION

REGULAR POLICY CHANGE NUMBER: 13

Asset and Eligibility Verification

Due to the requirements imposed by House Resolution (H.R.) 2642, the State is required to implement electronic verification of assets for all Aged, Blind or Disabled (ABD) applicants/beneficiaries through electronic requests to the financial institutions in FY 2010-11. The third party verification of assets allows counties receiving asset information from financial institutions through a third party vendor to supplement verification of assets for Medi-Cal applicants and beneficiaries whose Medi-Cal eligibility is based on being ABD.

The Department will enter into a contract with a financial vendor that will enable the counties to receive asset information for the ABD population. The third party verification vendor will provide counties with data from financial institutions that could indicate assets and property not reported by the applicant or beneficiary. The counties will have the responsibility to require the applicant or beneficiary to provide additional supporting documentation before an eligibility determination is made. Savings/cost avoidance will be achieved to the extent that the supplemental data increases the accuracy of eligibility determinations for the ABD population.

ADULT DAY HEALTH CARE - CDA

REGULAR POLICY CHANGE NUMBER: 14
 IMPLEMENTATION DATE: 7/1984
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 24

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$388,872,000	\$390,766,000
- STATE FUNDS	\$194,436,000	\$195,383,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$388,872,000	\$390,766,000
STATE FUNDS	\$194,436,000	\$195,383,000
FEDERAL FUNDS	\$194,436,000	\$195,383,000

DESCRIPTION

Adult Day Health Care (ADHC) is a community-based day program providing health, therapeutic, and social services designed to serve those at risk of institutionalization. The ADHC Program is funded via the Medi-Cal budget with State General Fund and Title XIX federal funds. The California Department of Public Health (CDPH) performs the licensing of Medi-Cal ADHCs. The Department of Aging (CDA) administers the program and certifies each center for Medi-Cal reimbursement.

This policy change includes the impact of the Budget Act and Health Trailer Bill of 2004, which implemented a twelve-month moratorium on the certification of new Adult Day Health Care centers effective August 16, 2004, including in-house applications, with specified exceptions. The Budget Act and Health Trailer Bill of 2005 included language to allow specific additional exemptions to the moratorium. State law [W&I code, Section 14043.46(g)] makes annual renewal of the moratorium the purview of the Director. The moratorium has been extended through FY 2010-11.

Assumptions:

1. ADHC rates are increased each year by the same percentage as the NF-A weighted average rate increase.
2. ABX4 5 (Chapter 5, Statutes of 2009), freezes rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. Therefore, no rate increase is assumed for rate year 2010-11 or 2011-12.
3. The estimated average monthly cost per ADHC user is expected to be \$1,048.84 for FY 2010-11 and \$1,050.21 for FY 2011-12. This is based on paid claims data through January 2011.
4. The projected average monthly users for FY 2010-11 are 30,897.
5. The projected average monthly users for FY 2011-12 are 31,007.

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 15
 IMPLEMENTATION DATE: 7/2000
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 25

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$118,070,000	\$113,786,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$118,070,000	\$113,786,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$118,070,000	\$113,786,000

DESCRIPTION

Local Educational Agencies (LEAs) consist of school districts, county offices of education, community colleges, and university campuses. LEAs may enroll as Medi-Cal providers through the LEA Medi-Cal Billing Option Program and submit claims for reimbursement for specific eligible health services provided to Medi-Cal eligible students. LEAs claim FFP for specific services as authorized in W & I Code Section 14132.06.

ADDITIONAL SERVICES FOR HCBS CLIENTS

REGULAR POLICY CHANGE NUMBER: 16
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1476

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$331,603,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$331,603,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$331,603,000

DESCRIPTION

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 by the state's Regional Center (RC) network of non-profit providers to persons with developmental disabilities. RC clients who have previously received or currently receive certain services will continue to be eligible for these services even if they are not under the HCBS waiver for persons with developmental disabilities. Services scheduled for coverage under this SPA include: habilitation, respite care, personal care services, homemaker services, home health aide services, and adult day health care. It is anticipated that the SPA will be approved in FY 2011-12, with a retroactive effective date of October 1, 2009.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

The budgeted amount for FY 2011-12 includes expenditures for the retroactive period of October 1, 2009 through June 30, 2011.

CASH BASIS

(In Thousands)	<u>Total Funds</u>	<u>CDDS GF</u>	<u>FFP Regular</u>	<u>FFP ARRA</u>	<u>Total FFP</u>	<u>IA #</u>
FY 2011-12	\$601,470	\$269,867	\$300,735	\$30,868	\$331,603	Pending

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 17
 IMPLEMENTATION DATE: 7/1984
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 28

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$45,464,000	\$45,464,000
- STATE FUNDS	\$18,319,000	\$22,732,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,464,000	\$45,464,000
STATE FUNDS	\$18,319,000	\$22,732,000
FEDERAL FUNDS	\$27,145,000	\$22,732,000

DESCRIPTION

The Multipurpose Senior Services Program provides a comprehensive array of social and health services to persons 65 or older who are "at risk" of long-term care but who wish to remain in the community. The program provides services under a federal home and community-based services waiver to an average of 16,335 clients in 11,789 client slots, at \$4,285 per year per client slot.

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.

CASH BASIS

(In Thousands)

FY 2010-11		Reimbursement	Regular	ARRA	Total
	<u>TF</u>	<u>From CDA</u>	<u>FFP</u>	<u>FFP</u>	<u>FFP</u>
MSSP	\$45,464	\$18,319	\$22,732	\$4,413	\$27,145
FY 2011-12		Reimbursement	Regular		
	<u>TF</u>	<u>From CDA</u>	<u>FFP</u>		
MSSP	\$45,464	\$22,732	\$22,732		

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

REINSTATEMENT OF OPTOMETRY SERVICES

REGULAR POLICY CHANGE NUMBER: 18
 IMPLEMENTATION DATE: 8/2010
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1504

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$1,210,000	\$1,584,000
- STATE FUNDS	\$605,000	\$792,000
PAYMENT LAG	0.8410	1.0000
% REFLECTED IN BASE	79.46 %	69.74 %
APPLIED TO BASE		
TOTAL FUNDS	\$209,000	\$479,300
STATE FUNDS	\$104,510	\$239,660
FEDERAL FUNDS	\$104,510	\$239,660

DESCRIPTION

As required by ABX3 5 (Chapter 20, Statutes of 2009), effective July 1, 2009, the Department excluded several optional benefits including optometry services for adults 21 years of age or older who are 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. Eyeglasses as a benefit have not been reinstated.

Assumptions:

1. Reinstatement was implemented on July 26, 2010, retroactive to July 1, 2009.
2. The Department will reimburse eligible Medi-Cal beneficiaries for out-of-pocket expenses up to the Medi-Cal rate paid for covered optometry services incurred on or after July 1, 2009.
3. Optometry services incurred from July 1, 2009 through July 26, 2010 are minimal.
4. Assume the managed care costs for the reinstatement of optometry services will be \$1,400,000 in FY 2010-11 and FY 2011-12. These costs are included in the managed care policy changes, and are shown in this policy change for informational purposes only.
5. Based on actual data, in FY 2009-10, optometry expenditures were \$8,596,000 after optometry services were discontinued for adult Medi-Cal beneficiaries.
6. Based on actual data, optometry expenditures are expected to increase by \$110,000 per month in FY 2010-11.
7. Assume expenditures will increase by 20% in FY 2011-12.

REINSTATEMENT OF OPTOMETRY SERVICES**REGULAR POLICY CHANGE NUMBER: 18**

8. The increase in optometry costs is estimated to be:

FY 2010-11: \$110,000 x 11 months = \$1,210,000 TF (\$605,000 GF)

FY 2011-12: \$1,320,000 x 1.2 = \$1,584,000 TF (\$792,000 GF)

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 19
 IMPLEMENTATION DATE: 12/2008
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1228

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$3,046,000	\$5,360,000
- STATE FUNDS	\$614,000	\$1,340,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	54.80 %	27.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,376,800	\$3,912,800
STATE FUNDS	\$277,530	\$978,200
FEDERAL FUNDS	\$1,099,260	\$2,934,600

DESCRIPTION

In January 2007, CMS awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for \$130 million in federal funds. The demonstration authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act, called the California Community Transitions (CCT), 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.

Participants are enrolled in the demonstration for a maximum of 12 months. Enrollment began December 1, 2008 and 57 individuals were enrolled through June 30, 2009 and 144 individuals for the period July 1, 2009 through June 30, 2010. Target enrollment for the period July 1, 2010 through June 30, 2011 is 198 individuals and 210 individuals for July 1, 2011 through June 30, 2012.

CCT participants who have developmental disabilities are provided services through the DD waiver and partially funded by MFP. The number of DD waiver beneficiaries expected to enroll into CCT is being included in this policy change, but their expenditures are budgeted in the MFP Funding to CDDS for CCT and the Home and Community Based Svcs. – CDDS policy changes.

During the 12 months a participant is enrolled in the demonstration, the Department will receive 75% FFP and an additional 5.79% enhanced FFP from July 1, 2010 through December 31, 2010 provided through the ARRA Act of 2009. The Education Jobs and Medicaid Assistance Act, HR 1586 of 2010, allows the Department to receive 79.39% FFP from January 1, 2011 through March 31, 2011 and 78.44% FFP from April 1, 2011 through June 30, 2011. The enhanced FMAP is allowed for the provision of demonstration services such as transition coordination, home modification and set-up, family training and regular HCBS waiver and State Plan services. After 12 months, individuals who had participated in the demonstration will receive services under the State Plan or via an appropriate home and community-based services waiver for which they are eligible at the regular FMAP.

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 19

Assumptions

1. This policy change shows the costs from moving beneficiaries who have resided in health care facilities to federally-allowed home and community based settings and providing them waiver and state plan services through the CCT Demonstration Project. The savings from moving beneficiaries out of nursing facilities is shown in the California Community Transitions Savings policy change.
2. Based on estimated costs for persons residing year-round in NF-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be \$55,635.
3. Waiver costs will be capped at \$48,180 for those beneficiaries transitioning from NF-B level of care.
4. All CCT services are reimbursed at 80.79% FFP and 19.21% GF through December 31, 2010. Beginning January 1, 2011 through March 31, 2011, the FFP will be reimbursed at 79.29% and 78.29% FFP for the period of April 1, 2011 through June 30, 2011. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF. The additional 11.59% ARRA FFP for the savings is budgeted in the ARRA – Additional FFP policy change.
5. Assume 60% of CCT participants will receive demonstration services.
6. Demonstration services are assumed to cost \$7,500 per participant.
7. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.

	2010-11		2011-12	
	TF	GF	TF	GF
Lagged savings NF-Bs	(\$4,211,000)	(\$2,105,500)	(\$6,282,000)	(\$3,141,000)
Lagged costs				
Waiver Services	\$3,067,000	\$ 618,000	\$5,119,000	\$ 1,280,000
HCB Enhanced Services	\$ 513,000	\$ 103,000	\$ 829,000	\$ 207,000
Waiver Personal Care Svs Adj.	(\$ 534,000)	(\$107,500)	(\$ 588,000)	(\$ 147,000)
Subtotal Costs (rounded)	\$3,046,000	\$ 613,500	\$5,360,000	\$ 1,340,000
Net (rounded)	(\$1,165,000)	(\$1,492,000)	(\$922,000)	(\$1,801,000)

*MFP Grant costs are budgeted in Item 4260-106-0890.

LANTERMAN REGIONAL CENTER DISALLOWANCE

REGULAR POLICY CHANGE NUMBER: 20
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1567

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$1,390,000	\$0
- STATE FUNDS	\$1,390,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,390,000	\$0
STATE FUNDS	\$1,390,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

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 targeted case management services provided to Medi-Cal eligible clients by the Regional Centers. In FY 2010-11, the Department returned the federal portion of the TCM payments to CMS and is being reimbursed by CDDS.

FY 2010-11 Cost: **\$1,390,000**

MFP FUNDING TO CDDS FOR CCT

REGULAR POLICY CHANGE NUMBER: 21
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1562

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,173,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,173,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$1,173,000

DESCRIPTION

This policy change budgets the supplemental federal funding associated with providing CDDS additional Title XIX for waiver services provided to Medi-Cal beneficiaries who participate in the California Community Transitions (CCT) project.

In January 2007, CMS awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act, called CCT, which 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.

In FY 2011-12, the Department will establish IA 09-86345 with CDDS to transfer the enhanced FFP for HCBS provided to CCT participants who have developmental disabilities. This federal funding will provide enhanced FFP for the waiver services provided to Medi-Cal beneficiaries with developmental disabilities during their 365 days of participation in the CCT demonstration.

Assumptions:

1. The Department provides HCBS to developmentally disabled CCT participants through CDDS and budgets the base federal match through the Home and Community Based Services policy change.
2. CCT services are reimbursed at 80.79% FFP from July 1, 2010 through December 31, 2010, 79.39% FFP from January 1, 2011 through March 31, 2011, 78.44% FFP from April 1, 2011 through June 30, 2011 and 75% FFP from July 1, 2011 through the end of the grant period.

MFP FUNDING TO CDDS FOR CCT**REGULAR POLICY CHANGE NUMBER: 21**

3. This policy change budgets the difference between the regular FMAP and the enhanced FMAP for Medi-Cal beneficiaries who have developmental disabilities and are enrolled in CCT. These participants are provided services through the DD Waiver, which are reimbursed at the regular FMAP. During the 365 days of enrollment into CCT, HCBS are provided to CCT participants and these services are eligible for the enhanced FMAP rates as listed above.

Estimated Costs:

	FY 2011-12
Total	\$1,173,000

*These costs will be initially paid through federal Title XIX. A shift will occur quarterly to reimburse the Title XIX with MFP Grant funding budgeted in Item 4260-106-0890.

SF COMMUNITY-LIVING SUPPORT WAIVER PILOT PROJECT

REGULAR POLICY CHANGE NUMBER: 22
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1436

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$4,993,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$4,993,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$4,993,000

DESCRIPTION

This policy change provides FFP for the San Francisco Community-Living Support Benefit Waiver (SF CLSBW) Pilot Project. A draft waiver application is pending with CMS. AB 2968 (Chapter 830, Statutes of 2006) requires the Department to develop and implement a community supported living benefit for Medi-Cal beneficiaries, 22 years of age and older, residing in the City and County of San Francisco who would otherwise reside in Laguna Honda Hospital, San Francisco General Hospital, skilled nursing facilities, shelters or be rendered homeless.

Eligible participants will have full-scope Medi-Cal eligibility or share-of-cost Medi-Cal for services to be rendered when residing in Residential Care Facilities for the Elderly (RCFEs) or in residency units made available by the Direct Access to Housing Program (DAH). Under the SF CLSBW Pilot Project, participants will be eligible for the following services:

- Community-living support benefits in licensed settings and in housing sites
- Care coordination
- Environmental accessibility adaptations
- Home-delivered meals
- Behavior assessment and planning

Assumptions:

1. The waiver has a maximum capacity of 486 over five years and enrollment will begin in July 2011. Target enrollment for the period of July 1, 2011 through June 30, 2012 is 221 individuals.
2. The annual cost is estimated to be \$76,940 per participant for FY 2011-12.
3. The Department will utilize CPEs from the City and County of San Francisco to match the federal funds for this waiver. This policy change budgets the FFP only.
4. Assume State Plan services will remain constant, but to the extent beneficiaries enroll into the waiver from skilled nursing facilities, there may be GF savings to the Medi-Cal program.

QUALITY OF LIFE SURVEYS FOR MFP

REGULAR POLICY CHANGE NUMBER: 23
 IMPLEMENTATION DATE: 8/2010
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1550

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$45,000	\$69,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	0.7930	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$35,700	\$69,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$35,680	\$69,000

DESCRIPTION

The purpose of this policy change is to budget the expenditures for the cost of completed Quality of Life (QoL) surveys administered to all CCT enrollees. CMS requires the Department to conduct QoL surveys with participants in the Money Follows the Person (MFP) Rebalancing Demonstration project called the California Community Transitions (CCT) project, within specified timeframes and methodology. MFP provider agencies, which are Medi-Cal home and community-based services waiver providers, conduct QoL surveys designed for the following situations:

1. Baseline QoL-Conducted before transition or within 10 days after the initial transition.
2. First Follow-up QoL-Conducted 11-12 months after the initial transition.
3. Second Follow-up-Conducted 24 months after initial transition.

The QoL surveys were 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.

Assumptions:

1. In FY 2010-11, 198 beneficiaries will be enrolled in the CCT demonstration project and 210 additional beneficiaries will enroll into CCT in FY 2011-12.
2. The QoL surveys are administered to all CCT enrollees twice and once again approximately one year after they have been living in community settings. Assume first follow-up QoLs are conducted 11 months after the initial transition.
3. CMS reimburses \$100 per completed survey for survey administration. The QoL surveys began in July 2010.

FY 2010-11 Estimated Costs: **\$45,000 TF**

FY 2011-12 Estimated Costs: **\$69,000 TF**

*MFP Grant costs are budgeted in Item 4260-106-0890.

INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER: 24
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1557

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$4,767,600	-\$4,767,600
PAYMENT LAG	0.8350	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$3,980,950	-\$4,767,600
FEDERAL FUNDS	\$3,980,950	\$4,767,600

DESCRIPTION

In September 2010, the Department requested that CMS approve an amendment to the State Plan (SPA) to replace the Family PACT Waiver in accordance with the Federal Patient Protection and Affordable Care Act. The SPA was approved on March 24, 2011. Under the SPA, 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.

Assumptions:

1. Assume a retroactive SPA implementation date of July 1, 2010.
2. Costs for eligible family planning services and supplies which were previously paid with 100% GF will now be claimed at 90%, and costs for family planning-related services at 50% FFP.
3. Based on FY 2009-10 data, costs for eligible family planning services and supplies were \$3,969,000 GF, and costs for family planning-related services were \$2,391,000 GF, for a total cost of \$6,360,000 GF.

<u>Total Cost</u>	<u>New FFP</u>
\$3,969,000 x 90% =	\$3,572,000
\$2,391,000 x 50% =	\$1,195,000
<u>\$6,360,000</u>	<u>\$4,767,000</u>

4. With enhanced funding, costs for these services and supplies will be \$4,767,000 FFP and \$1,592,000 GF for a GF savings of \$4,767,000 annually.

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 25
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1007

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$104,650,000	-\$105,528,150
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$104,650,000	-\$105,528,150
FEDERAL FUNDS	\$104,650,000	\$105,528,150

DESCRIPTION

In order to maximize revenues, the 2005-06 Budget Act and AB 131 (Chapter 80, Statutes of 2005), the Health Trailer Bill, required MRMIB to file a State Plan Amendment (SPA) in the State Children's Health Insurance Program (SCHIP) to claim 65% federal funding for prenatal care provided to women previously ineligible for federal funding for this care. The cost for this care had been 100% General Fund.

Assumptions:

- The cost of prenatal care for undocumented women was \$151,758,000 in FY 2009-10. It is estimated to be \$153,559,000 in FY 2010-11 and \$154,741,000 in FY 2011-12.
- Based on the estimated costs and 65% SCHIP FFP, the following amounts are budgeted for FY 2010-11 and FY 2011-12:

FY 2010-11: \$153,559,000 x .65 = \$99,813,350 FFP

FY 2011-12: \$154,741,000 x .65 = \$100,581,650 FFP

- The estimated costs for prenatal care for legal immigrants who have been in the country for less than five years are \$7,441,000 in FY 2010-11 and \$7,612,000 in FY 2011-12.

FY 2010-11: \$7,441,000 x .65 SCHIP FFP = \$4,837,000 FFP

FY 2011-12: \$7,612,000 x .65 SCHIP FFP = \$4,947,000 FFP

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 25

4. The federal funding received on a cash basis will be:

FY 2010-11 Savings: \$99,813,350 + \$4,837,000 = **\$104,650,000**

FY 2011-12 Savings: \$100,581,650 + \$4,947,000 = **\$105,528,000**

**Funding for prenatal care for undocumented women, and for legal immigrants who have been in the country for less than five years, has been shifted from the Medi-Cal Item, 4260-101, to the Healthy Families Item, 4260-113.

ADHC ONSITE TAR REVIEWS

REGULAR POLICY CHANGE NUMBER: 27
 IMPLEMENTATION DATE: 12/2009
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1466

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$615,000	-\$1,459,000
- STATE FUNDS	-\$307,500	-\$729,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	80.70 %	51.10 %
APPLIED TO BASE		
TOTAL FUNDS	-\$118,700	-\$713,500
STATE FUNDS	-\$59,350	-\$356,720
FEDERAL FUNDS	-\$59,350	-\$356,730

DESCRIPTION

ADHC on-site Treatment Authorization Request (TAR) adjudication, conducted by DHCS Field Office staff, began in November 2009 as part of a larger departmental effort to reduce fraud in ADHCs. DHCS Audits and Investigations (A&I) staff currently conduct audits on ADHCs. When an ADHC is sanctioned by A&I, it is required to hire a consultant to review participant eligibility. Participants not eligible for ADHC services, as determined by the consultant, are discharged from the facility. As part of the settlement agreements with A&I, sanctioned ADHCs may not resume billing until the DHCS Field Office staff conduct on-site TAR adjudication. Savings from the A&I activities, including ADHC sanctions, are captured in the base estimate, as these activities are ongoing. This policy change budgets the savings for the on-site TAR adjudication, which includes the reduction in approved number of ADHC days for some participants. Effective May 2010, on-site TAR adjudication was expanded to include non-sanctioned ADHC facilities.

Assumptions:

1. Savings began in December 2009.
2. In FY 2009-10, 395 days were denied through June 2010.
3. Beginning July 1, 2010, assume 186 ADHC TARs are adjudicated each month, and 65 days are denied each month.
4. Assume the average savings per one day of service denied is \$76.27.
5. Assume 9,774 service days will be denied in FY 2010-11.
Lagged Savings in FY 2010-11: $\$745,463 \times .825 \text{ lag} = \mathbf{\$615,000 \text{ TF (307,500 GF)}}$
6. Assume 19,134 service days will be denied in FY 2011-12.
Lagged Savings in FY 2011-12: $\$1,459,350 \times 1.0 \text{ lag} = \mathbf{\$1,459,000 \text{ TF (729,500 GF)}}$

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 28
 IMPLEMENTATION DATE: 12/2008
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1222

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,211,000	-\$6,282,000
- STATE FUNDS	-\$2,105,500	-\$3,141,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	54.80 %	27.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,903,400	-\$4,585,900
STATE FUNDS	-\$951,680	-\$2,292,930
FEDERAL FUNDS	-\$951,690	-\$2,292,930

DESCRIPTION

In January 2007, CMS awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for \$130 million in federal funds. The demonstration authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act, called the California Community Transitions (CCT), 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.

Participants will be enrolled in the demonstration for a maximum of 12 months. Enrollment began December 1, 2008 and 57 individuals were enrolled through June 30, 2009 and 144 individuals for the period July 1, 2009 through June 30, 2010. Target enrollment for the period July 1, 2010 through June 30, 2011 is 198 individuals and 210 individuals for July 1, 2011 through June 30, 2012.

CCT participants who have developmental disabilities are provided services through the DD waiver and partially funded by MFP. The number of DD waiver beneficiaries expected to enroll into CCT is being included in this policy change, but their expenditures are budgeted in the MFP Funding to CDDS for CCT and the Home and Community Based Svcs. – CDDS policy changes.

During the 12 months a participant is enrolled in the demonstration, the Department will receive 75% FFP and an additional 5.79% enhanced FFP from July 1, 2010 through December 31, 2010 provided through the ARRA Act of 2009. The Education Jobs and Medicaid Assistance Act, HR 1586 of 2010, allows the Department to receive 79.39% FFP from January 1, 2011 through March 31, 2011 and 78.44% FFP from April 1, 2011 through June 30, 2011. The enhanced FMAP is allowed for the provision of certain demonstration services such as transition coordination, home modification and set-up, family training and regular HCBS waiver and State Plan services. After 12 months, individuals who had participated in the demonstration will receive services under the State Plan or via an appropriate home and community-based services waiver at the regular FMAP.

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 28

Assumptions

1. This policy change shows the savings from moving beneficiaries who have resided in health care facilities to federally-allowed home and community based settings, and placing them under a waiver through the CCT Demonstration Project. The cost for waiver services for these beneficiaries is shown in the California Community Transitions Costs policy change.
2. Based on estimated costs for persons residing year-round in NF-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be \$55,635.
3. Waiver costs will be capped at \$48,180 for those beneficiaries transitioning from NF-Bs.
4. CCT services are reimbursed at 80.79% FFP and 19.21% GF from July 1, 2010 through December 31, 2010. Beginning January 1, 2011 through March 31, 2011, the FFP will be reimbursed at 79.29% and 78.29% FFP for the period of April 1, 2011 through June 30, 2011. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF. The additional 11.59% ARRA FFP for the savings is budgeted in the ARRA – Additional FFP policy change.
5. Assume 60% of CCT participants will receive demonstration services.
6. Demonstration services are assumed to cost \$7,500 per participant.
7. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.

	2010-11		2011-12	
	TF	GF	TF	GF
Lagged savings				
NF-Bs	(\$4,211,000)	(\$2,105,500)	(\$6,282,000)	(\$3,141,000)
Lagged costs				
Waiver Services	\$3,067,000	\$ 618,000	\$5,119,000	\$ 1,280,000
HCB Enhanced Services	\$ 513,000	\$ 103,000	\$ 829,000	\$ 207,000
Waiver Personal Care Svs Adj.	(\$ 534,000)	(\$107,500)	(\$ 588,000)	(\$ 147,000)
Subtotal Costs (rounded)	\$3,046,000	\$ 613,500	\$5,360,000	\$ 1,340,000
Net (rounded)	(\$1,165,000)	(\$1,492,000)	(\$ 922,000)	(\$ 1,801,000)

HOSPITAL INPATIENT RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 29
 IMPLEMENTATION DATE: 2/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1523

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$25,548,000	\$0
- STATE FUNDS	-\$10,294,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$25,548,000	\$0
STATE FUNDS	-\$10,294,000	\$0
FEDERAL FUNDS	-\$15,254,000	\$0

DESCRIPTION

SB 853, the Health Trailer Bill of 2010, freezes Medi-Cal inpatient services rates paid to all hospitals except Designated Public Hospitals (DPHs) at the rate that is the lesser of the rate that was in effect on January 1 or July 1, 2010. The rate freeze applies to both non-contract and contract hospitals. Any negotiated rate increases for contract hospitals would be nullified upon implementation of this legislation.

California Hospital Association v. David Maxwell-Jolly, et al. 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.

SB 90 (Chapter 19, Statutes of 2011) annuls the hospital inpatient rate freeze that is the lesser of the rate that was in effect on January 1 or July 1, 2010 and eliminates the remaining savings from the freeze. There are 95 hospitals that had negotiated multi-year rate increases that were scheduled to receive rate increases in FY 2010-11 until the rate freeze suspended those increases. With the rate freeze being repealed, these hospitals will receive the previously negotiated rate increases. Absent the rate freeze, it is likely other hospitals would have negotiated rate increases that would have taken effect sometime during FY 2010-11. Due to SB 90 being chaptered on April 13, 2011, there is insufficient time for any hospital that had not previously negotiated a multi-year rate increase to receive a rate increase in 2010-11, which will result in savings of \$25.5 million (\$10.3 million GF) in FY 2010-11.

The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's FMAP by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 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. This policy change includes the additional federal funds due to the FMAP increase in FY 2010-11 of \$2,480,000.

HOSPITAL INPATIENT RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 29

	TF	GF
FY 2010-11		
Rate Freeze Estimated Savings	(\$75,394,000)	(\$37,697,000)
Injunction Impact	\$ 21,636,000	\$10,818,000
SB 90 Impact	\$ 28,210,000	\$16,585,000
Net Impact	(\$ 25,548,000)	(\$10,294,000)
FY 2011-12		
Rate Freeze Estimate	(\$213,498,000)	(\$106,749,000)
Injunction & SB 90 Impact	\$213,498,000	\$106,749,000
Net Impact	\$ 0	\$ 0

FEDERAL DRUG REBATE CHANGE

REGULAR POLICY CHANGE NUMBER: 30
 IMPLEMENTATION DATE: 10/2010
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1559

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$39,702,000	\$203,000,000
- STATE FUNDS	\$39,702,000	\$203,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$39,702,000	\$203,000,000
STATE FUNDS	\$39,702,000	\$203,000,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

The Patient Protection and Affordable Care Act (PPACA), H.R. 3590, increased 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 rebates at the higher percentage for most drugs and retains the GF share at the current FMAP rate, for all rebates collected.

The Department is required to pay back the GF share of the differential to CMS. CMS agreed to collect 25% of the amount owed for the first quarter, 50% of the amount owed for the next three quarters, and 100% thereafter until reconciliation for these time periods is completed by CMS. Once the reconciliation is completed, the Department will be required to pay any outstanding amount owed.

Assumptions:

1. CMS will send the Department an estimated quarterly rebate offset amount (EQROA) to be remitted to the federal government. The EQROA will be reconciled with the total quarterly rebate offset amount (QROA) when the Department receives the unit offset amount from CMS.
2. In October 2010, CMS began collecting the additional FFP for the rebates collected by the Department retroactive to January 1, 2010.
3. CMS determined that the payment due in October 2010 was \$7,314,000 and the payment due in January 2011 was \$16,002,000 with discount factors of 25% and 50%, respectively.
4. The Department estimates that the rebate increase differential owed to CMS will be \$76 million per quarter. Currently, the Department pays CMS back at the current FMAP of that total.
5. Assume that CMS will collect the estimated additional amount due at a discount factor of 50% for the April 2011 payment and the July 2011 payment.

FEDERAL DRUG REBATE CHANGE**REGULAR POLICY CHANGE NUMBER: 30**

6. Assume that, beginning with the October 2011 payment, CMS will collect 100% of the estimated additional amount due.
7. In FY 2011-12, the Department will pay \$70 million to CMS for reconciliation of prior payments that included a discount factor.

FY 2010-11

October 2010 payment		\$ 7,314,000
January 2011 payment		\$ 16,002,000
April 2011 payment	$\$32,771,000 \times 50\% =$	<u>\$ 16,386,000</u>
		\$ 39,702,000

FY 2011-12

July 2011 payment	$\$38,000,000 \times 50\% =$	\$ 19,000,000
October 2011 payment	$\$38,000,000 \times 100\% =$	\$ 38,000,000
January 2012 payment	$\$38,000,000 \times 100\% =$	\$ 38,000,000
April 2012 payment	$\$38,000,000 \times 100\% =$	\$ 38,000,000
Reconciliation payment		<u>\$ 70,000,000</u>
		\$203,000,000

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

UBL AND MAIC INJUNCTION

REGULAR POLICY CHANGE NUMBER: 31
 IMPLEMENTATION DATE: 5/2010
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1509

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$60,000,000	\$60,000,000
- STATE FUNDS	\$30,000,000	\$30,000,000
PAYMENT LAG	0.9920	1.0000
% REFLECTED IN BASE	95.85 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,470,100	\$0
STATE FUNDS	\$1,235,040	\$0
FEDERAL FUNDS	\$1,235,040	\$0

DESCRIPTION

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 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 payors (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 was implemented in October 2009.

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.

This policy change reflects the higher reimbursement costs for drugs due to the injunction on the UBL.

	FY 2010-11	FY 2011-12
UBL	\$60,000,000	\$60,000,000
MAIC	0	0
Total Cost	\$60,000,000	\$60,000,000

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 33
 IMPLEMENTATION DATE: 3/2007
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 108

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$9,960,000	\$2,389,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$9,960,000	\$2,389,000
FEDERAL FUNDS	-\$9,960,000	-\$2,389,000

DESCRIPTION

This policy change budgets 100% GF costs to reimburse the federal share to CMS for drugs ineligible for FFP (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 the Centers for Medicare and Medicaid Services (CMS).

Effective March 2007, an automated quarterly report is available to determine the costs of drugs for which there is no FFP. The Department reimburses the federal government for FFP claimed for these drugs.

Assumptions:

1. The Department reimburses CMS quarterly for ongoing non-FFP drugs purchased.
2. In FY 2009-10, an analysis of non-FFP drug reporting determined the automated quarterly reports were not accurately capturing non-FFP drug claims. Therefore, the reports were re-run for the period FY 2004-05 through FY 2009-10 to adjust for the non-FFP drug costs to reimburse the federal share to CMS. FFP retroactive payments from third quarter of FY 2004-05 through third quarter FY 2009-10 will be paid in FY 2010-11.

<u>FY 2010-11</u>	<u>Est. Non-FFP Drug Expenditures</u>	<u>Est. FFP Repayment</u>
Retroactive payments	\$15,338,000	\$ 7,669,000
FY 2010-11	\$ 4,582,000	\$ 2,291,000
Total	\$19,920,000	\$ 9,960,000
 FY 2011-12	 \$ 4,778,000	 \$ 2,389,000

PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 34
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1434

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	-\$17,500,000
- STATE FUNDS	\$0	-\$8,750,000
PAYMENT LAG	1.0000	0.8990
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$15,732,500
STATE FUNDS	\$0	-\$7,866,250
FEDERAL FUNDS	\$0	-\$7,866,250

DESCRIPTION

The current rate of reimbursement for physician-administered drugs is the Average Wholesale Price (AWP) minus 5%. The Health Trailer Bill of 2010 established a new reimbursement rate methodology for physician-administered drugs that requires such drugs to be reimbursed consistent with Medi-Cal rates of payment for non-physician-administered pharmaceuticals beginning September 2011. The new methodology is expected to generate savings beginning December 2011.

The Department is conducting a study of the acquisition costs for drugs purchased by non-pharmacy providers prior to implementation of this reimbursement change, as well as the staffing needed to implement the rate adjustment.

Assumptions:

1. Assume implementation will begin in September 2011 and savings to begin in December 2011.
2. Annual savings are estimated to be \$30,000,000 TF (\$15,000,000 GF).
3. FY 2011-12 savings are estimated to be:

$$\$30,000,000 / 12 \text{ mos.} \times 7 \text{ mos.} = \$17,500,000 \text{ TF } (\$8,750,000 \text{ GF}).$$

ELIMINATION OF ACETAMINOPHEN DRUGS

REGULAR POLICY CHANGE NUMBER: 36
 IMPLEMENTATION DATE: 4/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1512

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,828,000	-\$8,959,000
- STATE FUNDS	-\$914,000	-\$4,479,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,828,000	-\$8,959,000
STATE FUNDS	-\$914,000	-\$4,479,500
FEDERAL FUNDS	-\$914,000	-\$4,479,500

DESCRIPTION

The Budget Act of 2010 eliminates specific nonprescription acetaminophen-containing products as Medi-Cal benefits for adults.

Assumptions:

1. Assume savings will begin on April 1, 2011.
2. Fee-for-service expenditures for nonprescription acetaminophen-containing products for adults are estimated to be \$7,638,000 annually.
3. Managed care savings are estimated to be \$1,359,000 annually.
4. Annual savings are estimated to be:
 $\$7,638,000 + \$1,359,000 = \$8,997,000$ TF

FY 2010-11 Savings:	TF	GF
FFS (Lagged)	\$1,488,000	\$ 744,000
Managed Care	\$ 340,000	\$ 170,000
Total FY 2010-11	\$1,828,000	\$ 914,000
FY 2011-12 Savings:	TF	GF
FFS (Lagged)	\$7,600,000	\$3,800,000
Managed Care	\$1,359,000	\$ 680,000
Total FY 2011-12	\$8,959,000	\$4,480,000

MEDI-CAL PHARMACY REFORMS

REGULAR POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 10/2009
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1395

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$31,400,000	-\$31,400,000
- STATE FUNDS	-\$15,700,000	-\$15,700,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	82.96 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$5,350,600	\$0
STATE FUNDS	-\$2,675,280	\$0
FEDERAL FUNDS	-\$2,675,280	\$0

DESCRIPTION

This policy change reflects the savings from the implementation of four pharmacy reforms that have resulted in lower pharmacy reimbursement costs and an increase in rebate revenue.

HIV/AIDS and Cancer Drugs

Since July 1, 2002, drug manufacturers have been required to negotiate a supplemental rebate on drugs used to treat HIV/AIDS and cancer drugs paid by the Medi-Cal FFS pharmacy program. Many manufacturers did not participate in the rebate program, and the Department's only recourse was administrative actions, which were not well-defined and were difficult to enforce.

Effective July 1, 2009, the Department implemented a mandatory rebate set at 20% of AMP, rather than negotiated rebates for these drugs, unless the manufacturer had a 10% or greater rebate in place for all of its HIV/AIDS and cancer drugs by December 31, 2009. The penalty for not participating in the rebate program is mandatory treatment authorization request approval for these drugs. The Department also expanded the rebate program to include all programs eligible for the federal Medicaid rebates.

The additional rebates as a result of the new contracts began in April 2010.

Upper Billing Limitation (UBL)

Private third party payers have contractual agreements with pharmacies to limit drug reimbursement, and these reimbursement levels are often lower than the Medi-Cal rate. Effective October 1, 2009, the Department implemented a policy that required pharmacy providers to bill Medi-Cal at a rate that is no higher than the lower of:

1. The lowest price reimbursed to pharmacies by other third party payers, excluding Medi-Cal managed care plans and Medicare Part D prescription drug plans, or
2. The lowest price routinely offered to any segment of the general public.

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. The cost associated with the UBL injunction is budgeted in the UBL and MAIC Injunction policy change.

MEDI-CAL PHARMACY REFORMS

REGULAR POLICY CHANGE NUMBER: 38

Therapeutic Category Review - Antipsychotics

Effective June 1, 2009, the Department conducted therapeutic category reviews of atypical antipsychotic drugs. Savings are realized in the form of increased rebates or a shift to less costly generic drugs. The contracts were implemented October 1, 2009. The collection of rebates began in April 2010.

340B Drug Program

The 340B Program limits the cost of covered outpatient drugs to certain entities including federal grantees, FQHC look-alikes and qualified disproportionate share hospitals. Federal rules require entities that dispense 340B-purchased drugs to Medi-Cal recipients to charge no more than the actual acquisition cost of the drug plus a dispensing fee. Federal rules allow the entity to carve out Medi-Cal recipients by purchasing non-340B drugs and dispensing them to Medi-Cal recipients at a higher reimbursement. Many drugs, primarily generic, are significantly less costly to the Medi-Cal program through the 340B program.

Effective October 1, 2009, the Department required all 340B entities to dispense only 340B purchased drugs to Medi-Cal beneficiaries.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
HIV/AIDS/cancer	\$10,000,000	\$10,000,000
Atypical antipsychotic drugs	\$11,400,000	\$11,400,000
340B providers	\$10,000,000	\$10,000,000
Upper Billing Limit	<u>In Base</u>	<u>In Base</u>
Total	\$31,400,000	\$31,400,000

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 39
 IMPLEMENTATION DATE: 1/2010
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1433

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$12,000,000	-\$12,000,000
- STATE FUNDS	-\$4,200,000	-\$4,200,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$12,000,000	-\$12,000,000
STATE FUNDS	-\$4,200,000	-\$4,200,000
FEDERAL FUNDS	-\$7,800,000	-\$7,800,000

DESCRIPTION

This policy change budgets the revenues resulting from the collection of Breast and Cervical Cancer Treatment Program 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. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP program in January 2010. This policy change reflects ongoing rebates invoiced. Revenues resulting from the resolution of disputed rebates are budgeted in the Disputed Drug Rebate PC.

Assumptions:

1. Payments began in January 2010.
2. Rebates are invoiced quarterly.
3. The ongoing rebates collected are estimated to be \$12,000,000 annually.

FY 2010-11: \$12,000,000 TF (\$4,200,000 GF)

FY 2011-12: \$12,000,000 TF (\$4,200,000 GF)

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 40
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1181

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	-\$30,800,000	-\$30,800,000
- STATE FUNDS	-\$15,400,000	-\$15,400,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$30,800,000	-\$30,800,000
STATE FUNDS	-\$15,400,000	-\$15,400,000
FEDERAL FUNDS	-\$15,400,000	-\$15,400,000

DESCRIPTION

This policy change budgets the rebate revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

Ongoing contracts were renewed and new diabetic supply contracts were signed in January 2010. These contracts expire in December 2012. The Department also 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 being based on the Wholesale Acquisition Cost (WAC) previously used. Reimbursement on the MAC has resulted in additional rebate revenues to the Department.

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.

CASH BASIS	Medical Supply Rebates
FY 2009-10	\$ 11,256,000
Est. FY 2010-11	\$ 30,800,000
Est. FY 2011-12	\$ 30,800,000

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 41
 IMPLEMENTATION DATE: 12/1999
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 51

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$50,460,000	-\$52,617,000
- STATE FUNDS	-\$7,014,000	-\$7,313,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$50,460,000	-\$52,617,000
STATE FUNDS	-\$7,014,000	-\$7,313,700
FEDERAL FUNDS	-\$43,446,000	-\$45,303,300

DESCRIPTION

Rebates for drugs covered through the Family PACT (FPACT) program are obtained by the Department from the drug companies involved. Rebates are estimated by using the actual FFS trend data for drug expenditures, and applying a historical percentage of the actual amounts collected to the trend projection.

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for FFP, which CMS determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

Assumptions:

1. The regular FMAP percentage is applied to 9.75% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 90.25% of the FPACT rebates.

CASH BASIS

(Dollars in
Thousands)
Fiscal Year

	<u>FPACT Drug Expenditures</u>	<u>FPACT Rebate</u>
FY 2009-10	\$149,512	(\$ 38,767)
Est. FY 2010-11		(\$ 50,460)
Est. FY 2011-12		(\$ 52,617)

AGED AND DISPUTED DRUG REBATE RESOLUTIONS

REGULAR POLICY CHANGE NUMBER: 42
 IMPLEMENTATION DATE: 4/2004
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1182

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$56,600,000	-\$45,000,000
- STATE FUNDS	-\$24,644,800	-\$22,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$56,600,000	-\$45,000,000
STATE FUNDS	-\$24,644,800	-\$22,430,000
FEDERAL FUNDS	-\$31,955,200	-\$22,570,000

DESCRIPTION

This policy change budgets the recovery of monies due to the resolution of disputed and aged drug rebate payments for the State Supplemental Rebate Program and the Federal Rebate Programs including the Breast and Cervical Cancer Treatment Program and the FPACT program.

Aged Rebates

Between 1991 and 2002, the Medi-Cal program accumulated large rebate disputes with participating drug companies for which the Department was cited in an audit of the rebate program by the Office of Inspector General (OIG). The Legislature approved funding in the Budget Act of 2003 for the Department to add additional staff to resolve aged drug rebate payment disputes.

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.

Disputed Rebates

Rebate invoices are sent quarterly to drug manufacturers and payment is due within 38 days from the invoice postmark date. Manufacturers may pay late, not pay, or pay a portion and formally dispute the remaining amount of rebates owed. Effective FY 2010-11, disputed rebates are being defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and receive payment.

Effective October 2008, the Department discontinued the collection of rebates for FPACT drugs that were not eligible for FFP. The percent of drugs not eligible for FFP has changed recently, ranging from 24% to 13.95%. This caused overpayment of FPACT rebates by some manufacturers. Manufacturers recently began to collect overpayments, resulting in a credit in FY 2010-11. It is anticipated that credits will offset rebates in FY 2011-12, resulting in the collection of insignificant FPACT disputed drug rebates.

Beginning in January 2010, the Department began collecting rebates retroactive to January 2002 for beneficiary drug claims for the full-scope federal BCCTP program.

AGED AND DISPUTED DRUG REBATE RESOLUTIONS

REGULAR POLICY CHANGE NUMBER: 42

Beginning in FY 2010-11, the Aged, BCCTP, and FPACT rebates are incorporated into the Disputed Federal and State rebates line item of this policy change as the majority of these rebates have been collected.

	Federal & State Rebates
FY 2010-11	(\$56,600,000)
FY 2011-12	(\$45,000,000)

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 43
 IMPLEMENTATION DATE: 1/1991
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 54

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$190,312,000	-\$197,374,000
- STATE FUNDS	-\$94,860,000	-\$98,379,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$190,312,000	-\$197,374,000
STATE FUNDS	-\$94,860,000	-\$98,379,800
FEDERAL FUNDS	-\$95,452,000	-\$98,994,200

DESCRIPTION

State supplemental drug rebates for drugs provided through fee-for-service and County Organized Health Systems are negotiated by the Department with drug manufacturers to provide additional drug rebates over and above the federal rebate levels (see the Federal Drug Rebate policy change).

Assumptions:

1. Family planning drugs are .389% of rebates and are funded with 90% federal funds and 10% General Funds.
2. In October 2009, CMS released Federal Upper Limits (FULs) for some products, which have created lower net cost for some generically available products. As a result of lower utilization of the equivalent brand name products, drug rebates are expected to decrease in FY 2010-11 and FY 2011-12.
3. Disputed Drug Rebates Resolutions had been budgeted in the Federal Drug Rebates, State Supplemental Rebates, and FPACT Rebates policy changes. Disputed Drug Rebate Resolutions is now a separate policy change and the dollars collected are no longer incorporated into the current rebate estimate below.

CASH BASIS (In Thousands)

<u>Fiscal Year</u>	<u>FFS Trends</u>	<u>Supplemental Rebate Savings</u>
FY 2009-10	\$2,948,240	(\$ 239,454)
Est. FY 2010-11		(\$ 190,312)
Est. FY 2011-12		(\$ 197,374)

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 44
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 55

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,333,020,000	-\$1,382,484,000
- STATE FUNDS	-\$664,436,000	-\$689,090,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,333,020,000	-\$1,382,484,000
STATE FUNDS	-\$664,436,000	-\$689,090,800
FEDERAL FUNDS	-\$668,584,000	-\$693,393,200

DESCRIPTION

The State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs. Rebates are estimated by using actual FFS trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.

Assumptions:

1. Family planning drugs are .389% of rebates and are funded with 90% federal funds and 10% General Funds.
2. Disputed Drug Rebates Resolutions had been budgeted in the Federal Drug Rebates, State Supplemental Rebates, and FPACT Rebates policy changes. Disputed Drug Rebate Resolutions is now a separate policy change and the dollars collected are no longer incorporated into the current rebate estimate below.

CASH BASIS (In Thousands)

<u>Fiscal Year</u>	<u>FFS Trends</u>	<u>Federal Rebate Savings</u>
FY 2009-10	\$2,948,240	(\$1,156,535)
Est. FY 2010-11		(\$1,333,020)
Est. FY 2011-12		(\$1,382,484)

MANAGED CARE INTERGOVERNMENTAL TRANSFERS

REGULAR POLICY CHANGE NUMBER: 48
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1054

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$272,649,000	\$341,704,000
- STATE FUNDS	\$109,081,000	\$170,852,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$272,649,000	\$341,704,000
STATE FUNDS	\$109,081,000	\$170,852,000
FEDERAL FUNDS	\$163,568,000	\$170,852,000

DESCRIPTION

The counties will transfer funds under an 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.

COHS:

The initial transfer of funds began in June 2006, effective retroactively to July 2005. The County of San Mateo increased its IGT funds effective February 1, 2010 and July 1, 2010. The IGT will continue on an ongoing basis.

IGTs for Solano, Santa Barbara, Monterey, and Santa Cruz Counties were effective retroactive to July 1, 2009; Merced and Sonoma Counties were effective retroactive to October 1, 2009; Orange and Yolo Counties were effective July 1, 2010. The IGTs will continue on an ongoing basis.

The IGT for Marin County is expected to be effective July 1, 2011. Once approved by CMS, it is anticipated the IGT will continue on an ongoing basis.

Two Plan Model:

An IGT for Los Angeles County was effective October 2006 and will continue on an ongoing basis.

IGTs for Alameda, Contra Costa, Kern, Riverside, San Bernardino, San Francisco, San Joaquin, and Santa Clara Counties were effective retroactive to October 1, 2008, and they will continue on an ongoing basis.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

MANAGED CARE INTERGOVERNMENTAL TRANSFERS

REGULAR POLICY CHANGE NUMBER: 48

(Dollars in Thousands)

FY 2010-11

	<u>IGT</u>	<u>Regular FFP</u>	<u>ARRA FFP</u>	<u>Total FFP</u>	<u>TF</u>
Total	\$109,081	\$136,324	\$27,244	\$163,568	\$272,649

FY 2011-12

	<u>IGT</u>	<u>Total FFP</u>	<u>TF</u>
Total	\$170,852	\$170,852	\$341,704

MANAGED CARE EXPANSION - VENTURA

REGULAR POLICY CHANGE NUMBER: 52
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1448

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$48,424,000
- STATE FUNDS	\$0	\$24,212,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$48,424,000
STATE FUNDS	\$0	\$24,212,000
FEDERAL FUNDS	\$0	\$24,212,000

DESCRIPTION

As part of Medi-Cal Redesign, the Budget Act of 2005 included staffing for a geographic expansion of managed care. This policy change reflects the expansion of COHS in Ventura County as a new COHS health plan.

Assumptions:

- Ventura County is establishing a new COHS health plan with an anticipated start up date of July 2011.
- Based on current covered aid codes in other counties served by the other COHS plans, the following aid codes will be enrolled in the Ventura County COHS: Family – 0A, 01, 02, 03, 04, 06, 08, 30, 32, 33, 34, 35, 37, 38, 39, 40, 42, 45, 46, 47, 54, 59, 72, 82, 83, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4F, 4G, 4K, 4M, 5K, 7A, 7J, 7X, 8P, 8R, Aged (Medi-Cal only and dual eligibles) – 10, 14, 16, 17, 1E, 1H, Disabled (both Medi-Cal only and dual eligibles) – 20, 24, 26, 27, 36, 60, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, Adult – 81, 86, 87, Long Term Care (LTC) (both Medi-Cal only and dual eligibles) – 13, 23, 53, 63, Breast and Cervical Cancer Treatment Program (BCCTP) – 0M, 0N, 0P, 0R, 0U, and 0T.
- The contract will identify services that are carved-out of the rate in Ventura County. Assume these include:

EPSDT supplemental specialty mental health services, EPSDT supplemental dental services, Fabrication of optical lenses, Laboratory Services provided under the state serum Alphafetoprotein-Testing, AIDS Waiver, Special AIDS Drugs, Skilled Nursing Facility Waiver, In Home Waiver, Model NF Waiver, Adult Day Health Care, Pediatric Day Health Care, MH-Hospital Inpatient, MH-Outpatient Services, Psychiatrist, Targeted Case Management, Short-Doyle/Medi-Cal Mental Health, Multipurpose Senior Services Program, Services in any State or Federal Governmental Hospitals, Childhood Lead Poisoning Case Management provided by Local County Health Departments, Home and Community Based Services, Personal Care Services, Alcohol and Substance Abuse Treatment Services, Outpatient Heroin Detoxification, Women, Infant, and Children Services, Medicare Part D drugs, California Children Services, Specialty Mental Health

MANAGED CARE EXPANSION - VENTURA**REGULAR POLICY CHANGE NUMBER: 52**

Services, directly observed therapy for treatment of tuberculosis, Dental Services, any Local Education Agency (LEA) Services, Erectile dysfunction drugs as listed in the contract, and Psychotherapeutic drugs.

4. The average monthly number of enrollees in the Plan is expected to be 93,407 beginning in July 2011.
5. In the first year of implementation, rates for carved-in services for enrollees are assumed to be equal to the current FFS costs for those services. Based on Ventura County-specific methodology, the weighted average monthly cost of carved-in services per enrollee per month is expected to be \$261.83 per member per month. The yearly cost of capitation payments is expected to be:

93,407 average monthly enrollees x \$261.83 x 12 months = \$293,481,000

6. The expansion of managed care into Ventura County is expected to have the following impact during the contract period:

\$293,481,000	Medi-Cal Managed Care capitation payments
<u>-\$293,481,000</u>	FFS savings for managed care enrollees
\$0	Net annual impact of shift to managed care

This does not include the impact of any future rate increases.

7. There will be a cost in FY 2011-12 on a cash basis due to the fact that capitation payments will begin immediately, while fee-for-service carved-in payments will continue to be paid for services provided before the expansion due to the time it takes providers to bill for services. The costs are expected to be:

	FY 2011-12
Managed Care Capitation Payments	\$293,481,000
FFS Savings	-\$293,481,000
FFS Payment Lag	0.835
FFS Lagged Savings	<u>-\$245,057,000</u>
FY Cost (Rounded)	\$48,424,000

MATERNITY SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 53
 IMPLEMENTATION DATE: 12/2010
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1443

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$25,040,000	\$0
- STATE FUNDS	\$12,520,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$25,040,000	\$0
STATE FUNDS	\$12,520,000	\$0
FEDERAL FUNDS	\$12,520,000	\$0

DESCRIPTION

The Department implemented a new maternity supplemental reimbursement structure for Two Plan Model plans effective October 1, 2009, and Sacramento and San Diego GMC model 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 for each delivery event.

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 has finalized rates with the remaining GMC model plans.

This policy change budgets the January 1, 2010 through June 30, 2010 maternity supplemental payments for several GMC model plans. All retroactive payments were made in FY 2010-11. Maternity supplemental payments for FY 2010-11 and ongoing are budgeted in the managed care model policy changes.

Assumptions:

1. Maternity supplemental payments are made based on the number of deliveries reported by each plan to the Department.
2. Retroactive costs are estimated to be \$10,849,000 for GMC Sacramento model plans and \$14,191,000 for San Diego model plans in FY 2010-11.

FY 2010-11 Costs:

$$\$10,849,000 + \$14,191,000 = \mathbf{\$25,040,000 \text{ TF } (\$12,520,000 \text{ GF})}$$

MANAGED CARE EXPANSION REGIONAL TWO-PLAN MODEL

REGULAR POLICY CHANGE NUMBER: 54
 IMPLEMENTATION DATE: 3/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1445

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$11,773,000	\$2,717,000
- STATE FUNDS	\$5,886,500	\$1,358,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,773,000	\$2,717,000
STATE FUNDS	\$5,886,500	\$1,358,500
FEDERAL FUNDS	\$5,886,500	\$1,358,500

DESCRIPTION

As part of a Medi-Cal Redesign, the budget Act of 2005 included staffing for a geographic expansion of managed care in 13 additional counties. This policy change reflects the expansion of managed care into a regional two-plan model including Fresno, (an existing managed care county) Kings, and Madera Counties. Because Fresno is already a managed care county, only the impact of implementation of managed care in Kings and Madera counties are budgeted in this policy change.

Assumption:

- Managed care will expand as a Regional Two-Plan model in Fresno, Kings, and Madera Counties in March 2011. There will be one commercial plan and one local initiative plan that will provide services to beneficiaries in all three counties.
- Fresno is already a managed care county and is budgeted in the Two-Plan policy change.
- The Regional Two-Plan model has three categories of aid codes: mandatory, voluntary, and excluded.
 The following aid codes are excluded from Two-Plan Model managed care enrollment: 0C, 0M, 0R, 0T, 0U, 0V, 1U, 1X, 1Y, 13, 17, 18, 2A, 23, 27, 28, 3D, 3T, 3V, 37, 44, 48, 5E, 5F, 5J, 5R, 5T, 5W, 50, 53, 55, 58, 6R, 6U, 6W, 6X, 6Y, 63, 67, 68, 69, 7C, 7F, 7G, 7H, 7K, 7M, 7N, 7P, 7R, 7T, 71, 73, 74, 76, 8E, 8F, 8G, 8H, 8N, 8T, 8U, 8V, 8W, 8X, 8Y, 80, 81, 83, 84, 85, 87, 88, 89, 9A, 9H, 9J, 9K, 9M, 9N, 9R, 9U, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1. The voluntary aid codes include the following: 0N, 0P, 10, 14, 16, 1E, 1H, 20, 24, 26, 36, 60, 64, 66, 2E, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6V, 03, 04, 40, 42, 45, 4A, 4F, 4G, 4H, 4L, 4K, 4M, 5K, 7J, 86. The mandatory aid codes include the following: 0A, 01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 47, 54, 59, 72, 82, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 7A, 7X, 8P, 8R.
- The contract identifies services that are carved-out of the rate in Fresno, Kings, and Madera Counties. Based on current carve-outs in other two-plan model counties, assume these include: Lenses for eyewear, Alphafeto Protein Testing, Direct Observed Therapy, AIDS Waiver, Special AIDS Drugs, Adult Day Health Care, MH-Hospital Inpatient, MH-Outpatient Services, Psychiatrist, Targeted Case Management, Childhood Lead Screening, Home and Community Based Services, Personal Care Services, Alcohol and Drug Treatment, Women, Infant, and Children Services, Medicare Part D drugs, State Supported Services, California Children Services, Specialty Mental

**MANAGED CARE EXPANSION REGIONAL TWO-PLAN
MODEL
REGULAR POLICY CHANGE NUMBER: 54**

Health Services, Directly observed therapy for treatment of tuberculosis, Dental Services, any Local Education Agency (LEA) Services, Psychotherapeutic Drugs, Services for Major Organ Transplants, Long-term Care Services, Acupuncture Services, Chiropractic Services, Prayer or Spiritual Healing, Pediatric Day Health Care, Optional Benefits and Erectile Dysfunction Drugs and Therapies.

5. Based on Fresno County data, assume 67% of the Medi-Cal population in Kings and Madera Counties will enroll into Managed Care. This will result in 28,460 average monthly enrollees in Madera County and 23,238 in Kings County.
6. In the first year of implementation, rates for carved-in services for enrollees are assumed to be equal to the current FFS cost for those services. Based on County specific methodology, the weighted average monthly cost of carved-in services in Kings County is expected to be \$147.75 per member per month and \$135.98 in Madera County. The yearly costs of capitation payments are expected to be \$41,201,000 in Kings County and \$46,440,000 in Madera County.
7. The expansion of managed care into Kings County and Madera County is expected to have the following impact during the contract period:

	<u>Kings County</u>	<u>Madera County</u>
Medi-Cal Managed Care Capitation payments	\$41,201,000	\$46,440,000
FFS savings for managed care enrollees	-\$41,201,000	-\$46,440,000
Net annual impact of shift to managed care	\$0	\$0

This does not include the impact of any future rate increases.

8. There will be a cost in FY 2010-11 and FY 2011-12 on a cash basis due to the fact that capitation payments will begin immediately, while fee-for-services carved-in payments will continue to be paid for services provided before the expansion due to the time it takes providers to bill for services. The costs in FY 2010-11 and FY 2011-12 are expected to be:

Kings County: $\$41,201,000 \div 12 \text{ mos} \times 4$ (March 1, 2011 start date) = \$13,734,000

Madera County: $\$46,440,000 \div 12 \text{ mos} \times 4$ (March 1, 2011 start date) = \$15,480,000

FY 2010-11	<u>Kings County</u>	<u>Madera County</u>	<u>Total</u>
Capitation Payments	\$13,734,000	\$15,480,000	\$29,214,000
FFS Savings	-\$13,734,000	-\$15,480,000	-\$29,214,000
FFS Payment Lag	0.597	0.597	0.597
FFS Lagged Savings	-\$8,199,000	-\$9,242,000	-\$17,441,000
FFS Cost (Rounded)	\$5,532,000	\$6,238,000	\$11,773,000
FY 2011-12			
Capitation Payments	\$41,201,000	\$46,440,000	\$87,641,000
FFS Savings	-\$41,201,000	-\$46,440,000	-\$87,641,000
FFS Payment Lag	0.969	0.969	0.969
FFS Lagged Savings	-\$39,924,000	-\$45,000,000	-\$84,924,000
FFS Cost (Rounded)	\$1,277,000	\$1,440,000	\$2,717,000

COURT-ORDERED MANAGED CARE RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 56
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1361

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$2,990,000	\$0
- STATE FUNDS	\$1,495,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,990,000	\$0
STATE FUNDS	\$1,495,000	\$0
FEDERAL FUNDS	\$1,495,000	\$0

DESCRIPTION

In the case of *Health Net of California v. Department of Health Services*, the Third District Court of Appeal ruled that the Department must pay \$17,590,000, including post judgment interest, to Health Net for a dispute over Two Plan Model capitation rates for years ranging from 1997 to 2002. In FY 2009-10 \$14.6 million was paid to Health Net and the remaining \$2.99 million was paid to the health plan in December 2010.

	<u>FY 2010-11</u>
Total Cost	\$2,990,000

INCREASE IN CAPITATION RATES FOR MCO TAX

REGULAR POLICY CHANGE NUMBER: 60
 IMPLEMENTATION DATE: 11/2009
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1455

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$6,926,000	\$206,829,000
- STATE FUNDS	\$2,791,000	\$103,414,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$6,926,000	\$206,829,000
STATE FUNDS	\$2,791,000	\$103,414,000
FEDERAL FUNDS	\$4,135,000	\$103,415,000

DESCRIPTION

AB 1422 (Chapter 157, Statutes of 2009) imposes an additional tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). 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. It is required that the tax proceeds 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 through June 30, 2011. Legislation has been proposed to extend the tax through December 30, 2013. Proceeds from the tax used to offset payments made to the State by the plans during the extended time period will be matched with federal funds at the level in effect at that time.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

Assumptions:

1. FY 2010-11 costs include the unpaid amount of the capitation rate increases for January 2009 through June 2009 for AHF and SCAN as well as the capitation rate increases due to the MCO tax levied on IGT revenues for FY 2010-11. The FY 2010-11 rate increases due to the MCO tax levied on revenues exclusive of the IGT revenues are budgeted in the managed care model policy changes.
2. The Department has proposed legislation to extend the MCO tax from July 1, 2011 through December 30, 2013. This policy change budgets the FY 2011-12 cost of rate increases for all plans subject to the tax.

INCREASE IN CAPITATION RATES FOR MCO TAX

REGULAR POLICY CHANGE NUMBER: 60

(In Thousands)	<u>MCO Tax</u>	<u>Reg FFP</u>	<u>ARRA FFP</u>	<u>Total FFP</u>	<u>TF</u>
Total FY 2010-11	\$2,791	\$3,463	\$672	\$4,135	\$6,926
	<u>MCO Tax</u>	<u>FFP</u>	<u>TF</u>		
Total FY 2011-12	\$103,414	\$103,415	\$206,829		

MANAGED CARE EXPANSION - MENDOCINO

REGULAR POLICY CHANGE NUMBER: 62
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1447

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$14,687,000
- STATE FUNDS	\$0	\$7,343,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$14,687,000
STATE FUNDS	\$0	\$7,343,500
FEDERAL FUNDS	\$0	\$7,343,500

DESCRIPTION

As part of Medi-Cal Redesign, the Budget Act of 2005 included staffing for a geographic expansion of managed care. This policy change reflects the expansion of the Partnership Health Plan of California (PHC) County Organized Health Systems (COHS) into Mendocino County.

Assumptions:

- Partnership Health Plan COHS is expected to expand into Mendocino County in July 2011.
- Based on current covered aid codes in other counties served by this contractor, the following aid codes will be enrolled in the Mendocino COHS: Family – 0A, 01, 02, 03, 04, 06, 08, 30, 32, 33, 34, 35, 37, 38, 39, 40, 42, 45, 46, 47, 54, 59, 72, 82, 83, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4F, 4G, 4K, 4M, 5K, 7A, 7J, 7X, 8P, 8R, Aged (Medi-Cal only and dual eligibles) – 10, 14, 16, 17, 1E, 1H, Disabled (both Medi-Cal only and dual eligibles) – 20, 24, 26, 27, 36, 60, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, Adult – 81, 86, 87. Long Term Care (LTC) (both Medi-Cal only and dual eligibles) – 13, 23, 53, 63, Breast and Cervical Cancer Treatment Program (BCCTP) – 0M, 0N, 0P, 0R, 0U, and 0T.
- The contract identifies services that are carved-out of the rate in Mendocino County. Based on current carve-outs in other Partnership counties, assume these include:

EPSDT supplemental specialty mental health services, EPSDT supplemental dental services, Fabrication of optical lenses, Laboratory Services provided under the state serum Alphafetoprotein-Testing, AIDS Waiver, Special AIDS Drugs, Skilled Nursing Facility Waiver, In Home Waiver, Model NF Waiver, Adult Day Health Care, Pediatric Day Health Care, MH-Hospital Inpatient, MH-Outpatient Services, Psychiatrist, Targeted Case Management, Short-Doyle/Medi-Cal Mental Health Services, Multipurpose Senior Services Program, Services in any State or Federal Governmental Hospitals, Childhood Lead Poisoning Case Management provided by Local County Health Departments, Home and Community Based Services, Personal Care Services, Alcohol and Substance Abuse Treatment Services, Outpatient Heroin Detoxification, Women, Infant, and Children Services, Medicare Part D drugs, California Children Services, Specialty Mental Health Services, Directly Observed Therapy for

MANAGED CARE EXPANSION - MENDOCINO**REGULAR POLICY CHANGE NUMBER: 62**

treatment of tuberculosis, Dental Services, any Local Education Agency (LEA) Services, Erectile dysfunction drugs as listed in the contract, and Psychotherapeutic drugs.

4. The average monthly number of enrollees in the Plan is expected to be 22,617 in FY 2011-12.
5. Rates for carved-in services for enrollees are assumed to be equal to the current FFS costs for those services. Based on Mendocino County-specific methodology, the weighted average monthly cost of carved-in services per enrollee per month is expected to be \$327.97 per member per month. The annual cost of capitation payments in FY 2011-12 is expected to be:

22,617 average monthly enrollees x \$327.97 x 12 months = \$89,012,000

6. The expansion of managed care into Mendocino County is expected to have the following impact during the contract period:

\$89,012,000	Medi-Cal Managed Care capitation payments
<u>-\$89,012,000</u>	FFS savings for managed care enrollees
\$0	Net annual impact of shift to managed care

7. There will be a cost in FY 2011-12 on a cash basis due to the fact that capitation payments will begin immediately, while fee-for-service carved-in payments will continue to be paid for services provided before the expansion due to the time it takes providers to bill for services. The costs are expected to be:

	FY 2011-12
Managed Care Capitation Payments	<u>\$89,012,000</u>
FFS Savings	-\$89,012,000
FFS Payment Lag	0.835
FFS Lagged Savings	<u>-\$74,325,000</u>
FY Cost (Rounded)	\$14,687,000

MANAGED CARE EXPANSION - MARIN

REGULAR POLICY CHANGE NUMBER: 63
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1561

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$13,935,000
- STATE FUNDS	\$0	\$6,967,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$13,935,000
STATE FUNDS	\$0	\$6,967,500
FEDERAL FUNDS	\$0	\$6,967,500

DESCRIPTION

As part of Medi-Cal Redesign, the Budget Act of 2005 included staffing for a geographic expansion of managed care. This policy change reflects the expansion of the Partnership Health Plan of California (PHC) County Organized Health Systems (COHS) into Marin County.

Assumptions:

- Partnership Health Plan COHS is expected to expand into Marin County in July 2011.
- Based on current covered aid codes in other counties served by this contractor, the following aid codes will be enrolled in the Marin COHS: Family – 01, 02, 03, 04, 06, 08, 30, 32, 33, 34, 35, 37, 38, 39, 40, 42, 45, 46, 47, 54, 59, 72, 82, 83, 0A, 3A, 3D, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 5K, 7A, 7J, 7X, 8P, 8R, Aged (Medi-Cal only and dual eligibles) – 10, 14, 16, 17, 1E, 1H, Disabled (both Medi-Cal only and dual eligibles) – 20, 24, 26, 27, 36, 60, 64, 66, 67, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6R, 6V, 6W, 6X, 6Y, Adult – 81, 86, 87. Long Term Care (LTC) (both Medi-Cal only and dual eligibles) – 13, 23, 53, 63, Breast and Cervical Cancer Treatment Program (BCCTP) – 0M, 0N, 0P, 0R, 0U, and 0T.
- The contract identifies services that are carved-out of the rate in Marin County. Based on current carve-outs in other Partnership counties, assume these include:

EPSDT supplemental specialty mental health services, EPSDT supplemental dental services, Fabrication of optical lenses, Laboratory Services provided under the state serum, Alphafetoprotein-Testing, Special AIDS Drugs, Adult Day Health Care, Pediatric Day Health Care, MH-Hospital Inpatient, MH-Outpatient Services, Psychiatrist, Targeted Case Management, Short-Doyle/Medi-Cal Mental Health Services, Multipurpose Senior Services Program, Services in any State or Federal Governmental Hospitals, Childhood Lead Poisoning Case Management provided by Local County Health Departments, Home and Community Based Services, Personal Care Services, Alcohol and Substance Abuse Treatment Services and Outpatient Heroin Detoxification, Women, Infant, and Children Services, California Children Services, Specialty Mental Health Services, Directly Observed therapy for treatment of tuberculosis, Dental Services, any Local Education Agency (LEA) Services, Erectile dysfunction drugs as listed in the contract, and Psychotherapeutic drugs.

MANAGED CARE EXPANSION - MARIN**REGULAR POLICY CHANGE NUMBER: 63**

4. The average monthly number of enrollees in the Plan is expected to be 16,332 in FY 2011-12.
5. Rates for carved-in services for enrollees are assumed to be equal to the current FFS costs for those services. Based on Marin County-specific methodology, the weighted average monthly cost of carved-in services per enrollee per month is expected to be \$430.91 per member per month. The annual cost of capitation payments in FY 2011-12 is expected to be:

16,332 average monthly enrollees x \$430.91 x 12 months = \$84,452,000

6. The expansion of managed care into Marin County is expected to have the following impact during the contract period:

\$84,452,000	Medi-Cal Managed Care capitation payments
<u>-\$84,452,000</u>	FFS Savings for managed care enrollees
\$0	Net annual impact of shift to managed care

7. There will be a cost in FY 2011-12 on a cash basis due to the fact that capitation payments will begin immediately, while fee-for-service carved-in payments will continue to be paid for services provided before the expansion due to the time it takes providers to bill for services. The costs are expected to be:

	FY 2011-12
Managed Care Capitation Payments	\$ 84,452,000
FFS Savings	-\$ 84,452,000
FFS Payment Lag	0.835
FFS Lagged Savings	<u>-\$ 70,517,000</u>
	\$ 13,935,000

FAMILY PLANNING INCREASED FED MATCHING FUNDS

REGULAR POLICY CHANGE NUMBER: 64
 IMPLEMENTATION DATE: 1/2010
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1444

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$14,347,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$14,347,000	\$0
FEDERAL FUNDS	\$14,347,000	\$0

DESCRIPTION

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. Previously, a 50% federal funding match was drawn down. Implementation of a new cost accounting methodology will result in a 90% federal funding match for family planning services. 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.

This policy change budgets for the enhanced FFP claimed retroactively for the period of April 2009 to March 2010. The enhanced FFP for the April 2010 through June 2010 period was claimed in FY 2009-10. Beginning in July 2010 the enhanced FFP for Family Planning services is budgeted in the managed care model policy changes.

Assumptions:

1. Family planning services will be claimed at 90% FFP retroactively for the period of April 2009 to March 2010 in FY 2010-11.
2. Family planning services claimed at 50% FFP will now be claimed at 90% FFP, resulting in a 40% increase in federal reimbursement.
3. Assume \$14,347,000 will be claimed retroactively in FY 2010-11.

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 65
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1082

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

This is an informational policy change displaying the Medi-Cal fee-for-service (FFS) expenditures for Medi-Cal managed care plan enrollees. FFS expenditures occur for managed care enrollees for covered Medi-Cal services excluded by the health plan contract. In Calendar Year 2010 FFS payments for managed care enrollees totaled:

	Expenditures by Aid Category		
	<u>*Other</u>	<u>CCS/GHPP</u>	<u>Total</u>
Families	\$376,008,000	\$478,881,000	\$854,889,000
Disabled	\$276,089,000	\$330,737,000	\$606,826,000
Aged	\$70,758,000	\$55,000	\$70,813,000
200% Poverty	\$6,812,000	\$33,564,000	\$40,376,000
MI Child	\$7,702,000	\$19,599,000	\$27,201,000
133% Poverty	\$7,684,000	\$8,117,000	\$15,801,000
Other	\$1,730,000	\$6,000	\$1,736,000
100% Poverty	\$7,869,000	\$16,920,000	\$24,789,000
Blind	\$3,638,000	\$4,551,000	\$8,189,000
MI Adult	\$3,732,000	\$379,000	\$4,111,000
Totals	\$762,022,000	\$892,809,000	\$1,654,831,000

*Other expenditures reflect the impact of the Drug Rebates.

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 66
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1482

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$598,000
- STATE FUNDS	\$0	-\$299,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$598,000
STATE FUNDS	\$0	-\$299,000
FEDERAL FUNDS	\$0	-\$299,000

DESCRIPTION

Partnership Health Plan of California (PHC)'s Medi-Cal managed care contract covers undocumented beneficiaries (aid codes 55, 58, 5F, 5G, 5N, C1 – C9 and D1 – D9) in Solano, Napa and Yolo Counties. Effective July 1, 2011, this contract will be amended to remove these aid codes and these beneficiaries will receive services through fee-for-service (FFS).

Assumptions:

- It is assumed the annual member months will be 4,123 for Solano County, 1,753 for Napa County, and 2,178 for Yolo County.
- The FY 2011-12 undocumented beneficiary rates are assumed to be \$292.79 for Solano County, \$297.93 for Napa County, and \$266.49 for Yolo County.
- The FY 2011-12 cost of undocumented beneficiaries by county is expected to be:

Solano County:	4,123 x \$292.79 = \$1,207,000
Napa County:	1,753 x \$297.93 = \$522,000
Yolo County:	2,178 x \$266.49 = \$580,000

$\$1,207,000 + \$522,000 + \$580,000 = \$2,309,000$

- The shift of undocumented beneficiaries to FFS is expected to have the following impact:

\$2,309,000	FFS cost
<u>-\$2,309,000</u>	Managed Care savings
\$0	Net annual impact of shift to FFS

**DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM
PHC
REGULAR POLICY CHANGE NUMBER: 66**

5. There will be a savings in FY 2011-12 due to the capitation payments ending on June 30, 2011, while there is a lag in FFS payments due to the time it take for providers to bill and be paid for services.

	FY 2011-12
FFS Cost	\$2,309,000
Managed Care Savings	-\$2,309,000
FFS Payment Lag	0.741
Lagged Costs	\$1,711,000
FY Savings (Rounded)	-\$598,000

COVERAGE FOR FORMER AGNEWS RESIDENTS

REGULAR POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 7/2007
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1199

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$9,630,000	\$4,609,000
- STATE FUNDS	-\$4,815,000	\$2,304,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$9,630,000	\$4,609,000
STATE FUNDS	-\$4,815,000	\$2,304,500
FEDERAL FUNDS	-\$4,815,000	\$2,304,500

DESCRIPTION

The California Department of Developmental Services (CDDS) submitted a plan to the Legislature in January 2005 to close the Agnews Developmental Center. Effective April 1, 2009, Agnews closed and all consumers have been transitioned to the community. A total of 300 Agnews clients moved into communities in Alameda, San Mateo, and Santa Clara counties. Of these, 237 are currently enrolled in managed care.

Due to the significant behavioral, health, and personal care needs of these clients, current capitation rates do not provide sufficient funding to meet Agnews clients' needs. The Department established a mechanism whereby the plans were paid a supplemental payment in addition to the capitation rate for these individuals, followed by periodic reconciliations to fully reimburse the plans for reasonable costs. This arrangement will last until the Department has implemented an appropriate capitation rate for these individuals.

Assumptions:

1. The plans received a supplemental payment of \$4,919 for former Agnews clients until capitation rates were implemented in their contracts. Average monthly costs were based on actual Agnews Developmental Center physician and ancillary healthcare expenditures for FY 2004-05, adjusted for inflation, as reported by CDDS.
2. The plans were paid their initial capitation based on the beneficiary's aid code. The average capitation rate for this population was \$257.39. The plan then submitted an invoice to the Department requesting payment for the difference between the capitation payments and the supplemental payments.
3. New full risk capitation rates were implemented December 2010 and are effective retroactively to January 1, 2008 for the Santa Clara Family Health Plan and July 1, 2008 for the Health Plan San Mateo. Effective July 1, 2010 the Alameda Alliance Health Plan contract was amended to reduce the previous interim rates until full risk capitation rates are agreed upon. The rates are as follows:

COVERAGE FOR FORMER AGNEWS RESIDENTS

REGULAR POLICY CHANGE NUMBER: 67

	<u>Medi-Cal Only</u>	<u>Dual</u>
Alameda Alliance	\$2,930.25	\$977.28
Santa Clara Family Health Plan	\$3,152.87	\$1,247.66
Health Plan of San Mateo	\$3,148.87	\$1,004.78

4. It is estimated \$18,564,000 will be repaid to the Department in FY 2010-11 for the reconciliation of the retroactive period.

FY 2010-11	<u>TF</u>	<u>GF</u>
Two-Plan	\$7,539,000	\$3,769,500
COHS	\$1,395,000	\$ 697,500
	<u>\$8,934,000</u>	<u>\$4,467,000</u>
Reconciliation	-\$18,564,000	-\$9,282,000
Total	-\$9,630,000	-\$4,815,000

FY 2011-12	<u>TF</u>	<u>GF</u>
Two-Plan	\$3,945,000	\$1,972,500
COHS	\$ 664,000	\$ 332,000
Total	\$4,609,000	\$2,304,500

BTR—MANDATORY SPD ENROLLMENT INTO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 68
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1498

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$11,501,000	\$111,117,000
- STATE FUNDS	\$5,807,500	\$82,676,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,501,000	\$111,117,000
STATE FUNDS	\$5,807,500	\$82,676,500
FEDERAL FUNDS	\$5,693,500	\$28,440,500

DESCRIPTION

Beginning June 1, 2011, it will be mandatory for 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. This change is included in the California Bridge to Reform section 1115(a) Demonstration (BTR).

ASSUMPTIONS

1. Assume mandatory enrollment of SPDs into Medi-Cal managed care plans in Two-Plan and GMC counties will begin in June 2011.
2. Assume the 341,800 affected SPD beneficiaries will be phased-in, by birth month, over twelve months.
3. The average fee-for-service expenditure for this population is \$575.89 PMPM, excluding services that will not be capitated under mandatory enrollment.
4. Assume the managed care average monthly payments will be \$486.89 PMPM, and the managed care plans will provide at least an equivalent scope of services.
5. Deferral of the June 2011 capitation payment for the Two-Plan and GMC model plans is no longer included in this policy change.
6. Assume that current managed care operating policies will be applied to these new eligibles, e.g., LTC coverage in managed care for the month of admission and the following month only. However, individuals that are currently in LTC will not move to managed care.
7. Assume there is no selection bias during the enrollment process—all acuity levels will be randomly enrolled.

**BTR—MANDATORY SPD ENROLLMENT INTO MANAGED
CARE**
REGULAR POLICY CHANGE NUMBER: 68

8. Mandatory enrollment of CCS eligible children will be suspended until the CCS pilot counties are determined. Once the pilot counties are selected, CCS children in the remaining two Plan model and GMC counties will be subject to mandatory enrollment.
9. All other children except foster children will be included in the mandatory enrollment.
10. Assume Home and Community-Based Services waiver eligibles will be included in the mandatory enrollment.
11. Upon request, exemptions may be allowed for continuity of care reasons when the eligible is being treated for complex medical conditions and the treating provider is not participating in the managed care plan. These exemptions could significantly affect the savings.

Changes to these assumptions could appreciably alter the fiscal impact.

The enrollment of SPDs into managed care will have the following impact to ongoing expenditures:

In Thousands	FY 2010-11		FY 2011-12	
	TF	GF	TF	GF
Managed Care Capitation Cost	\$13,863	\$6,932	\$1,233,839	\$616,920
FFS Savings (lagged)	(\$2,362)	(\$1,124)	(\$1,122,722)	(\$534,243)
Total	\$11,501	\$5,808	\$111,117	\$82,677

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 69
 IMPLEMENTATION DATE: 8/2010
 ANALYST: Dee Britton
 FISCAL REFERENCE NUMBER: 1508

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$166,887,000	\$284,191,000
- STATE FUNDS	\$66,806,000	\$142,095,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	59.36 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$115,495,200
STATE FUNDS	\$0	\$57,747,610
FEDERAL FUNDS	\$0	\$57,747,610

DESCRIPTION

AB 1629 (Chapter 875, Statutes of 2004) requires the Department to collect a Quality Assurance Fee (QAF) from freestanding skilled nursing facilities (NF-Bs), including adult subacute days and excluding pediatric and rural swing bed days. The State uses the fee to draw down FFP and to fund rate increases.

The Budget Act of 2010 increases the amount of revenues upon which the QAF is assessed by including revenue from Multi-Level Retirement Communities (MLRCs), and changing the methodology to calculate the QAF. Currently, the Department bases the QAF on revenue data that is two years old. For example, the FY 2009-10 QAF assessment is based on 2007 revenues. Beginning in FY 2010-11, the Department will use the two-year old data as the base revenues, and apply growth and trending adjustments to project the actual revenues expected for the fiscal year. This will increase the amount of revenues upon which the QAF is assessed from the previous year. The incremental increase in the QAF revenues from year to year will be used to increase rates for these facilities, so there will be no cost to the GF on an accrual basis.

The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is currently 5.5% of gross revenues. The California Department of Public Health (CDPH) lowered the licensing and certification fees for NF-Bs in FY 2010-11. This allows the Department to further increase the QAF by the amount of the licensing and certification fees not being assessed for the NF-Bs for 2010-11, up to the 5.5% cap, contributing to the increase in rates to these facilities.

The FY 2010-11 rate increase due to changes in the QAF is estimated to be 3.93%. FY 2011-12 will also include an additional rate increase due to the increase in the QAF safe harbor limit from 5.5% to 6.0%, scheduled to take effect on October 1, 2011.

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 69

Assumptions:

1. This policy change budgets only the cost of the rate increases. The increase to the General Fund revenues is shown here for informational purposes, as the revenues are not part of the Medi-Cal budget.
2. Implementation will be retroactive to August 1, 2010.
3. The increase in the additional amount of QA fee collected is estimated to be \$70,295,000 in FY 2010-11. The increase in rate payments is estimated to be \$166,887,000 TF (\$66,806,000 GF) in FY 2010-11.

\$70,295,000 QAF collection - \$66,806,000 GF rate increase = -\$3,489,000 FY 2010-11 GF
(The GF impact of the rate increase is assumed to be equal to the QAF collected. The difference noted above is due to payment lags and the timing of payments and collections.)

4. The increase in the additional amount of QA fee collected is estimated to be \$59,991,000 in FY 2011-12. The increase in rate payments is estimated to be \$115,483,000 TF (\$57,741,000 GF) in FY 2011-12.

\$59,991,000 QAF collection - \$57,741,000 GF rate increase = -\$2,250,000 FY 2011-12 GF
(The GF impact of the rate increase is assumed to be equal to the QA fee collected. The difference noted above is due to payment lags and the timing of payments and collections.)

5. It is assumed that licensing and certification fees will remain at the FY 2010-11 level in FY 2011-12.
6. This policy change includes the additional FFP due to the American Recovery and Reinvestment Act of 2009 and the Education, Jobs and Medicaid Assistance Act of 2010 of \$15,569,000 in FY 2010-11.

Lagged Costs	FY 2010-11	FY 2011-12
August 2010 Rate Adjustment	\$166,887,000	\$168,708,000
August 2011 Rate Adjustment		\$115,483,000
Total Rate Adjustment	\$166,887,000	\$284,191,000

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1329

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$188,906,000	\$268,317,000
- STATE FUNDS	\$94,453,000	\$134,158,500
PAYMENT LAG	0.9637	0.9717
% REFLECTED IN BASE	22.05 %	18.03 %
APPLIED TO BASE		
TOTAL FUNDS	\$141,907,000	\$213,715,200
STATE FUNDS	\$70,953,480	\$106,857,580
FEDERAL FUNDS	\$70,953,490	\$106,857,580

DESCRIPTION

The Medi-Cal program reimburses participating Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) according to the Prospective Payment System (PPS). For the dual Medicare/Medi-Cal beneficiaries or beneficiaries enrolled in managed care plans, an interim rate is established and paid to the clinics. Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, managed care plans, and Medicare) in order to prepare a final settlement with the clinic.

Los Angeles County owned or operated cost-based reimbursement clinics (CBRCs) are reimbursed at 100% of reasonable and allowable costs. An interim rate is paid to the clinics and is adjusted once the audit reports are finalized. That rate is used for subsequent fiscal year claims. The Department is scheduled to complete the audits for 2006-07 in 2010-11 and for 2007-08 in 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.

Currently, there are 657 active FQHCs, 282 active RHCs and 29 active CBRCs.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FQHCs Reconciliation	\$74,201,000	\$92,526,000
RHCs Reconciliation	\$4,883,000	\$4,519,000
LA CBRCs Reconciliation	\$62,822,000	\$72,272,000
July 2010 LA CBRC Rate Increase	\$47,000,000	\$47,000,000
July 2011 LA CBRC Rate Increase	\$52,000,000	\$52,000,000
TOTAL	\$188,906,000	\$268,317,000

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 8/2007
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1046

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$37,645,000	\$84,002,000
- STATE FUNDS	\$18,822,500	\$42,001,000
PAYMENT LAG	0.8656	0.9304
% REFLECTED IN BASE	100.00 %	43.59 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$44,087,500
STATE FUNDS	\$0	\$22,043,750
FEDERAL FUNDS	\$0	\$22,043,750

DESCRIPTION

This policy change budgets the annual LTC rate adjustment for Nursing Facility-As (NF-A), Distinct Part Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, Distinct Part Subacute, Pediatric Subacute, and ICF/DD, ICF/DD-H, and ICF/DD-N facilities. The NF-B rate increase is defined by AB 1629 (Chapter 875, Statutes of 2004) and is included in the SNF Rate Changes and QA Fee policy change.

Assumptions:

1. ABX4 5 (Chapter 5, Statutes of 2009), froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. 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, DP/NF adult and pediatric subacute, and rural swing bed providers.
2. The cumulative weighted rate increase for DP/NF-Bs, Rural Swing Beds, Distinct Part Subacute, and Pediatric Subacutes is estimated to be 4.31% in FY 2010-11 and 4.76% in FY 2011-12.
3. No rate increase is assumed for NF-As, ICF/DD, ICF/DD-H and ICF/DD-N facilities during rate years 2010-11 and 2011-12.
4. Pursuant to ABX4 9, the Uniform Holiday Schedule for FY 2009-10 will increase the number of days that the adult day services facilities are closed. The closures will 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 rate year 2009-10 and for each additional rate year that the freeze is in effect. Effective in rate year 2010-11, ICF/DD providers received the add-on to reflect the increased staffing to due the Uniform Holiday Schedule.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 71

5. The estimated eleven-month impact of the August 1, 2010 rate increase in FY 2010-11 for Managed Care costs is \$7,193,000, and the annualized impact is estimated to be \$7,847,000. The estimated eleven-month impact of the August 1, 2011 rate increase in FY 2011-12 for Managed Care costs is \$7,970,000, and the annualized impact is estimated to be \$8,695,000. Managed Care costs are not included in this policy change. They are included in each applicable managed care plan's policy change.

<u>Fee-for-Service</u>	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FY 2010-11 LTC Rate Increase	\$37,198,000	\$40,579,000
FY 2011-12 LTC Rate Increase		\$42,976,000
Uniform Holiday Schedule Add-On	\$ 447,000	\$ 447,000
Total FFS Cost	\$37,645,000	\$84,002,000

QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

REGULAR POLICY CHANGE NUMBER: 72
 IMPLEMENTATION DATE: 1/2011
 ANALYST: Dee Britton
 FISCAL REFERENCE NUMBER: 1563

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,250,000	\$44,600,000
- STATE FUNDS	-\$4,250,000	\$22,300,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,250,000	\$44,600,000
STATE FUNDS	-\$4,250,000	\$22,300,000
FEDERAL FUNDS	\$0	\$22,300,000

DESCRIPTION

The Health Trailer Bill of 2010 implemented a quality and accountability payments program for freestanding nursing facilities (NF-Bs). 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 Skilled Nursing Facility Quality and Accountability Special Fund (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 on NF-Bs for 2011-12, and the savings achieved from setting the professional liability insurance cost category at the 75th percentile. There will be no net impact to the General Fund (GF), because the GF will receive corresponding increased revenues from the Quality Assurance Fee levied upon NF-B facilities. The California Department of Aging (CDA) has direct appropriation authority of \$1.9 million from the Special Fund to pay for the Ombudsman costs starting in FY 2010-11. The California Department of Public Health (CDPH) administrative costs will be reimbursed from the Special Fund by the DHCS starting in FY 2011-12.

This policy change budgets the transfer of GF to the Special Fund in FY 2010-11 and FY 2011-12. Additionally, the policy change budgets the supplemental payments expected to be made to NF-Bs through the Special Fund in FY 2011-12.

Assumptions:

1. Administrative costs as well as supplemental payments are eligible for an FFP match.
2. In FY 2010-11, \$4,250,000 will be transferred from the GF to the Special Fund.
3. In FY 2011-12, \$24,750,000 will be transferred from the GF to the Special Fund for payment of CDA Ombudsman costs, CDPH administrative costs and supplemental payments to nursing facilities.
4. In FY 2011-12, \$1,500,000 in penalties will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund.
5. In FY 2011-12, supplemental payments are estimated to be \$44,600,000 (\$22,300,000 GF).

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 74
 IMPLEMENTATION DATE: 10/2005
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 88

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$12,173,000	\$20,504,000
- STATE FUNDS	\$6,086,500	\$10,252,000
PAYMENT LAG	0.8100	0.9580
% REFLECTED IN BASE	100.00 %	82.38 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$3,461,100
STATE FUNDS	\$0	\$1,730,530
FEDERAL FUNDS	\$0	\$1,730,530

DESCRIPTION

This Policy Change budgets the annual Medicare Economic Index (MEI) increase for all federally qualified health centers (FQHCs) and rural health clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology. The annual ongoing MEI increases will be applied each October.

Assumptions:

1. Estimated annual expenditures for FY 2010-11 are \$1,368,825,377 and expenditures without the MEI increase are estimated to be \$1,352,594,246. Estimated annual expenditures for FY 2011-12 are \$1,430,037,141 and estimated expenditures without the MEI are \$1,424,339,782.
2. Assume utilization will increase 4.06% per year based on the average percent increase of visits over the past 3 years.
3. The MEI increase effective October 1, 2010 is 1.2%.
4. The MEI increase effective October 1, 2011 is 0.4%.
5. For FY 2010-11, an estimated utilization increase of 7.32% is assumed on top of the average expenditures for FY 2009-10. A 1.2% increase of each month's expenditures from October 2010 through June 2011 are summed to find the MEI impact in FY 2010-11.
6. For FY 2011-12, an estimated utilization increase of 8.98% is assumed on top of the estimated average expenditures for FY 2010-11. An annualized 1.2% MEI for the October 2010 increase and nine months of the October 2011 0.4% MEI increase are summed to find the MEI impact in FY 2011-12.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 74

FY 2010-11:2010 Increase **\$12,173,000****FY 2011-12:**

2010 Increase: \$16,231,000

2011 Increase: \$4,273,000**\$20,504,000**

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 77
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 96

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$1,039,000	\$2,813,000
- STATE FUNDS	\$519,500	\$1,406,500
PAYMENT LAG	0.7450	0.8667
% REFLECTED IN BASE	62.18 %	24.82 %
APPLIED TO BASE		
TOTAL FUNDS	\$292,700	\$1,832,900
STATE FUNDS	\$146,370	\$916,450
FEDERAL FUNDS	\$146,380	\$916,460

DESCRIPTION

1. Hospice Services

Pursuant to state regulations, Medi-Cal hospice service rates are established in accordance with Section 1902 (a)(13), (42 USC 1396 a(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. Total actual expenditures for hospice services in FY 2009-10 were \$52,858,000. This policy change budgets estimated increases, effective October 1, 2010 and October 1, 2011. The estimated weighted increase for hospice service rates is 2.55% in FY 2010-11 and 3.39% for FY 2011-12.

2. Hospice Room and Board

Hospice room and board rates had been set at 95% of the weighted statewide average rate for NF-As and NF-Bs. In February 2003, the Department changed the methodology to tie each hospice facility's room and board rate to 95% of the individual facility's affiliated nursing facility rate and included ICF/DDs, ICF/DD-Hs, & ICF/DD-Ns. This was done to comply with the CMS Medicaid Manual requirements. This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 and its related State Plan Amendments.

ABX4 5 (Chapter 5, Statutes of 2009), freezes rates for rate year 2009-10 and every year thereafter at the 2008-09 levels for long-term care facilities; therefore, no rate increase is assumed for hospice room and board for rate year 2009-10 and forward.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FY 2010-11 Hospice Services	\$1,039,000	\$1,386,000
FY 2011-12 Hospice Services		\$1,427,000
TOTAL	\$1,039,000	\$2,813,000

NF-B RATE CHANGES AND QA FEE

REGULAR POLICY CHANGE NUMBER: 78
 IMPLEMENTATION DATE: 8/2011
 ANALYST: Dee Britton
 FISCAL REFERENCE NUMBER: 1021

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$36,966,000
- STATE FUNDS	\$0	\$18,483,000
PAYMENT LAG	1.0000	0.9537
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$35,254,500
STATE FUNDS	\$0	\$17,627,240
FEDERAL FUNDS	\$0	\$17,627,240

DESCRIPTION

AB 1629 (Chapter 875, Statutes of 2004) required the Department to provide a cost of living adjustment (COLA), implement a facility-specific rate methodology, and impose a quality assurance (QA) fee for freestanding skilled nursing facilities (NF-Bs), including adult subacute days and excluding pediatric subacute and rural swing days. The State General Fund and the NF-Bs share the increased FFP generated by the QA fee. The QA fee and rate methodology was to sunset on July 31, 2008. SB 853 (Chapter 717, Statutes of 2010) has extended the sunset date to July 31, 2012.

Assumptions:

1. 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. Therefore, no rate increase is assumed for rate years 2010-11 and 2011-12.
2. A rate adjustment for rate years 2010-11 and 2011-12 will be provided through an additional QA fee. This rate adjustment is budgeted in the AB 1629 Rate Adjustments Due to QA Fee Increase policy change.
3. 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 ongoing add-on costs to the reimbursement rates for these facilities. In FY 2010-11, there will be additional start-up costs for IT and training related activities. The rate adjustment will be effective August 1, 2011, and be retroactive to August 1, 2010.

NF-B RATE CHANGES AND QA FEE

REGULAR POLICY CHANGE NUMBER: 78

	<u>FY 2011-2012</u>
FY 2010-11 Rate Add-on	\$24,211,000
FY 2011-12 Rate Add-on	<u>\$12,755,000</u>
Total Rate Add-on	\$36,966,000

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 79
 IMPLEMENTATION DATE: 5/2011
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1505

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$8,310,000	-\$78,951,000
- STATE FUNDS	-\$4,155,000	-\$39,475,500
PAYMENT LAG	0.3183	0.9651
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$2,645,100	-\$76,195,600
STATE FUNDS	-\$1,322,540	-\$38,097,800
FEDERAL FUNDS	-\$1,322,540	-\$38,097,800

DESCRIPTION

Senate Bill 853 added Welfare and Institutions Code section 14105.08, which mandates that Medi-Cal rates for radiology services may not exceed 80 percent of Medicare rates, effective October 1, 2010. Radiology rates in excess of this amount will be reduced.

Rate reductions will be implemented, retroactive to October 1, 2010, following assessment of the impact of the reduction.

Assumptions:

1. Implementation will begin in May 2011.
2. The rate reductions will apply to radiology services that are paid at reimbursement rates exceeding 80 percent of Medicare rates.
3. Based on CY 2010 data, the rate reductions will result in an annual fee-for-service savings of \$49,864,000. There is no managed care impact as a result of this reduction, because managed care capitation rates are calculated using radiology rates that are at or below 80 percent of Medicare rates.

FY 2010-11 Savings:

49,864,000 / 12 months x 2 months = **\$8,310,000** (\$4,155,000 GF)

FY 2011-12 Savings:

FY 2010-11 Retro Savings	\$ 29,087,000
FY 2011-12 Savings	\$ 49,864,000
Total FY 2011-12 Savings	\$ 78,951,000
GF	\$ 39,457,500

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 80
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1073

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$1,740,752,000	\$1,704,697,000
- STATE FUNDS	\$601,839,000	\$607,279,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,740,752,000	\$1,704,697,000
STATE FUNDS	\$601,839,000	\$607,279,000
FEDERAL FUNDS	\$1,138,913,000	\$1,097,418,000

DESCRIPTION

As part of the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) and the California Bridge to Reform Demonstration (BTR), changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on SPA 05-022, the federal Disproportionate Share Hospital (DSH) allotment is available for uncompensated Medi-Cal and uninsured costs incurred by Disproportionate Share Hospitals (DSH). The 2010-11 and 2011-12 DSH allotments are estimated to be \$1,097,418,000.

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100 percent of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and nonfederal DSH funds through intergovernmental transfer-funded payments for expenditures above 100 percent of costs, up to 175 percent of the hospitals' uncompensated Medi-Cal and uninsured costs.
- Nondesignated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund based on hospitals' uncompensated Medi-Cal and uninsured costs up to the OBRA limits.
- Private DSH hospitals, under the Special Terms and Conditions, are allocated a total of \$160.00 from the federal DSH allotment and State General Fund each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the \$160.00.

The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010.

The General Fund (GF) reflected in this policy change is paid from Item 4260-101-0001, the FFP from Item 4260-601-7502 or 4260-101-0890, and the IGTs from Item 4260-606-0834.

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 80

It is assumed that the DSH payments will be made as follows on a cash basis:

(In Thousands)

FY 2010-11	TF	GF	FF	IGT
DSH 2009-10	\$ 178,114	\$ 435	\$ 132,947	\$ 44,732
DSH 2010-11	\$1,562,638	\$ 8,359	\$1,005,966	\$ 548,313
	\$1,740,752	\$ 8,794	\$1,138,913	\$ 593,045
FY 2011-12				
DSH 2010-11	\$ 142,058	\$ 760	\$ 91,451	\$ 49,847
DSH 2011-12	\$1,562,639	\$ 8,359	\$1,005,967	\$ 548,313
	\$1,704,697	\$ 9,119	\$1,097,418	\$ 598,160

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 81
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1071

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$450,887,000	\$355,272,000
- STATE FUNDS	\$225,443,500	\$177,636,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$450,887,000	\$355,272,000
STATE FUNDS	\$225,443,500	\$177,636,000
FEDERAL FUNDS	\$225,443,500	\$177,636,000

DESCRIPTION

As part of the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) and the California Bridge to Reform Demonstration (BTR), changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. These payments are determined using the formulas and methodology in effect for the 2004-05 fiscal year. These payments along with the \$160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute. The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund. The remaining Demonstration Waiver periods will reflect an increase in Medi-Cal DSH replacement payment based on the Consumer Price Index (CPI-U). For 2009-10, as required by ABX4 5 (Chapter 5, Statutes of 2009), the Medi-Cal DSH replacement payments to private hospitals were reduced by 10%.

SB 90 (Chapter 19, Statutes of 2011) 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. The amounts included in this policy change have been reduced accordingly.

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 81

It is assumed that the DSH replacement payments will be made as follows on a cash basis:

FY 2010-11	TF	GF	FFP
2008-09	\$ 982,000	\$ 491,000	\$ 491,000
2009-10	\$ 48,614,000	\$ 24,307,000	\$ 24,307,000
2010-11	\$461,291,000	\$230,645,500	\$230,645,500
	<u>\$510,887,000</u>	<u>\$255,443,500</u>	<u>\$255,443,500</u>
SB 90	<u>(\$60,000,000)</u>	<u>(\$30,000,000)</u>	<u>(\$30,000,000)</u>
Net	\$450,887,000	\$225,443,500	\$225,443,500
FY 2011-12			
2010-11	\$ 36,481,000	\$ 18,240,500	\$ 18,240,500
2011-12	\$468,791,000	\$234,395,500	\$234,395,500
	<u>\$505,272,000</u>	<u>\$252,636,000</u>	<u>\$252,636,000</u>
SB 90	<u>(\$150,000,000)</u>	<u>(\$75,000,000)</u>	<u>(\$75,000,000)</u>
Net	\$355,272,000	\$177,636,000	\$177,636,000

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 82
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1085

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$322,692,000	\$280,502,000
- STATE FUNDS	\$161,346,000	\$140,251,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$322,692,000	\$280,502,000
STATE FUNDS	\$161,346,000	\$140,251,000
FEDERAL FUNDS	\$161,346,000	\$140,251,000

DESCRIPTION

As part of the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) and the California Bridge to Reform Demonstration (BTR), changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to private hospitals. Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund, intergovernmental transfers (IGTs), interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments, and 33.60% of the Stabilization funding for Private Hospitals as calculated by the formulas set forth in SB 1100 and SB 474. This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 688).

SB 1100 (Chapter 560, Statutes of 2005) requires the transfer of \$118,400,000 annually from the General Fund (Item 4260-101-0001) to the Private Hospital Supplemental Fund to be used for the non-federal share of the supplemental payments. Part of the distribution of the Private Hospital Supplemental Fund will be based on the requirements specified in SB 1100, while the remainder will be subject to negotiations with the California Medical Assistance Commission.

Assumptions:

1. The State Funds (SF) item includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs. The annual appropriation has been reduced to reflect that the expenditures, from the Fund, are on a cash basis.
2. Interest earned in a fiscal year will be available for distribution in the following fiscal year.
3. IGTs will total \$20,000,000 and will generate \$20,000,000 in FFP in FY 2010-11 and FY 2011-12. This includes the annual L.A. County IGT of \$5,000,000 as specified in SB 474 (Chapter 518, Statutes of 2007).

**MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL
PAYMENT
REGULAR POLICY CHANGE NUMBER: 82**

4. Distribution of the Private Hospital Supplemental Fund will be determined through negotiations with the California Medical Assistance Commission. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.
5. ABX4 6 (Chapter 6, Statutes of 2009) requires that any increased federal funding available to the MH/UCD project be deposited in the Federal Trust Fund. Additional federal funds due to ARRA will be deposited in the General Fund and expenditures from this fund will be at 50% FFP.
6. It is assumed that in FY 2011-12, Budget Trailer Bill language will transfer \$32,700,000 from the Private Hospital Supplemental Fund to the State General Fund.

(In Thousands)	<u>TF</u>	<u>GF</u>	<u>FFP</u>
FY 2009-10			
FY 2008-09 Ending Balance	\$ 65,440,000	\$ 32,720,000	\$ 32,720,000
Appropriation (from GF)	\$ 236,800,000	\$ 118,400,000	\$ 118,400,000
FY 2008-09 interest	\$ 1,122,000	\$ 561,000	\$ 561,000
IGT	\$ 27,548,000	\$ 13,774,000	\$ 13,774,000
Total	<u>\$ 330,910,000</u>	<u>\$ 165,455,000</u>	<u>\$ 165,455,000</u>
Cash Expenditures in FY 2009-10	<u>\$ 230,444,000</u>	<u>\$ 115,222,000</u>	<u>\$ 115,222,000</u>
FY 2009-10 Ending Balance	\$ 100,466,000	\$ 50,233,000	\$ 50,233,000
FY 2010-11			
FY 2009-10 Ending Balance	\$ 100,466,000	\$ 50,233,000	\$ 50,233,000
Appropriation (from GF)	\$ 236,800,000	\$ 118,400,000	\$ 118,400,000
FY 2009-10 interest	\$ 166,000	\$ 83,000	\$ 83,000
Est. 2005-06 Stabilization Transfer	\$ 10,660,000	\$ 5,330,000	\$ 5,330,000
IGT	\$ 40,000,000	\$ 20,000,000	\$ 20,000,000
Total	<u>\$ 388,092,000</u>	<u>\$ 194,046,000</u>	<u>\$ 194,046,000</u>
Cash Expenditures in FY 2010-11	<u>\$ 322,692,000</u>	<u>\$ 161,346,000</u>	<u>\$ 161,346,000</u>
FY 2010-11 Ending Balance	\$ 65,400,000	\$ 32,700,000	\$ 32,700,000
FY 2011-12			
FY 2010-11 Ending Balance	\$ 65,400,000	\$ 32,700,000	\$ 32,700,000
Appropriation (from GF)	\$ 236,800,000	\$ 118,400,000	\$ 118,400,000
Est. FY 2010-11 interest	\$ 148,000	\$ 74,000	\$ 74,000
Est. 2005-06 Stabilization Transfer	\$ 3,554,000	\$ 1,777,000	\$ 1,777,000
IGT	\$ 40,000,000	\$ 20,000,000	\$ 20,000,000
Total	<u>\$ 345,902,000</u>	<u>\$ 172,951,000</u>	<u>\$ 172,951,000</u>
Cash Expenditures to Hospitals	<u>\$ 280,502,000</u>	<u>\$ 140,251,000</u>	<u>\$ 140,251,000</u>
Cash Expenditures to GF	<u>\$ 65,400,000</u>	<u>\$ 32,700,000</u>	<u>\$ 32,700,000</u>
FY 2011-12 Ending Balance	\$ -	\$ -	\$ -

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 83
IMPLEMENTATION DATE: 9/2005
ANALYST: Marc Lowry
FISCAL REFERENCE NUMBER: 1072

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$24,449,000	\$42,735,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$24,449,000	\$42,735,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$24,449,000	\$42,735,000

DESCRIPTION

Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), a Safety Net Care Pool (SNCP) was established to support the provision of services to the uninsured. The SNCP makes available \$586 million in federal funds each of the five Demonstration Years (DYs) for baseline and stabilization funding and an additional \$180 million per DY for implementing a healthcare coverage initiative during the last three years of the MH/UCD (Health Care Coverage Initiative). The SNCP is to be distributed through the certified public expenditures (CPEs) of designated public hospitals (DPHs) for uncompensated care to the uninsured and the federalizing of four state-funded health care programs. The four state-funded health care programs are the Genetically Handicapped Persons Program (GHPP), California Children Services (CCS), Medically Indigent Adult Long-Term Care (MIA LTC), and Breast and Cervical Cancer Treatment Program (BCCTP).

This policy change budgets the SNCP funding for the DPHs. The SNCP funding for the four state programs is in separate policy changes in the Medi-Cal Estimate.

In 2007, SB 474 allocated an annual \$100,000,000 of the SNCP FFP for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds will be claimed using the CPEs of the County of Los Angeles or its DPHs. Expenditures from this fund are budgeted in the Hosp Financing – South LA Preservation policy change.

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be budgeted in the Stabilization policy change. The FFP paid to the DPHs, SLAMSP, and drawn down by the state-funded programs cannot exceed \$586 million.

ABX3 5 (Chapter 20, Statutes of 2009) reduced the payments to DPHs and the SLAMSP Fund by 10%, effective July 1, 2009. It is estimated that the DPHs SNCP payments will be reduced by approximately \$44.2 million for Demonstration Year 5 (2009-10). The Department will use the available State-Only programs' expenditures from Demonstration Years 2007-08 and 2009-10 to fulfill the \$54.2 million FFP for FY 2009-10.

MH/UCD—SAFETY NET CARE POOL**REGULAR POLICY CHANGE NUMBER: 83**

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional federal funding due to ARRA is budgeted in the Federal Flexibility – SNCP – ARRA policy change.

The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration (Demonstration) was extended for two months, until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the new BTR demonstration. A modified SNCP continues in the new demonstration; see policy change Bridge to Reform – Safety Net Care Uncompensated Care Pool.

The estimated SNCP FFP required by the state-funded programs and the DPHs are:

(Dollars in Thousands)	Accrual	
	State-Only Funded Programs	Due to DPHs (including SLAMSP)
Demonstration Year		
2005-06	\$83,151	\$502,849
2006-07	\$54,800	\$531,200
2007-08	\$76,190	\$509,810
2008-09	\$54,450	\$531,550
2009-10	\$86,910	\$499,090

The estimated payments to the DPHs are:

(Dollars in Thousands)	Cash		
	FY 2009-10	FY 2010-11	FY 2011-12
Demonstration Year			
2005-06		\$1,949	
2006-07			\$35,918
2007-08			\$6,817
2008-09	\$36,834		
2009-10	\$278,788	\$22,500	
Total	\$315,622	\$24,449	\$42,735

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 84
 IMPLEMENTATION DATE: 9/2007
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1154

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$70,553,000	\$34,329,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$70,553,000	\$34,329,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$70,553,000	\$34,329,000

DESCRIPTION

Under the Medi-Cal Hospital/Uncompensated Care section 1115(a) Medicaid Demonstration (MH/UCD), \$180 million in federal funds is available annually to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10.

The federal funds available will reimburse the Health Care Coverage Initiative (HCCI) counties at 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 submission for FFP. No GF will be expended for this program. Funding will be provided through the Health Care Support Fund, Item 4260-601-7503.

The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's FMAP by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 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 additional federal funding due to ARRA is budgeted in the Federal Flexibility SNCP – ARRA policy change.

The MH/UCD would have ended on August 31, 2010. The Demonstration was extended until October 31, 2010. The new section 1115(a) California Bridge to Reform Demonstration (BTR) became effective November 1, 2010. The federal funds for the extension period (September and October 2010) are provided through the new BTR funding for the first year of the BTR ending June 30, 2011. This policy change budgets the FFP for the HCCI under the MH/UCD. The HCCI has been replaced by a modified program under the BTR which is reflected in the Low Income Health Program policy changes.

MH/UCD—HEALTH CARE COVERAGE INITIATIVE**REGULAR POLICY CHANGE NUMBER: 84**

Enrollment began on September 1, 2007. The funding allocations were awarded as follows:

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	\$ 8,204,250
Contra Costa County/Contra Costa Health Services	\$ 15,250,000
County of Orange	\$ 16,871,578
County of San Diego, Health and Human Services Agency	\$ 13,040,000
County of Kern, Kern Medical Center	\$ 10,000,000
Los Angeles County Department of Health Services	\$ 54,000,000
San Francisco Department of Public Health	\$ 24,370,000
San Mateo County	\$ 7,564,172
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	\$ 20,700,000
Ventura County Health Care Agency	\$ 10,000,000
Total	<u>\$180,000,000</u>

The estimated Health Care Coverage Initiative payments on a cash basis are:

FY 2010-11	TF	FFP
2007-08	\$ 13,048,000	\$ 13,048,000
2008-09	\$ 6,649,000	\$ 6,649,000
2009-10	\$ 50,856,000	\$ 50,856,000
Total	\$ 70,553,000	\$ 70,553,000
FY 2011-12		
2007-08	\$ 15,259,000	\$ 15,259,000
2008-09	\$ 3,417,000	\$ 3,417,000
2009-10	\$ 15,653,000	\$ 15,653,000
Total	\$ 34,329,000	\$ 34,329,000

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 85
IMPLEMENTATION DATE: 7/2010
ANALYST: Marc Lowry
FISCAL REFERENCE NUMBER: 1459

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$228,850,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$228,850,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$228,850,000	\$0

DESCRIPTION

Under the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), \$180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, \$360 million of the funding was unused. On February 1, 2010, CMS approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the Safety Net Care Pool. The Department will claim this amount in FY 2010-11 using the certified public expenditures from Designated Public Hospitals, the Coverage Initiative Program, and State-Only funded programs, including County Medical Services Program, County Mental Health Services for the Uninsured funded through Mental Health Services Act, Expanded Access to Primary Care, and AIDS Drug Assistance Program.

AB 1653 (Chapter 218, Statutes of 2010) allows the State to retain up to \$420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund 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 the 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 these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for Hospital QAF payments. It is estimated that \$131.15 million of the total \$420 million will be applied to this policy change. Therefore, these flexibilities are expected to result in reductions to the General Fund of the remaining \$228.85 million in FY 2010-11.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11. The additional FFP due to these changes in FMAP is budgeted in the ARRA – SNCP policy change.

	<u>TF</u>	<u>FF</u>
FY 2010-11	\$228,850,000	\$228,850,000

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYSICIAN COSTS

REGULAR POLICY CHANGE NUMBER: 86
 IMPLEMENTATION DATE: 5/2008
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1078

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$74,616,000	\$164,604,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$74,616,000	\$164,604,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$74,616,000	\$164,604,000

DESCRIPTION

As part of the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) and the California Bridge to Reform Demonstration (BTR), changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, pursuant to SPA 05-023, reimbursement based on Certified Public Expenditures (CPEs) will be available to Designated Public Hospitals (DPHs) for their uncompensated costs incurred for physician and non-physician practitioner professional services. The reimbursement will be available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's Physician and Non-physician costs will be reconciled to the Medi-Cal 2552-96 cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

Assumptions:

1. Payments for 2008-09 were made in FY 2010-11; payments for 2009-10 and 2010-11 are expected to be made in FY 2011-12.
2. The cost of the DPHs' physician and non-physician practitioner professional services are expected to increase each year. An increase of 6.53% is estimated for 2009-10 over 2008-09 and an increase of 7.08% for 2010-11 over 2009-10. The increase percentage is determined using the Consumer Price Index US City Average from May for each year.
3. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional funding of \$11,058,000 in FY 2010-11 due to the FMAP increase is included in this policy change.

**MH/UCD & BTR—DPH PHYSICIAN & NON-PHYSICIAN
COSTS**
REGULAR POLICY CHANGE NUMBER: 86

FY 2010-11	<u>Growth</u>	<u>Estimated Expenditures</u>
2008-09		\$ 74,616,000
FY 2011-12		
2009-10	6.53%	\$ 79,488,000
2010-11	7.08%	<u>\$ 85,116,000</u>
		\$ 164,604,000

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 87
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1153

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$21,067,000	\$44,495,000
- STATE FUNDS	\$10,533,500	\$31,410,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$21,067,000	\$44,495,000
STATE FUNDS	\$10,533,500	\$31,410,500
FEDERAL FUNDS	\$10,533,500	\$13,084,500

DESCRIPTION

Under the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), 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 distributed as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between
 - a. The NDPHs' aggregate payment increase and,
 - b. The sum of \$0.544 million and the 0.64 percent of the total stabilization funding.
- Private Hospitals will receive total funds payment equal to the difference between
 - a. The Private Hospitals' aggregate payment increase and,
 - b. 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.

Assumptions:

1. Stabilization funding is calculated after the interim reconciliation of the DPH interim payments is completed.
2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.
3. Stabilization funding to NDPHs, private hospitals, and distressed hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.

MH/UCD—STABILIZATION FUNDING**REGULAR POLICY CHANGE NUMBER: 87**

4. Once the final reconciliation is finalized, the Department will be able to determine the distribution of the stabilization funds.
 - Stabilization funds to DPHs, if any, will be GF only. DPHs will not receive the federal fund match.
 - Stabilization funds to NDPHs, if any, will be split as defined by SB 1100. The Department will distribute 75% of any allocated NDPH stabilization funds directly and the remaining 25% will be transferred to the NDPH Supplemental Fund. Payments through the NDPH Supplemental fund are negotiated between the hospitals and the California Medical Assistance Commission (CMAC).
 - Stabilization funds to Private Hospitals, if any, will be split as defined by SB 1100. The Department will distribute 66.4% of any allocated Private Hospital stabilization funds directly and the remaining 33.6% will be distributed to the Private Hospital Supplemental Fund. Payments through the Private Hospital Supplemental fund are negotiated between the hospitals and CMAC.
 - Distressed Hospital payments will be distributed as negotiated between the hospitals and CMAC.
5. The Budget Act of 2009 included Stabilization funding reductions to distressed hospitals. These reductions included \$6,320,000 GF for 2008-09 (Demonstration Year 4) and \$5,877,000 GF for 2009-10 (Demonstration Year 5).
6. The amount shown below for 2005-06 excludes \$14,214,000 TF (\$7,107,000 GF) that will be transferred to the Private Hospital Supplemental Fund. This amount is reflected in the MH/UCD & BTR—Private Hospital Supplemental Payment Policy Change.
7. The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010.

The estimated stabilization payments are:

FY 2010-11	TF	GF
2005-06	\$ 21,067,000	\$ 10,534,000
Total	\$ 21,067,000	\$ 10,534,000
 FY 2011-12		
2005-06	\$ 24,572,000	\$ 21,061,000
2006-07	\$ 19,923,000	\$ 10,350,000
Total	\$ 44,495,000	\$ 31,411,000

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 88
IMPLEMENTATION DATE: 9/2005
ANALYST: Marc Lowry
FISCAL REFERENCE NUMBER: 1108

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$166,185,000	\$106,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$166,185,000	\$106,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$166,185,000	\$106,000,000

DESCRIPTION

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), the Department may claim federal reimbursement for the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) from the Safety Net Care Pool funding established by the MH/UCD. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.

This policy change reflects the 50 percent federal reimbursement received by the Department for a portion of the CCS and GHPP program claims based on the certification of public expenditures. Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF savings is reflected in the Family Health Estimate. The General Fund savings created will be used to support safety net hospitals under the MH/UCD.

ABX3 5 (Chapter 20, Statutes of 2009), reduced the Safety Net Care Pool (SNCP) payments to Designated Public Hospitals and the South Los Angeles Medical Services Preservation Fund by 10% effective July 1, 2009 for Demonstration Year 5 (2009-10). The Department will increase the amount of the CPE of the four State-Only programs to utilize any remaining federal funds in the SNCP. The additional FFP received for CPEs using the CCS and GHPP programs are also budgeted in this policy change. Additional information regarding this reduction is in the Reduction to Hosp. Financing-DPH SNCP by 10% policy change.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June

MH/UCD & BTR—CCS AND GHPP**REGULAR POLICY CHANGE NUMBER: 88**

30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to October 31, 2010, resulting in additional \$453.362 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change budgets those federal funds that are claimed using CPEs from the CCS and GHPP programs.

The MH/UCD was extended until October 31, 2010. Effective November 1, 2010, CMS approved a new five-year demonstration, California Bridge to Reform (BTR). The Special Terms and Conditions of the new demonstration allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP). The CCS and GHPP programs are included in the list of DSHP. This policy change includes the impact of the Bridge to Reform.

	CCS	GHPP	Total
FY 2005-06	\$ 15,523,000	\$ 8,485,000	\$ 24,008,000
FY 2006-07	\$ 46,856,000	\$ 15,300,000	\$ 62,156,000
FY 2007-08	\$ 18,000,000	\$ 8,000,000	\$ 26,000,000
FY 2008-09	\$ 20,958,000	\$ 19,096,000	\$ 40,054,000
FY 2009-10	\$ 55,430,000	\$ 34,819,000	\$ 90,249,000
FY 2010-11			
Stabilization-MH/UCD	\$ 17,618,000	\$ 16,000,000	\$ 33,618,000
10% reduction in DPH SNCP	\$ 7,500,000	\$ 7,500,000	\$ 15,000,000
SNCP ARRA	\$ 32,228,000	\$ 6,339,000	\$ 38,567,000
DSHP-BTR	\$ 53,000,000	\$ 26,000,000	\$ 79,000,000
FY 2010-11	\$110,346,000	\$ 55,839,000	\$166,185,000
FY 2011-12			
DSHP-BTR	\$ 70,800,000	\$ 35,200,000	\$106,000,000

MH/UCD—SOUTH LA PRESERVATION FUND

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 3/2009
ANALYST: Marc Lowry
FISCAL REFERENCE NUMBER: 1219

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$39,167,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$39,167,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$39,167,000	\$0

DESCRIPTION

In 2007, Martin Luther King Jr.-Harbor Hospital in L.A. County was closed. Martin Luther King Jr.-Harbor Hospital was a designated public hospital (DPH) as specified in SB 1100 (Chapter 560, Statutes of 2005) and, as such, received Safety Net Care Pool (SNCP) funds based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD). The SNCP makes available \$586 million in federal funds each of the five Demonstration Years (DYs) through the certified public expenditures (CPEs) of the DPHs for uncompensated care to the uninsured.

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 prior to its closure, SB 474 (Chapter 518, Statutes of 2007) created the South Los Angeles Medical Services Preservation (SLAMSP) Fund. Federal funds will be claimed from the SNCP using the CPEs of the County of Los Angeles or its DPHs. This funding will be used by the County for 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 had it remained opened. The County of Los Angeles can also use this funding to cover indirect costs associated with adequately maintaining the hospital building for reopening.

SNCP monies for 2007-08, 2008-09, and 2009-10 have been allocated towards the South Los Angeles Medical Services Preservation. For 2007-08, Martin Luther King Jr.-Harbor Hospital was operational for 45 days and received SNCP funding directly. For 2007-08, \$87.700 million was allocated to the SLAMSP fund and paid in FY 2008-09. For 2008-09, \$100 million was allocated to the SLAMSP Fund. Of the \$100 million, \$50 million was paid in FY 2008-09 and \$50 million was paid out in FY 2009-10.

ABX3 5 (Chapter 20, Statutes of 2009) reduced the payments to DPHs and the SLAMSP Fund by 10%, effective July 1, 2009. It is estimated that the SLAMSP Fund allocation for 2009-10 will be reduced by \$10 million, for an estimated allocation of \$90 million. Of the \$90 million, \$67.5 million was paid out in FY 2009-10.

MH/UCD—SOUTH LA PRESERVATION FUND**REGULAR POLICY CHANGE NUMBER: 89**

The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration was extended to October 31, 2010. It is estimated that the SLAMSP funding allocation for the 60-day extension is \$16.667 million. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010, and funding for SLAMSP ceases as of October 31, 2010.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional federal funding due to ARRA is budgeted in the Federal Flexibility – SNCP – ARRA policy change.

The cash distributions for the SLAMSP fund are expected to be:

Fiscal Year	FY 2010-11
2009-10	\$ 22,500,000
2010-11	\$ 16,667,000
Total	\$ 39,167,000

MH/UCD—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 90
 IMPLEMENTATION DATE: 10/2007
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1152

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$4,165,000	\$67,235,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,165,000	\$67,235,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$4,165,000	\$67,235,000

DESCRIPTION

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) and California Bridge to Reform Demonstration (BTR), each Designated Public Hospital's (DPH) fiscal year interim per diem rate, comprised of 100 percent federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 cost report for the respective fiscal year ending. Payments resulting from the Interim Reconciliation will be funded with federal funds. The reconciliations, Interim and Final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and 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 DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, and Medi-Cal administrative day, crossover, and interim payments.

Final payment reconciliation will be completed when the Department has audited the hospitals' cost reports, which is expected to occur within three years of the submission of the cost report.

Assumptions:

1. DPHs' interim reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the filed Medi-Cal 2552-96 cost report costs and their respective payments.
2. DPH's final reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the audited Medi-Cal 2552-96 cost report costs and the respective payments.

MH/UCD—DPH INTERIM & FINAL RECONS**REGULAR POLICY CHANGE NUMBER: 90**

3. The final reconciliation for 2005-06 is expected to be completed by December 2011. When reconciled with the tentative settlement of \$42,891,000, there is an expected payout of \$7,000,000, of which \$4,165,000 was paid in December 2010.
4. The final reconciliation for 2006-07 is expected to be completed by December 2011 and is estimated to be \$64,400,000. There are no plans to issue a tentative settlement for 2006-07.

FY 2010-112005-06 Final Reconciliation **\$ 4,165,000 FF****FY 2011-12**

2005-06 Final Reconciliation \$ 2,835,000 FF

2006-07 Final Reconciliation \$64,400,000 FF**Total** **\$67,235,000 FF**

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 91
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1162

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$45,824,000	\$99,769,000
- STATE FUNDS	\$22,912,000	\$49,884,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	82.20 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$17,758,900
STATE FUNDS	\$0	\$8,879,440
FEDERAL FUNDS	\$0	\$8,879,440

DESCRIPTION

Along with the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) and the California Bridge to Reform Demonstration (BTR), a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, based on SPA 05-021, Designated Public Hospitals (DPHs) receive interim per diem rates based on costs from two years prior trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in hospital's costs. This growth increase is expected to be different from the former CMAC negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

Assumptions:

1. The DPHs received an increase in their interim per diem rates for dates of service on or after July 1, 2009, of 6.53%.
2. The DPHs received an increase in their interim per diem rates for dates of service on or after July 1, 2010, of 7.08%.
3. The DPHs are expected to receive an increase in their interim per diem rates for dates of services on or after July 1, 2011, of 7.08%.
4. An additional cost of \$45,824,000 is estimated to occur in FY 2010-11.
5. An additional cost of \$99,769,000 is estimated to occur in FY 2011-12.
6. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/50% FFP and are budgeted as 50% GF/50% FF. The full adjustment is shown in the Base Adjustment – MH/UCD & BTR DPH Interim Rate policy change.

MH/UCD—DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 92
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1070

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$8,272,000	\$0
- STATE FUNDS	\$4,136,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,272,000	\$0
STATE FUNDS	\$4,136,000	\$0
FEDERAL FUNDS	\$4,136,000	\$0

DESCRIPTION

As part of the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD), changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on SB 1100, the Distressed Hospital Fund, Item 4260-601-8033, was established for hospitals that participate in the Selective Provider Contracting Program. SB 1100 requires the transfer of 20 percent of the July 2005 balance of the "Prior supplemental funds" (PSFs) to the Distressed Hospital Fund in each year for five years. PSFs are defined in SB 1100 as the following:

- Emergency Services and Supplemental Payments (ESSP) Fund, Item 4260-601-0693, (SB 1255, Voluntary Governmental Transfer);
- Medi-Cal Medical Education Supplemental Payment Fund, Item 4260-601-0550;
- Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund, Item 4260-601-0549;
- Small and Rural Hospital Supplemental Payment Fund, Item 4260-601-0688.

This funding, along with accrued interest in these funds, federal matching funds, and accrued interest in the Distressed Hospital Fund will be distributed through negotiations between the hospitals and the California Medical Assistance Commission (CMAC). Accrued interest is available for distribution in the fiscal year after it is earned.

Contract hospitals that meet the following requirements, as determined by CMAC, are eligible for distressed funds:

1. The hospital serves a substantial volume of Medi-Cal patients.
2. The hospital is a critical component of the Medi-Cal program's health care delivery system.
3. The hospital is facing a significant financial hardship.

The Budget Act of 2009 included a reduction to distressed hospital payments including a \$6,191,000 SF reduction to the Distressed Hospital Fund. This reduction is budgeted in the Reduction to Distressed Hospital Funding policy change.

MH/UCD—DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 92

The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010. No additional funding for the Distressed Hospital Fund was included in the Bridge to Reform Demonstration.

It is assumed Distressed Hospital payments will be made on a cash basis as follows:

	<u>TF</u>	<u>SF</u>	<u>FF</u>
FY 2009-10			
FY 2008-09 Ending Balance	\$5,034,000	\$2,517,000	\$2,517,000
Est. Transfer from Prior Supplement Funds	\$28,608,000	14,304,000	\$14,304,000
FY 2008-09 Est. Interest earned in Distressed Fund	<u>\$230,000</u>	<u>\$115,000</u>	<u>\$115,000</u>
Distressed Funds Available*	\$33,872,000	\$16,936,000	\$16,936,000
Payments to Hospitals*	\$18,046,000	\$9,023,000	\$9,023,000
Reduction to Distressed Hospital Funding**	<u>\$12,382,000</u>	<u>\$6,191,000</u>	<u>\$6,191,000</u>
Cash Expenditures	\$30,428,000	\$15,214,000	\$15,214,000
FY 2009-10 Ending Balance	\$3,444,000	\$1,722,000	\$1,722,000
FY 2010-11			
FY 2009-10 Ending Balance	\$3,444,000	\$1,722,000	\$1,722,000
Transfer from Prior Supplement Funds	\$4,788,000	\$2,394,000	\$2,394,000
Est. Interest earned in Distressed Fund	<u>\$40,000</u>	<u>\$20,000</u>	<u>\$20,000</u>
Distressed Funds Available*	<u>\$8,272,000</u>	<u>\$4,134,000</u>	<u>\$4,134,000</u>
Cash Expenditures	\$8,272,000	\$4,134,000	\$4,134,000
FY 2010-11 Ending Balance	\$0	\$0	\$0

* The additional 11.59% ARRA FFP is budgeted in the ARRA-Additional FFP policy change.

** The reduction to the Distressed Hospital Fund is \$8,636,000 SF and \$8,636,000 FFP prior to the 11.59% ARRA FFP adjustment. With the 11.59% ARRA FFP adjustment (budgeted in the ARRA-Additional FFP policy change), SF would be \$6,191,000 and FFP would be \$11,081,000.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 93
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1076

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$5,616,000	\$3,808,000
- STATE FUNDS	\$2,808,000	\$1,904,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,616,000	\$3,808,000
STATE FUNDS	\$2,808,000	\$1,904,000
FEDERAL FUNDS	\$2,808,000	\$1,904,000

DESCRIPTION

As part of the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) and the California Bridge to Reform Demonstration (BTR), changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursement will be available to Nondesignated Public Hospitals (NDPHs). NDPHs will receive payments from the NDPH Supplemental Fund (Item 4260-601-3096) using State General Fund and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers).

Assumptions:

1. The State Funds (SF) item includes the annual General Fund appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated.
2. SB 1100 (Chapter 560, Statutes of 2005) requires that \$1,900,000 annually be transferred from the General Fund (Item 4260-101-0001) to the NDPH Supplemental Fund to be used for the non-federal share of payments.
3. Distribution of the NDPH Supplemental Fund will be determined through negotiations with the California Medical Assistance Commission.
4. The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010.
5. ABX4 6 (Chapter 6, Statutes of 2009) requires that any increased federal funding available to the MH/UCD project be deposited in the Federal Trust Fund. Additional federal funds due to ARRA will be deposited in the General Fund and expenditures from this fund will be at 50% FFP.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 93

	<u>TF</u>	<u>SF</u>	<u>FFP</u>
FY 2009-10			
FY 2008-09 Ending Balance	\$ 1,170,000	\$ 585,000	\$ 585,000
Appropriation (GF)	\$ 3,800,000	\$ 1,900,000	\$ 1,900,000
Est. FY 2008-09 Interest Earned	\$ 32,000	\$ 16,000	\$ 16,000
Total	<u>\$ 5,002,000</u>	<u>\$ 2,501,000</u>	<u>\$ 2,501,000</u>
Cash Expenditures in FY 2009-10	\$ 3,200,000	\$ 1,600,000	\$ 1,600,000
FY 2009-10 Ending Balance	\$ 1,802,000	\$ 901,000	\$ 901,000
FY 2010-11			
FY 2009-10 Ending Balance	\$ 1,802,000	\$ 901,000	\$ 901,000
Appropriation (GF)	\$ 3,800,000	\$ 1,900,000	\$ 1,900,000
FY 2009-10 Interest Earned	\$ 14,000	\$ 7,000	\$ 7,000
Total	<u>\$ 5,616,000</u>	<u>\$ 2,808,000</u>	<u>\$ 2,808,000</u>
Cash Expenditures in FY 2010-11	<u>\$ 5,616,000</u>	<u>\$ 2,808,000</u>	<u>\$ 2,808,000</u>
FY 2010-11 Ending Balance	\$ -	\$ -	\$ -
FY 2011-12			
FY 2010-11 Ending Balance	\$ -	\$ -	\$ -
Appropriation (GF)	\$ 3,800,000	\$ 1,900,000	\$ 1,900,000
Est. FY 2010-11 Interest Earned	\$ 8,000	\$ 4,000	\$ 4,000
Total	<u>\$ 3,808,000</u>	<u>\$ 1,904,000</u>	<u>\$ 1,904,000</u>
Cash Expenditures in FY 2011-12	<u>\$ 3,808,000</u>	<u>\$ 1,904,000</u>	<u>\$ 1,904,000</u>
FY 2011-12 Ending Balance	\$ -	\$ -	\$ -

MH/UCD—FEDERAL FLEX. & STABILIZATION - SNCP ARRA

REGULAR POLICY CHANGE NUMBER: 94
 IMPLEMENTATION DATE: 4/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1460

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment under the Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration (MH/UCD) will increase for expenditures incurred from October 1, 2008 to October 31, 2010, resulting in additional \$453.362 million federal funds available in the SNCP.

The Department may claim these funds using certified public expenditures from Designated Public Hospitals, the Coverage Initiative Program, and State-Only funded programs, including Breast and Cervical Cancer Treatment, Medically Indigent Adults/Long Term Care, California Children's Services, Genetically Handicapped Persons, County Medical Services Program, County Mental Health Services for the Uninsured funded through Mental Health Services Act, Expanded Access to Primary Care, Department of Veterans Affairs, and AIDS Drug Assistance Program.

The MH/UCD which would have ended on August 31, 2010 was extended for 60 days until October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010. Under the new demonstration, this federal flexibility funding is no longer applicable.

AB 1653 (Chapter 218, Statutes of 2010) allows the state to retain up to \$420 million from the portion of the Hospital Quality Assurance Revenue Fund (HQARF) 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 Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for the QAF Hospital payment schedule. Therefore, these flexibilities resulted in reductions to the General Fund of \$2.519 million in FY 2008-09, \$87.342 million in FY 2009-10 and \$74.651 million in FY 2010-11.

MH/UCD—FEDERAL FLEX. & STABILIZATION - SNCP ARRA**REGULAR POLICY CHANGE NUMBER: 94**

This PC is for informational purposes only because all CPEs being used are in DHCS's budget. No other Department's CPEs were needed to claim the full amount. The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the Hospital Financing – MIA-LTC and Hospital Financing – BCCTP policy changes. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the Hospital Financing - CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF savings are reflected in that estimate.

	FFP
	<u>FY 2010-11</u>
CCS	\$ 32,228,000
GHPP	\$ 6,339,000
MIA-LTC	\$ 5,750,000
BCCTP	\$ 741,000
Grand Total	<u>\$ 45,058,000</u>

MH/UCD—REDUCTION TO DPH SNCP BY 10%

REGULAR POLICY CHANGE NUMBER: 95
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1256

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$1,820,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$1,820,000	\$0
FEDERAL FUNDS	\$1,820,000	\$0

DESCRIPTION

The Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) establishes a Safety Net Care Pool (SNCP). As required by ABX3 5 (Chapter 20, Statutes of 2009), the SNCP payments to Designated Public Hospitals (DPHs) and the South Los Angeles Medical Services Preservation (SLAMSP) Fund will be reduced by 10% beginning on or after the first day of the month following 90 days after the enacted date. ABX3 5 was enacted on March 3, 2009 and the 10% reduction is effective July 1, 2009 for the SNCP Demonstration Year 2009-10. The Department will increase the amount of CPE of the four State-Only programs to utilize any remaining federal funds in the SNCP. The payment reductions to the DPHs and the SLAMSP are factored into the Hosp Financing - Safety Net Care Pool policy change and the Hosp Financing - South LA Preservation Fund policy change. This policy change reflects the GF savings from the additional CPEs for the two State-Only programs budgeted in the Medi-Cal Estimate.

Assumptions:

1. The annualized DPH and SLAMSP Fund's SNCP estimated payments are expected to be \$542 million; a 10% reduction equals \$54.2 million.
2. The Department used available State-Only programs' expenditures for Demonstration Year 2007-08 to fulfill part of the \$54.2 million CPE for 2009-10. The Department claimed \$21.74 million for Demonstration Year 2007-08 services in FY 2009-10.
3. The Department claimed \$15.64 million for Demonstration Year 2009-10 services in FY 2009-10.
4. The additional \$16.82 million of the \$54.2 million will be CPE'd during FY 2010-11.

MH/UCD—REDUCTION TO DPH SNCP BY 10%

REGULAR POLICY CHANGE NUMBER: 95

The specific State-Only programs' additional FFP is shown below:

	FY 2010-11
	FFP
CCS	\$ 7,500,000
GHPP	\$ 7,500,000
MIA-LTC	\$ 1,820,000
BCCTP	\$ 0
Total Savings	\$16,820,000

The CCS and GHPP programs are budgeted in the Family Health Local Assistance Estimate. The General Fund savings related to the CPE of CCS and GHPP is included in the Family Health Local Assistance Estimate. The FY 2010-11 savings for these programs are estimated to be \$15,000,000.

The MIA-LTC and BCCTP programs are budgeted in the Medi-Cal Local Assistance Estimate. The General Fund savings related to the CPE of the MIA-LTC and BCCTP programs is estimated to be \$1,820,000 in FY 2010-11.

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 9/2005
ANALYST: Marc Lowry
FISCAL REFERENCE NUMBER: 1084

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$2,136,000	-\$800,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$2,136,000	-\$800,000
FEDERAL FUNDS	\$2,136,000	\$800,000

DESCRIPTION

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital Uninsured Care Demonstration (MH/UCD) waiver, the Department may claim federal reimbursement for State-Only Breast and Cervical Cancer Treatment Program (BCCTP) costs from the Safety Net Care Pool (SNCP) funding established in the MH/UCD.

The Budget Act of 2001 (Chapter 106, Statutes of 2001) authorized the BCCTP effective January 1, 2002, for women under 200% of the FPL. A State-Only program covers women aged 65 or older, women with inadequate health coverage, undocumented women, and males for cancer treatment only. The coverage term is 18 months for breast cancer and 2 years for cervical cancer. Beneficiaries are screened through Centers for Disease Control (CDC) and Family PACT providers.

This policy change reflects the adjustment for the federal reimbursement received by the Department for a portion of the State-Only BCCTP costs, based on the certification of public expenditures. The General Fund savings created from the federalization of the State-Only BCCTP, and three other state-funded programs, will be used to support safety net hospitals under the MH/UCD.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to October 31, 2010, resulting in additional \$453.362 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects the adjustment for the federal reimbursement received by the Department using BCCTP CPEs.

The MH/UCD was extended until October 31, 2010. Effective November 1, 2010, CMS approved a new five-year demonstration, California Bridge to Reform (BTR). The Special Terms and Conditions of the new demonstration allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP). BCCTP is included in the list of DSHP. This policy change includes the impact of the Bridge to Reform demonstration.

MH/UCD & BTR—BCCTP
REGULAR POLICY CHANGE NUMBER: 96

The FFP is budgeted in the Health Care Support Fund (HCSF) Item 4260-601-7503.

	FFP (HCSF)
FY 2005-06	\$ 591,000
FY 2006-07	\$ 291,000
FY 2007-08	\$ 0
FY 2008-09	\$ 1,211,000
FY 2009-10	\$ 517,000
FY 2010-11	
Stabilization-MH/UCD	\$ 545,000
SNCP ARRA	\$ 741,000
DSHP-BTR	\$ 850,000
FY 2010-11	\$ 2,136,000
FY 2011-12	
DSHP-BTR	\$ 800,000

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 97
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1161

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$514,666,500	-\$463,898,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$514,666,500	-\$463,898,000
FEDERAL FUNDS	\$514,666,500	\$463,898,000

DESCRIPTION

Along with the Medi-Cal Hospital/Uncompensated Care Demonstration (MH/UCD) and the California Bridge to Reform Demonstration (BTR), a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, based on SPA 05-021, Designated Public Hospitals (DPHs) no longer received CMAC negotiated per diem rates for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. DPHs receive interim per diem rates based on estimated costs using the hospitals' Medi-Cal costs trended forward. These interim payments are 100% federal funds matching the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

The previous CMAC negotiated per diem rates were paid with 50% FFP and 50% GF. Typically, the items in the Medi-Cal Estimate base trend are paid with 50% FFP and 50% GF. Since the DPH interim rate is paid with 100% FFP, an adjustment to shift from 50% GF to 100% FFP must be made in the base estimate data.

Assumptions:

- Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP due to ARRA on a date-of-service basis. In FY 2010-11 the increase due to ARRA is \$181,144,000 and in FY 2011-12 the increase is \$38,333,000, on a cash basis.

	<u>Expenditures</u>	<u>GF to FF shift</u>
FY 2010-11	\$ 1,029,333,000	\$ 514,666,500
FY 2011-12	\$ 927,796,000	\$ 463,898,000

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 9/2005
ANALYST: Marc Lowry
FISCAL REFERENCE NUMBER: 1079

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$26,102,000	-\$17,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$26,102,000	-\$17,000,000
FEDERAL FUNDS	\$26,102,000	\$17,000,000

DESCRIPTION

Effective September 1, 2005, based on the Special Terms and Conditions of the Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD), the Department may claim federal reimbursement for the Medically Indigent Adult Long-Term Care (MIA LTC) program from the Safety Net Care Pool (SNCP) funding established by the MH/UCD. The MIA LTC program is a State-Only funded program that covers persons ages 21 to 65 who do not have linkage to another program and who are citizens or legal residents and are residing in a Nursing Facility Level A or B.

This policy change reflects the adjustment for the federal reimbursement received by the Department for a portion of the MIA LTC program claims based on the certification of public expenditures. The General Fund savings created will be used to support safety net hospitals under the MH/UCD.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to October 31, 2010, resulting in additional \$453.362 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects the adjustment for the federal reimbursement received by the Department using MIA LTC CPEs.

The MH/UCD was extended until October 31, 2010. Effective November 1, 2010, CMS approved a new five-year demonstration, California Bridge to Reform (BTR). The Special Terms and Conditions of the new demonstration allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP). The MIA-LTC program is included in the list of DSHP. This policy change includes the impact of the Bridge to Reform demonstration.

The FFP is budgeted in the Health Care Support Fund Item 4260-601-7503.

MH/UCD & BTR—MIA-LTC
REGULAR POLICY CHANGE NUMBER: 98

	FFP
FY 2005-06	\$12,834,000
FY 2006-07	\$ 7,328,000
FY 2007-08	\$14,743,000
FY 2008-09	\$21,355,000
FY 2009-10	\$23,846,000
FY 2010-11	
Stabilization-MH/UCD	\$ 6,752,000
SNCP ARRA	\$ 5,750,000
DSHP-BTR	\$13,600,000
FY 2010-11	\$26,102,000
FY 2011-12	
DSHP-BTR	\$17,000,000

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 99
 IMPLEMENTATION DATE: 10/2010
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1475

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$7,141,120,000	\$0
- STATE FUNDS	\$2,896,060,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,141,120,000	\$0
STATE FUNDS	\$2,896,060,000	\$0
FEDERAL FUNDS	\$4,245,060,000	\$0

DESCRIPTION

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. The fee was deposited into the Hospital Quality Assurance Revenue Fund (HQARF) (Item 4260-601-3158) created by AB 188 (Chapter 645, Statutes of 2009). This fund is used to provide supplemental payments to private and non-designated public hospitals, grants to designated public hospitals, and increased payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1653 (Chapter 218, Statutes of 2010) revises the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383. AB 1653 altered the methodology, timing, and frequency of supplemental payments, increased capitation payments, and increased payments to mental health plans. AB 1653 also allowed the State to retain up to \$420 million from the portion of the QAF fund 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 was allocated to the designated public hospitals and was identical to the amount of the sum retained by the State from the QAF fund. The Department claimed these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and distributed those funds in conformity with the Hospital QAF payment schedule.

All federal approvals for the original 7-quarter QAF program were received prior to making the supplemental payments. Legislation has been proposed for an additional QAF program through June 30, 2011.

This policy change reflects the supplemental payments to the hospitals, except for the \$420 million direct grants to designated public hospitals that would be funded by Federal Flexibility & Stabilization federal funds. Those amounts are shown in a separate policy change.

HOSPITAL QAF - HOSPITAL PAYMENTS**REGULAR POLICY CHANGE NUMBER: 99****Assumptions:**

1. The QAF was originally effective for April 2009 – December 2010; however, an additional 6-month QAF program is assumed.
2. First payment of the quality assurance fee from the hospitals was due October 8, 2010. On an accrual basis, this fee is expected to generate \$0.44 billion in FY 2008-09, \$1.76 billion in FY 2009-10, and \$1.9 billion in FY 2010-11.
3. First payment to the hospitals occurred in October 2010.
4. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

Payments to the hospitals are estimated to be:

	<u>TF</u>	<u>SF (HQARF)</u>	<u>FF</u>	<u>ARRA FF</u>
FY 2010-11	\$7,141,120,000	\$2,896,060,000	\$3,523,530,000	\$ 721,530,000

AB 1653 SUPPLEMENTAL PAYMENTS TO DPHS

REGULAR POLICY CHANGE NUMBER: 100
 IMPLEMENTATION DATE: 10/2010
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1568

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$420,000,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$420,000,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$420,000,000	\$0

DESCRIPTION

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 alters the methodology, timing, and frequency of supplemental payments, increases capitation payments, and increases payments to mental health plans. AB 1653 allows the Department to proceed with implementing the Quality Assurance Fee (QAF) once a letter indicating likely federal approval has been received. AB 1653 also allows the State to retain up to \$420 million from the portion of the Hospital Quality Assurance Revenue Fund (HQARF) (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 these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the QAF Hospital payment schedule.

This policy change reflects the retention of the \$420 million from the HQARF fund by the State and the payment of \$420 million in federal flexibility funds to the DPHs for their CPEs. The retention and the payments were both completed in December 2010. Other supplemental payments authorized by AB 1383 and AB 1653 are shown in a separate PC. The funding adjustment is reflected in the management summary.

FY 2010-11	<u>TF</u>	<u>GF</u>	<u>Hosp. QA Rev. Fund</u>	<u>FF</u>
	\$420,000,000	\$-420,000,000	\$420,000,000	\$420,000,000

FREESTANDING CLINICS & VETERANS' HOMES SUPPL.

REGULAR POLICY CHANGE NUMBER: 101
 IMPLEMENTATION DATE: 12/2010
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1140

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$21,705,000	\$321,600,000
- STATE FUNDS	\$0	\$0
 PAYMENT LAG	 1.0000	 1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
 APPLIED TO BASE		
TOTAL FUNDS	\$21,705,000	\$321,600,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$21,705,000	\$321,600,000

DESCRIPTION

AB 959 (Chapter 162, Statutes of 2006) adds freestanding, non-hospital based clinics and state veterans' homes to the current Medi-Cal supplemental payment program. Under this program, freestanding, non-hospital based 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. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down FFP is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities. Supplemental payments to freestanding, non-hospital based clinics are expected to total \$66,000,000 annually.

State veterans homes that are enrolled as Medi-Cal providers and are operated by the State are also eligible to receive supplemental payments. Eligible state veterans' homes may claim FFP on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes. These payments are expected to total \$6,600,000 annually.

Supplemental payments to state veterans' homes will be effective retroactively beginning with the rate year starting August 1, 2006. Supplemental payments to freestanding, non-hospital based clinics will be effective retroactively beginning July 1, 2006, pending an approved State Plan Amendment. Since facilities must submit cost reports and the Department must certify expenditures before FFP can be claimed, supplemental payments for services provided during a fiscal year will not be issued until the following fiscal year. Supplemental payments for both state veterans' homes and freestanding, non-hospital based clinics are expected to begin in FY 2010-11.

FREESTANDING CLINICS & VETERANS' HOMES SUPPL.

REGULAR POLICY CHANGE NUMBER: 101

Program payment amounts are estimated to be:

	FY 2010-11
State Veterans' Homes for FY 2006-07	\$5,000,000
State Veterans' Homes for FY 2007-08	\$5,000,000
State Veterans' Homes for FY 2008-09	\$5,150,000
State Veterans' Homes for FY 2009-10	\$6,555,000
Total FFP	\$21,705,000

	FY 2011-12
Freestanding Outpatient Clinics for FY 2006-07	\$60,000,000
Freestanding Outpatient Clinics for FY 2007-08	\$60,000,000
Freestanding Outpatient Clinics for FY 2008-09	\$63,000,000
Freestanding Outpatient Clinics for FY 2009-10	\$66,000,000
Freestanding Outpatient Clinics for FY 2010-11	\$66,000,000
State Veterans' Homes for FY 2010-11	\$6,600,000
Total FFP	\$321,600,000

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 102
 IMPLEMENTATION DATE: 4/2004
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 78

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$295,087,000	\$238,879,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$295,087,000	\$238,879,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$295,087,000	\$238,879,000

DESCRIPTION

AB 915 (Chapter 747, Statutes of 2002) created a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. Hospitals will now receive outpatient supplemental payments based on certified public expenditures for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries by the participating facilities. The non-federal share used to draw down FFP is paid exclusively with funds from the participating facilities.

Payments of \$295,087,000 are expected to be made by June 2011. Payments of \$238,879,000 are expected to be made by June 2012.

Estimated costs are as follows:

	FY 2010-11	FY 2011-12
FY 2008-09 FFP Payment	\$ 55,356,000	
FY 2009-10 FFP Payment	\$239,731,000	
FY 2010-11 FFP Payment		\$238,879,000
TOTAL	\$295,087,000	\$238,879,000

IGT FOR NON-SB 1100 HOSPITALS

REGULAR POLICY CHANGE NUMBER: 103
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1158

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$124,068,000	\$100,000,000
- STATE FUNDS	\$49,862,000	\$50,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$124,068,000	\$100,000,000
STATE FUNDS	\$49,862,000	\$50,000,000
FEDERAL FUNDS	\$74,206,000	\$50,000,000

DESCRIPTION

W & I Code, Section 14164, provides general authority for the Department to accept Intergovernmental Transfers (IGTs) from a governmental entity in the State in support of the Medi-Cal program. Non-SB 1100 hospitals may request that the Department accept an IGT for federal matching and return the IGT transfer funds and federal match funds to the non-SB 1100 hospital. This policy change provides authority to accept the IGTs and match them with federal funds, and is a placeholder for possible IGT requests.

The Department may enter into an interagency agreement (IA) with a county to accept an IGT to the Department to be matched with federal funds and distributed to a hospital designated by the county or health care district. The IGTs are included in the Management Summary funding pages as part of Reimbursements, Item 4260-610-0995.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

	<u>TF</u>	<u>IGT</u>	<u>Regular FFP</u>	<u>ARRA FFP</u>
FY 2010-11	\$ 124,068,000	\$ 49,862,000	\$ 62,034,000	\$ 12,172,000
FY 2011-12	\$ 100,000,000	\$ 50,000,000	\$ 50,000,000	

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 104
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1458

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$166,293,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$166,293,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$166,293,000

DESCRIPTION

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.

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.

The Department submitted a SPA to CMS to obtain approval for the new supplemental payment program. Upon approval, supplemental payments will be authorized retroactive to January 2009 and are expected to begin in FY 2011-12. Annual payments are estimated to be \$55,431,000.

The Supplemental Payment Program will be included in the SMH Waiver.

	FY 2011-12
FY 2008-09 FFP	\$27,715,000
FY 2009-10 FFP	\$55,431,000
FY 2010-11 FFP	\$55,431,000
FY 2011-12 FFP	\$27,716,000
TOTAL FFP Payments	\$166,293,000

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 105
 IMPLEMENTATION DATE: 7/1991
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 82

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$106,565,000	\$98,792,000
- STATE FUNDS	\$49,395,000	\$46,590,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$106,565,000	\$98,792,000
STATE FUNDS	\$49,395,000	\$46,590,500
FEDERAL FUNDS	\$57,170,000	\$52,201,500

DESCRIPTION

SB 1732 (Chapter 1635, Statutes of 1988) and SB 2665 (Chapter 1310, Statutes of 1990) authorize Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying hospital facilities, i.e., disproportionate share contract hospitals. These funds are budgeted in Items 4260-102-0001 and 4260-102-0890.

SB 1128 (Chapter 757, Statutes of 1999) authorizes a distinct part skilled nursing facility (DP-NF) 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-NF 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. The funding will be Certified Public Expenditures (CPEs) and FFP. The FFP is budgeted in Item 4260-101-0890.

FY 2010-11	<u>Total Funds</u>	<u>GF</u>	<u>FFP</u>
Hospitals	\$98,790,000	\$49,395,000	\$49,395,000
DP-NFs	\$7,775,000	\$0	\$7,775,000
Total	\$106,565,000	\$49,395,000	\$57,170,000
FY 2011-12	<u>Total Funds</u>	<u>GF</u>	<u>FFP</u>
Hospitals	\$93,181,000	\$46,590,000	\$46,591,000
DP-NFs	\$5,611,000	\$0	\$5,611,000
Total	\$98,792,000	\$46,590,000	\$52,202,000

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 106
 IMPLEMENTATION DATE: 2/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 104

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$93,158,000	\$67,130,000
- STATE FUNDS	\$37,445,000	\$33,565,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$93,158,000	\$67,130,000
STATE FUNDS	\$37,445,000	\$33,565,000
FEDERAL FUNDS	\$55,713,000	\$33,565,000

DESCRIPTION

In the Budget Act of 2003 and the 2003 Health Care Trailer Bill (AB 1762), the Legislature authorized Los Angeles and Alameda Counties to submit IGTs to the Medi-Cal program to be used as the non-federal share of costs in order to draw down Title XIX federal funds. The State Plan Amendment was approved March 31, 2005. Under the authority of Sections 14164 and 14087.3 of the Welfare and Institutions Code, the Department will use the funds to reimburse specified hospitals for costs of trauma care centers provided to Medi-Cal beneficiaries.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

The non-federal match is paid by Los Angeles and Alameda Counties via Intergovernmental Transfer through the Special Deposit Fund 4260-601-0942142.

	Fund 4260-601-0942142	Regular FFP	Additional FFP	TF
FY 2010-11	\$37,445,000	\$46,579,000	\$9,134,000	\$93,158,000
FY 2011-12	\$33,565,000	\$33,565,000		\$67,130,000

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 107
 IMPLEMENTATION DATE: 6/2002
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 86

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$45,300,000	\$32,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,300,000	\$32,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$45,300,000	\$32,000,000

DESCRIPTION

The Budget Act of 2001 authorized payment of federal financial participation (FFP) based on Certified Public Expenditures (CPE) to Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals. The acute care hospital must be owned and operated by a public entity, such as a city, county, or health care district. This program is designed to allow DP-NFs to claim FFP on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program.

Payments are not made through the fiscal intermediary; consequently, they are not reflected in the Medi-Cal base trend data and must be budgeted in this policy change. Expenditures projected for FY 2010-11 are \$45,300,000 FFP. Expenditures projected for FY 2011-12 are \$32,000,000 FFP.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FFP based on CPEs	\$45,300,000	\$32,000,000

DSH OUTPATIENT PAYMENT METHOD CHANGE

REGULAR POLICY CHANGE NUMBER: 108
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1038

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$12,500,000	\$7,500,000
- STATE FUNDS	\$6,250,000	\$3,750,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$12,500,000	\$7,500,000
STATE FUNDS	\$6,250,000	\$3,750,000
FEDERAL FUNDS	\$6,250,000	\$3,750,000

DESCRIPTION

This policy change reflects the change in payment methodology for the Outpatient Disproportionate Share Hospital (DSH) program. Outpatient DSH has a total cap of \$10,000,000 when combined with federal matching funds.

Prior to January 1, 2005, the Department paid each hospital by authorizing the Fiscal Intermediary to increase each hospital's claims by a percentage factor using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals, effective January 1, 2005 eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year. The Department will accelerate the fourth quarter payment in FY 2010-11 in order to maximize federal matching funds under the Education, Jobs and Medicaid Assistance Act of 2010.

Assumption:

- In FY 2010-11 \$12,500,000 and in FY 2011-12 \$7,500,000 will be paid through PANs.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
Ongoing Annual Payment	\$12,500,000	\$7,500,000

SRH OUTPATIENT PAYMENT METHOD CHANGE

REGULAR POLICY CHANGE NUMBER: 109
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1039

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$10,000,000	\$6,000,000
- STATE FUNDS	\$5,000,000	\$3,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,000,000	\$6,000,000
STATE FUNDS	\$5,000,000	\$3,000,000
FEDERAL FUNDS	\$5,000,000	\$3,000,000

DESCRIPTION

This policy change reflects the change in payment methodology for the Outpatient Small and Rural Hospital (SRH) program. Outpatient SRH has a total cap of \$8,000,000 when combined with federal matching funds.

Prior to January 1, 2005, the Department paid each hospital by authorizing the Fiscal Intermediary to increase each hospital's claims by a percentage factor using the methodology specified in statute. In order to provide a more efficient way to reimburse hospitals, effective January 1, 2005 eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year. The Department will accelerate the fourth quarter payment in FY 2010-11 in order to maximize federal matching funds under the Education, Jobs and Medicaid Assistance Act of 2010.

Assumption:

1. In FY 2010-11 \$10,000,000 and in FY 2011-12 \$6,000,000 will be paid through PANs.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
Annual Payment	<u>\$10,000,000</u>	<u>\$6,000,000</u>

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 117
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1232

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$111,555,000	\$153,210,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$111,555,000	\$153,210,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$111,555,000	\$153,210,000

DESCRIPTION

Federal financial participation (FFP) will be paid to the California Department of Developmental Services (CDDS) for the transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) beneficiaries.

The Department submitted a State Plan Amendment (SPA) requesting approval to obtain the federal match for the active treatment and transportation costs. The SPA was approved April 2011 and reimbursement for these costs are retroactive to July 1, 2007.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

The CDDS budget is on an accrual basis, while the DHCS budget is on a cash basis. The following estimates have been provided by CDDS.

CASH BASIS

(Dollars in Thousands)	<u>Total Funds</u>	<u>CDDS GF</u>	<u>FFP Regular</u>	<u>FFP ARRA</u>	<u>Total FFP</u>	<u>IA #</u>
FY 2010-11	\$205,287	\$93,732	\$102,644	\$8,911	\$111,555	Pending
FY 2011-12	\$287,690	\$134,480	\$143,845	\$9,365	\$153,210	

ARRA-ADDITIONAL FFP FOR LOCAL MATCH

REGULAR POLICY CHANGE NUMBER: 118
 IMPLEMENTATION DATE: 10/2008
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1417

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$140,892,000	\$3,900,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$140,892,000	\$3,900,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$140,892,000	\$3,900,000

DESCRIPTION

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.

The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011.

This policy change reflects the estimated additional FFP that will be received by Local Education Agencies (LEAs), the Multipurpose Senior Services program (MSSP), and local governments who do CPEs through DHCS. The additional FFP to local governments who do IGTs are budgeted in each of the individual policy changes. The additional FFP impact to local governments related to other departments' budgets is included in the other departments' policy changes.

Additional FFP: (In Thousands)	<u>Local Government</u>	<u>LEA</u>	<u>Total</u>
FY 2010-11	\$118,800	\$22,092	\$140,892
FY 2011-12	\$0	\$3,900	\$3,900

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 123
 IMPLEMENTATION DATE: 5/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1488

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$43,625,000	\$639,025,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$43,625,000	\$639,025,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$43,625,000	\$639,025,000

DESCRIPTION

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA), authorizes the outlay of federal money estimated to be \$45 billion over 10 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 Acts' requirements. In November 2009, CMS approved California's Health Information Technology Planning – Advanced Planning Document for the purpose of creating the initial landscape assessment, campaign plan and strategic and implementation plan. 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 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.

The Medi-Cal Fiscal Intermediary (FI) is in the process of designing, developing and implementing a system necessary to enroll, pay and audit providers and hospitals who participate in the Medi-Cal HER Incentive Payments Program. System costs are budgeted in the FI Estimate.

The administration costs under the HITECH are budgeted separately in the ARRA HITECH Incentive Program policy change.

Assumptions:

1. Payments to the providers will begin in May 2011.

ARRA HITECH - PROVIDER PAYMENTS**REGULAR POLICY CHANGE NUMBER: 123**

2. Assume 500 of the eligible professionals and 22 of the eligible hospitals will receive first year incentive payments in FY 2010-11 and 7,000 of the eligible professionals and 305 of the eligible hospitals will receive first year incentive payments in FY 2011-12.
3. Assume the incentive payments for professionals are \$21,250 for the first year and \$8,500 for years two through six. The years do not have to be consecutive.
4. Assume the hospital incentive payments are limited to \$3,000,000 per hospital.
5. Hospital incentive payments will be made over a minimum of three years and a maximum of six years. The years do not have to be consecutive. Payments will be limited to 50 percent for the first plan year and 40 percent for the second plan year.
6. Assume 100 percent of the hospitals from the first calendar year will receive incentive payments in the second calendar year.

CASH BASIS**FY 2010-11**

Year 1 Professional Payments	\$10,625,000	
Year 1 Hospital Payments	\$33,000,000	
	<u>\$43,625,000</u>	(\$43,625,000 FFP)

FY 2011-12

Year 1 Professional Payments	\$148,750,000	
Year 2 Professional Payments	\$6,375,000	
Year 1 Hospital Payments	\$457,500,000	
Year 2 Hospital Payments	\$26,400,000	
	<u>\$639,025,000</u>	(\$639,025,000 FFP)

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 125
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1526

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$30,681,000	\$8,368,000
- STATE FUNDS	\$12,361,000	\$4,184,000
PAYMENT LAG	0.9805	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$30,082,700	\$8,368,000
STATE FUNDS	\$12,119,960	\$4,184,000
FEDERAL FUNDS	\$17,962,760	\$4,184,000

DESCRIPTION

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, so that they can reimburse the Regional Centers for arranging the services.

The Department will enter into an interagency agreement with DDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs. This policy change budgets for the increased ICF-DD administrative costs, retroactive to July 1, 2007, in FY 2010-11 and ongoing.

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues. ICF-DDs are held harmless for the QAF expenditure and the fee will be remitted to facilities through increased rates. This policy change budgets for the cost of the increased rates due to the QAF. The increase to the General Fund revenue due to the QAF is not a part of the Medi-Cal budget.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 125

FY 2010-11 (in thousands):

ICF-DD Admin Fee	QA Fee Reimbursement	Total (lagged)	DHCS GF	Regular FFP	Total FFP
<u>\$6,280</u>	<u>\$25,013</u>	<u>\$30,681</u>	<u>\$12,361</u>	<u>\$15,341</u>	<u>\$18,320</u>

FY 2011-12 (in thousands):

ICF-DD Admin Fee	QA Fee Reimbursement	Total (lagged)	DHCS GF	Total FFP
<u>\$1,607</u>	<u>\$6,760</u>	<u>\$8,368</u>	<u>\$4,184</u>	<u>\$4,184</u>

HEALTHY FAMILIES - CDMH

REGULAR POLICY CHANGE NUMBER: 126
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 89

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$40,559,000	\$27,543,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,559,000	\$27,543,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$40,559,000	\$27,543,000

DESCRIPTION

This policy change reflects the FFP portion only for the program cost of providing additional services to severely emotionally disturbed children who have exhausted Healthy Families mental health benefits. This estimate was provided by the California Department of Mental Health (CDMH).

CASH BASIS

	<u>DHCS FFP</u>	<u>County Match</u>	<u>CDMH GF</u>	<u>IA #</u>
FY 2010-11	\$40,559,000	\$15,199,000	\$0	02-25271
FY 2011-12	\$27,543,000	\$16,501,000	\$0	02-25271

*Funding is through Item 4260-113-0890 (Title XXI).

MINOR CONSENT SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 127
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 103

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$7,989,000	\$7,620,000
- STATE FUNDS	\$7,989,000	\$7,620,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,989,000	\$7,620,000
STATE FUNDS	\$7,989,000	\$7,620,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

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 1993 to 1999. The terms of the settlement include payment of \$73.3 million plus interest, of which Los Angeles County paid \$6.8 million. The balance of \$66.5 million plus interest is being withheld from California's Medicaid payments over a ten year period beginning with the first "adjustment" made on July 1, 2003. The final payment will be made in FY 2011-12.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
Total General Fund Cost	\$7,989,000	\$7,620,000

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 128
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1340

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$5,222,000	\$1,973,000
- STATE FUNDS	\$2,611,000	\$986,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,222,000	\$1,973,000
STATE FUNDS	\$2,611,000	\$986,500
FEDERAL FUNDS	\$2,611,000	\$986,500

DESCRIPTION

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.

Assumption:

1. Payments are estimated to total \$5,222,000 for FY 2010-11 and \$1,973,000 for FY 2011-12.

	FY 2010-11	FY 2011-12
Hospitals	\$5,222,000	\$1,973,000

TWO-PLAN MODEL NOTICES OF DISPUTE

REGULAR POLICY CHANGE NUMBER: 133
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 95

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$2,000,000
- STATE FUNDS	\$2,000,000	\$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,000,000	\$2,000,000
STATE FUNDS	\$2,000,000	\$2,000,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

This policy change includes funds for settlement agreements for disputes between the Department and managed care plans.

ARRA-ADDITIONAL FFP FOR DHCS

REGULAR POLICY CHANGE NUMBER: 136
 IMPLEMENTATION DATE: 10/2008
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1385

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$2,706,419,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$2,706,419,000	\$0
FEDERAL FUNDS	\$2,706,419,000	\$0

DESCRIPTION

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.

The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011.

This policy change reflects the estimated additional FFP that will be received by DHCS. The additional ARRA funding for other departments is included in the other departments' policy changes, and the additional DHCS-related ARRA funding for local governments is included in the ARRA-Additional FFP for Local Match policy change.

(In Thousands)

<u>FY 2010-11</u>	<u>TF</u>	<u>GF</u>	<u>FFP</u>
Title XIX	\$0	-\$2,706,419	\$2,706,419

FY 2010-11 HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 137
 IMPLEMENTATION DATE: 10/2010
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1477

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

This policy change reflects the funding for health care coverage for children in the Medi-Cal program due to implementation of a quality assurance fee (QAF) for hospitals.

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a QAF on applicable general acute care hospitals during April 2009 through December 2010. 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 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. AB 1653 (Chapter 218, Statutes of 2010) revises the Medi-Cal hospital provider fee and supplemental payments enactment by AB 1383. AB 1653 alters the methodology, timing, and frequency of supplemental payments, increases capitation payments, and increases payments to mental health plans. SB 90 (Chapter 19, Statutes of 2011) enacted a modified Hospital QAF program for the period of January to June 2011.

All federal approvals for the original 7-quarter QAF program have been received.

Assumptions:

1. The QAF was originally effective for April 2009 – December 2010; however, SB 90 extended it for six more months, until June 2011.
2. First payment of the quality assurance fee from hospitals was due October 8, 2010.
3. These funds will be used as the non-federal share of the cost for children's health care coverage, under the Medi-Cal program, which will result in a corresponding offset to the General Fund.

FY 2010-11 HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 137

4. For each of the first seven quarters, \$80 million is estimated to be available for Medi-Cal children's health care coverage. For the two extension quarters authorized by SB 90, \$105 million is estimated to be available for Medi-Cal children's health care coverage. Therefore, a total of \$770 million is estimated in FY 2010-11.

The funding adjustment is reflected in the management summary. The estimated receipt of funds for children's health care coverage is:

	<u>TF</u>	<u>GF</u>	<u>Hosp. QA Rev Fund</u>
July – Dec. 2010	\$0	\$-560,000,000	\$560,000,000
Jan. – June 2011 (SB 90)	\$0	\$-210,000,000	\$210,000,000
FY 2010-11	\$0	\$-770,000,000	\$770,000,000

MEDI-CAL COST CONTAINMENT STRATEGIES

REGULAR POLICY CHANGE NUMBER: 138
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Jenn Brooks
 FISCAL REFERENCE NUMBER: 1478

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

The Department is implementing strategies to reduce Medi-Cal costs. These strategies are reflected in separate policy changes and are shown here for informational purposes.

(Dollars in Thousands)

	FY 2010-11		FY 2011-12	
	TF	GF	FF	GF
Copayments for Dental Services	\$ (4,653)	\$ (2,327)	\$ (55,839)	\$ (27,920)
Copayments for Emergency ER Visits			\$ (66,848)	\$ (33,424)
Copayments for Non-Emergency ER Visits			\$ (127,390)	\$ (63,695)
Copayments for Hospital Inpatient Days			\$ (275,294)	\$ (130,653)
Pharmacy Copayments			\$ (257,122)	\$ (128,561)
Hearing Aid Cap			\$ (458)	\$ (229)
Limit Enteral Nutrition to Tube Feeding			\$ (27,543)	\$ (13,771)
Eliminate ADHC Services			\$ (339,203)	\$ (169,601)
ADHC Transition			\$ 170,000	\$ 85,000
Elimination of Cough and Cold Products			\$ (4,206)	\$ (2,103)
Copayments for Physician and Clinic Visits			\$ (260,967)	\$ (130,484)
Physician and Clinic Seven Visit Soft Cap			\$ (82,082)	\$ (402,796)
10% Provider Payment Reduction			\$ (760,634)	\$ (380,317)
10% Provider Payment Reduction for LTC Facilities			\$ (368,107)	\$ (184,053)
Non-AB 1629 LTC Rate Freeze			\$ (73,111)	\$ (36,555)
Total	\$ (4,653)	\$ (2,327)	\$ (2,528,804)	\$ (1,271,395)

NUVARING COST SHIFT

REGULAR POLICY CHANGE NUMBER: 139
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1492

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$12,656,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$12,656,000	\$0
FEDERAL FUNDS	\$12,656,000	\$0

DESCRIPTION

The Department has completed an assessment of the cost accounting methodology to draw down enhanced federal funding for the contraceptive, Nuvaring under the Family Planning, Access, Care and Treatment (FPACT) program. Nuvaring is eligible for a 90% federal match. The Department was previously drawing down a 50% federal funding match. Implementation of a correction to the Fiscal Intermediary's system resulted in a 90% federal funding match for Nuvaring contraceptives reimbursable through the FPACT Program. The correction was implemented on May 10, 2010. Claiming at 90% began in FY 2009-10.

Assumptions:

1. Savings for Nuvaring due to the shift in funding are captured in the Family Planning Initiative policy change, beginning in May 2010.
2. The following claims adjustments for Nuvaring were made in FY 2010-11. These adjustments claim the additional 40% federal match for paid claims with dates of service prior to the FI system correction implemented on May 10, 2010.
3. FY 2010-11 savings are estimated to be:

Dates of Service	Adjustments for Additional FFP
2008	\$ 5,725,000
2009	\$ 5,072,000
2010	\$ 1,859,000
Total	\$12,656,000

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 140
 IMPLEMENTATION DATE: 7/1999
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 35

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$6,000,000	\$6,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$6,000,000	\$6,000,000
FEDERAL FUNDS	-\$6,000,000	-\$6,000,000

DESCRIPTION

This policy change includes funds to repay CMS for improperly claimed FFP for ancillary services for Medi-Cal beneficiaries residing in institutions for mental diseases (IMDs). Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for FFP. These ancillary services are to be county-funded. Because separate aid codes or other identifiers are not available to indicate a Medi-Cal beneficiary is residing in an IMD, repayment of the FFP is calculated retrospectively based on information on impacted beneficiaries provided by the California Department of Mental Health.

Reimbursement to the Department of Health Care Services for the cost of these services from CDMH and the providers is budgeted in the Reduction in IMD Ancillary Services Costs policy change.

	FY 2010-11 Repayment	FY 2011-12 Repayment
10/01/08-09/30/09	\$6,000,000	\$0
10/01/09-09/30/10	\$0	\$6,000,000
Total	\$6,000,000	\$6,000,000

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 141
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1087

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

This policy change budgets for the Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds that have been allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments for FY 2010-11 and FY 2011-12. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

This policy change also budgets for the CTPS/Proposition 99 funding added by the Budget Act of 2010, which provides additional funding for Medi-Cal hospital outpatient services.

CTPS/Proposition 99 funding results in a reduction in GF costs.

FY 2010-11		
Hospital Services Account	4260-101-0232	\$69,074,000
Physicians' Services Account	4260-101-0233	\$0
Unallocated Account	4260-101-0236	\$23,296,000
Total CTPS/Prop. 99		\$92,370,000
GF		-\$92,370,000
Net Impact		\$0

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 141

FY 2011-12

Hospital Services Account	4260-101-0232	\$70,593,000
Physicians' Services Account	4260-101-0233	\$105,000
Unallocated Account	4260-101-0236	<u>\$24,589,000</u>
Total CTPS/Prop. 99		\$95,287,000
GF		<u>-\$95,287,000</u>
Net Impact		\$0

This funding adjustment is identified in the management summary funding pages.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 142
 IMPLEMENTATION DATE: 4/1998
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 111

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$8,700,000	-\$8,700,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$8,700,000	-\$8,700,000
FEDERAL FUNDS	\$8,700,000	\$8,700,000

DESCRIPTION

Services provided by Indian health clinics to Native Americans eligible for Medi-Cal are eligible for 100% federal funding.

Assumptions:

1. Currently, there are 48 Indian health clinics participating.
2. Based on actual federal claims in calendar year 2010, the Department has projected a total of \$17,400,000 will be spent on services provided by Indian Health Clinics in FY 2010-11 and FY 2011-12.
3. The costs of these services are fully reflected in the base estimate. This policy change budgets the shift in funding from 50% GF/50% FFP to 100% FFP.
4. Recent changes posted in the Federal Register, Volume 75, Number 115, June 16, 2010, updated the per visit rate payable to Indian Health Clinics. As a result, effective calendar year 2010, the per rate visit payable to Indian Health Clinics has changed to \$289.00, an increase from the prior year's rate of \$268.00.

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FFP	\$8,700,000	\$8,700,000

DISCONTINUE PART B PREMIUM FOR UNMET SOC BENES

REGULAR POLICY CHANGE NUMBER: 143
 IMPLEMENTATION DATE: 4/2011
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1506

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$335,000	-\$1,342,000
- STATE FUNDS	-\$335,000	-\$1,342,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$335,000	-\$1,342,000
STATE FUNDS	-\$335,000	-\$1,342,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

The Budget Act of 2010 included the elimination of the payment of Medicare Part B premiums for those beneficiaries with an unmet share of cost (SOC) of \$500 or less. This change will be implemented April 1, 2011. Premium payments for beneficiaries with unmet SOC's greater than \$500 were eliminated effective December 1, 2008.

Assumptions:

1. It is assumed that implementation and savings will begin on April 1, 2011.
2. Part B premiums are \$115.40 per month per beneficiary from January through December 2011. Premiums are estimated to be \$115.40 per month per beneficiary from January through June 2012.
3. Based on the most recent 12 months of data, assume 969 average monthly eligibles who have a share of cost of \$500 or less will not meet their share of cost each month.

969 eligibles x \$115.40 = \$111,823 savings per month.

FY 2010-11 Savings: \$111,823 x 3 months = **\$335,000 GF**

FY 2011-12 Savings: \$111,823 x 12 months = **\$1,342,000 GF**

FI COST CONTAINMENT PROJECTS

REGULAR POLICY CHANGE NUMBER: 145
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 124

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$402,000
- STATE FUNDS	\$0	-\$201,000
PAYMENT LAG	1.0000	0.8119
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$326,400
STATE FUNDS	\$0	-\$163,190
FEDERAL FUNDS	\$0	-\$163,190

DESCRIPTION

The Fiscal Intermediary is implementing the following proposals to contain Medi-Cal costs, which are not yet fully reflected in the base estimate.

<u>Project Number</u>	<u>Impl. Date</u>	<u>Title</u>	<u>FY 2011-12 Savings</u>
08-01	July-11	Establish Controls for X0032 (Transportation)	\$102,000
07-17	Sept-11	Pharmacy Duplicates	\$300,000
TOTAL			\$402,000

ANTI-FRAUD INITIATIVE

REGULAR POLICY CHANGE NUMBER: 146
 IMPLEMENTATION DATE: 1/2011
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1392

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$948,000	-\$5,146,000
- STATE FUNDS	-\$474,000	-\$2,573,000
PAYMENT LAG	0.8130	0.9630
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$770,700	-\$4,955,600
STATE FUNDS	-\$385,360	-\$2,477,800
FEDERAL FUNDS	-\$385,360	-\$2,477,800

DESCRIPTION

Effective July 1, 2010, the Department expanded its anti-fraud activities focusing on physician services. Savings began in January 2011.

Physicians Services/Provider Report Card Program

The Medi-Cal Provider Error Study (MPES) has shown that physicians and physician groups are associated with a significant percentage of billing errors ranging from miscoding to providing medically unnecessary services.

The Department will implement a "Practice Report Card" as a preventive measure to display to providers their payment patterns and types of errors the Department has uncovered through research and data mining. In December 2010, the Department sent each provider who can prescribe medication to Medi-Cal beneficiaries a baseline "report card" comparing the number and type of their prescriptions against other similar types and specialties of providers. A second round of report cards will be sent six months later and annually thereafter.

The Department estimates the preventative impact of Practice Report Cards will reduce excessive and non-medically necessary prescribing. Savings will be phased in over 12 months and the savings for the report card strategy is estimated to be \$6.5 million annually.

Total Savings	<u>FY 2010-11</u>	<u>FY 2011-12</u>
Physician Services Activities	\$948,000	\$5,146,000

FQHC/RHC AUDIT STAFFING

REGULAR POLICY CHANGE NUMBER: 147
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1437

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	-\$6,117,000
- STATE FUNDS	\$0	-\$3,058,500
PAYMENT LAG	1.0000	0.8540
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$5,223,900
STATE FUNDS	\$0	-\$2,611,960
FEDERAL FUNDS	\$0	-\$2,611,960

DESCRIPTION

The Department will receive three 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.

Assumptions:

1. Assume three new positions will be recruited, hired, and trained by July 1, 2011.
2. Assume the new staff will complete 12 reconciliation audits each month. Reconciliation audits consist of reconciling Managed Care, CHDP, Medicare Crossover and Medicare Advantage plan visits and payments to assure the FQHC/RHC providers were paid an amount equal to their prospective payment system rate.
3. Based on recent data, assume each reconciliation audit saves \$42,477.

12 audits X \$42,477 = \$509,724 savings per month
 \$509,724 X 12 months = **\$6,117,000 TF (\$3,058,500 GF) FY 2011-12 savings**

REDUCTION IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER: 148
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1422

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

This policy change reflects the GF reimbursement from California Department of Mental Health (CDMH) and Medi-Cal providers for improperly claimed Medi-Cal funding for ancillary services for Medi-Cal beneficiaries residing in institutions for mental diseases (IMDs). Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for FFP. These ancillary services are to be county-funded. Because separate aid codes or other identifiers are not available to indicate if a Medi-Cal beneficiary is residing in an IMD, the claims are not easily identifiable. Currently, repayment of the FFP is required by CMS, and the repayment is calculated retrospectively based on information on beneficiaries' dates of residence in an IMD provided by CDMH.

The Department is developing a process, in collaboration with CDMH, to stop inappropriate billings for ancillary services, and has released instructions to the provider community via a memorandum and the Medi-Cal provider bulletin. In addition, the Department anticipates utilizing a three-step approach as outlined below:

1. The Department and CDMH have developed one list of IMD facilities, which has been distributed to IMD facilities and which will be published in the Medi-Cal Provider Manual. Outreach will be conducted to help ensure that expenses for ancillary services are billed to the appropriate entity.
2. The Department will reconcile data identifying Medi-Cal beneficiaries residing in IMDs with increased frequency and will send Erroneous Payment Collection (EPC) notices to collect from providers that incorrectly billed Medi-Cal for these ancillary services. This process is expected to start in FY 2011-12.
3. The Department and CDMH will develop a system to address unresolved EPCs. The Department will invoice CDMH for reimbursement of the costs and CDMH will seek reimbursement from the counties.

REDUCTION IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER: 148

4. In FY 2011-12, the Department expects to collect 50% of costs for FY 2007-08 and FY 2008-09. Of the 50%, 90% is expected to be collected from providers through the EPC process and 10% is expected to come from CDMH.

Date of Service	FY 2011-12
FY 2007-08	\$ 6,000,000
FY 2008-09	\$ 6,000,000
Total Savings	\$12,000,000 GF

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 149
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1185

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$16,672,000
- STATE FUNDS	\$0	-\$8,336,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$16,672,000
STATE FUNDS	\$0	-\$8,336,000
FEDERAL FUNDS	\$0	-\$8,336,000

DESCRIPTION

This policy change includes the retroactive adjustments to dental rates impacting fiscal years prior to the budget year FY 2011-12.

Assumptions:

1. Sacramento Geographic Managed Care dental rates have changes that will be retroactive to July 2009. The prior rate of \$10.51 for all eligibles has changed to \$10.91 for those under 21 and \$2.52 for those 21 or over effective July through December 2009. The rates are \$11.16 for those under 21 and \$2.58 for those 21 or over effective January through December 2010. The rates are \$11.83 for those under 21 and \$2.91 for those 21 or over effective January through December 2011.
2. PHP dental rates have changes that will be retroactive to July 2009. The prior rate of \$10.51 for all eligibles has changed to \$10.91 for those under 21 and \$2.52 for those 21 or over effective July through December 2009. The rates are \$11.16 for those under 21 and \$2.58 for those 21 or over effective January through December 2010. The rates are \$11.83 for those under 21 and \$2.91 for those 21 or over effective January through December 2011.
3. PACE retroactive rate adjustments are reflected in the PACE (Other M/C) policy change.
4. SCAN retroactive rate adjustments are reflected in the Senior Care Action Network policy change.
5. The revised rates were implemented on an ongoing basis beginning with the March 2011 capitation payments. This policy change budgets the retroactive changes for the period from July 2009 through February 2011.
6. It is estimated that all retroactive adjustments will be made in July to December 2011.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 149

		<u>Existing Rate</u>	<u>New Rate</u>	<u>Change</u>	<u>Eligible Months</u>	<u>Dental Retro Rate Adjustment</u>
FY 2010-11						
GMC	July-Dec. 2009					
	<21	\$10.51	\$10.91	\$0.40	776,299	\$311,000
	21+	\$10.51	\$2.52	-\$7.99	379,554	(\$3,033,000)
	January-Dec. 2010					
	<21	\$10.51	\$11.16	\$0.65	1,627,724	\$1,058,000
	21+	\$10.51	\$2.58	-\$7.93	798,747	(\$6,334,000)
	January-Feb. 2011					
	<21	\$10.51	\$11.83	\$1.32	300,827	\$397,000
	21+	\$10.51	\$2.91	-\$7.60	147,572	(\$1,121,000)
PHP	July-Dec. 2009					
	<21	\$10.51	\$10.91	\$0.40	1,213,123	\$485,000
	21+	\$10.51	\$2.52	-\$7.99	389,162	(\$3,109,000)
	January-Dec. 2010					
	<21	\$10.51	\$11.16	\$0.65	2,617,159	\$1,701,000
	21+	\$10.51	\$2.58	-\$7.93	823,806	(\$6,533,000)
	January-Feb. 2011					
	<21	\$10.51	\$11.83	\$1.32	457,092	\$603,000
	21+	\$10.51	\$2.91	-\$7.60	144,384	(\$1,097,000)
Total FY 2011-12 Dental Retroactive Adjustments						(\$16,672,000)

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 150
 IMPLEMENTATION DATE: 8/2009
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1449

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$67,619,000	\$0
- STATE FUNDS	-\$67,619,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$67,619,000	\$0
STATE FUNDS	-\$67,619,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

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; 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.

<u>FY 2010-11</u>	<u>Settlement Payments</u>
Westcliff Medical Labs	\$ 4,044,000
Seacliff Diagnostics	\$ 188,000
Teva	\$ 3,500,000
Alpharma	\$ 969,000
AstraZeneca	\$ 15,200,000
Novartis	\$ 3,598,000
Dey Pharma	\$ 10,986,000
Allergan	\$ 449,000
Forest Pharm.	\$ 2,202,000
Eisai/Elan	\$ 1,169,000
GlaxosmithKlein Pharm.	\$ 22,108,000
KOS Pharm.	\$ 389,000
Ortho-McNeil-Janssen Pharm.	\$ 1,185,000
Schwarz Pharma	\$ 118,000
Serono	\$ 635,000
CVS Caremark, Inc.	\$ 879,000
Total GF Savings	\$ 67,619,000

DELAY CHECKWRITE JUNE 2011 TO JULY 2011

REGULAR POLICY CHANGE NUMBER: 152
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1473

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. The Budget Act of 2010 included the provision that beginning in FY 2010-11, an additional checkwrite for institutional providers whose claims are processed by the fiscal intermediary would be delayed and paid during the next fiscal year. From then on, two checkwrites would be delayed at the end of each fiscal year.

The checkwrite normally paid on June 23, 2011 would be paid in July 2011. Because this delay would have been ongoing, this would have resulted in a decrease in expenditures estimated to be \$287.4 million TF in FY 2010-11 only.

However, in order to maximize the enhanced federal funding which expires June 30, 2011, the June 23rd checkwrite will not be delayed. Therefore, the FY 2010-11 savings from the delay have been deleted from this policy change. The acceleration of the June 23rd checkwrite results in an additional \$17.816 million FFP. (In the November 2010 Estimate, the savings were retained in this policy change and deleted through the Accelerated Payments policy change.)

MEDICARE PAYMENTS - PART D PHASED-DOWN ARRA

REGULAR POLICY CHANGE NUMBER: 154
 IMPLEMENTATION DATE: 3/2010
 ANALYST: Karen Fairgrievies
 FISCAL REFERENCE NUMBER: 1490

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$311,669,000	-\$31,502,000
- STATE FUNDS	-\$311,669,000	-\$31,502,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$311,669,000	-\$31,502,000
STATE FUNDS	-\$311,669,000	-\$31,502,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

On January 1, 2006, Medicare's Part D benefit began. Part D provides a prescription drug benefit to all dual eligibles and other Medicare eligibles that enroll in Part D. Dual eligibles had previously received drug benefits through Medi-Cal. To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligibles. These contributions are called the Phased-down Contribution or "clawback". For more information on the Phased-down Contribution, see the Medicare Payments – Part D Phased-down policy change.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2010-11. The changes in the PMPM are:

	<u>Original PMPM</u>	<u>ARRA PMPM</u>	<u>Difference</u>
2008 PMPM	\$ 93.15	\$ 71.56	\$ (21.59)
2009 PMPM	\$ 99.82	\$ 76.68	\$ (23.14)
2010 PMPM	\$ 102.54	\$ 78.77	\$ (23.77)
2011 PMPM Jan - Mar	\$ 100.77	\$ 83.10	\$ (17.67)
2011 PMPM Apr - Jun	\$ 100.77	\$ 86.91	\$ (13.86)

The retroactive adjustment from October 2008 through January 2010 was \$393,405,000 and was applied as a credit to the Department's Medicare Part D payments. Starting with the February 2010 invoice, the new phased-down PMPM incorporating ARRA was used, reducing the Department's monthly Medicare Part D invoice.

MEDICARE PAYMENTS - PART D PHASED-DOWN ARRA

REGULAR POLICY CHANGE NUMBER: 154

Assumptions:

1. Beginning with the January 2010 invoice paid in March 2010, the Department utilized a \$393,405,000 credit. The Department applied the February – April 2010 invoice that would have been paid in April – June 2010, respectively.
2. Of the \$393,405,000 credit from the retroactive adjustment, \$369,117,000 was offset with expenditures in FY 2009-10 and the balance of \$24,288,000 was offset in FY 2010-11.

ARRA Credit	
<u>Invoice Month</u>	<u>Credit</u>
Oct 2008 - January 2010	\$ (393,405,000)
FY 2009-10	\$ 369,117,000
FY 2010-11	\$ 24,288,000

3. Additional savings due to reduction in the PMPM for ongoing monthly invoices are estimated to be \$77,857,000 in FY 2009-10, \$287,381,000 in FY 2010-11, and \$31,502,000 in FY 2011-12.

ARRA PMPM Adjustment	
	<u>Estimated Savings</u>
FY 2009-10	\$ 77,857,000
FY 2010-11	\$ 287,381,000
FY 2011-12	\$ 31,502,000

4. The total savings due to ARRA is estimated to be \$446,974,000 in FY 2009-10, \$311,669,000 in FY 2010-11, and \$31,502,000 in FY 2011-12 for a total of \$790,145,000.

Total Estimated Savings	
FY 2009-10 Credit Savings	\$ 369,117,000
FY 2009-10 Original ARRA	\$ 77,857,000
FY 2009-10	<u>\$ 446,974,000</u>
FY 2010-11 Credit Savings	\$ 24,288,000
FY 2010-11 Original ARRA	\$ 211,854,000
FY 2010-11 Extend ARRA	\$ 75,527,000
FY 2010-11	<u>\$ 311,669,000</u>
FY 2010-11 Extend ARRA	\$ 31,502,000
FY 2011-12	<u>\$ 31,502,000</u>
Total ARRA Savings	\$ 790,145,000

BTR—DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 218
 IMPLEMENTATION DATE: 3/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1570

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$1,006,880,000	\$650,000,000
- STATE FUNDS	\$415,273,000	\$325,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,006,880,000	\$650,000,000
STATE FUNDS	\$415,273,000	\$325,000,000
FEDERAL FUNDS	\$591,607,000	\$325,000,000

DESCRIPTION

The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Based on the Special Terms and Conditions of the California Bridge to Reform Demonstration, the Safety Net Care Pool includes a Delivery System Reform Incentive Pool (DSRIP) to support California's public hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve.

The total federal funding for DSRIP shall not exceed total computable expenditures of \$6.506 billion over the five Demonstration Years (DYs). Annual federal funds available will be the applicable FMAP of annual total computable expenditure limits as following:

(Dollars in Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	\$ 1,006,880	\$ 591,607
2011-12	\$ 1,300,000	\$ 650,000

There are four areas for which funding is available under the DSRIP:

- (1) Infrastructure Development
- (2) Innovation and Redesign
- (3) Population-focused Improvement
- (4) Urgent Improvement

Public hospitals will submit their DSRIP proposal for approval and be paid based on milestones. Public hospitals will provide the non-federal share of their DSRIP through intergovernmental transfers (IGTs).

This policy change budgets the IGTs and the federal funds for the DSRIP. For Demonstration Year 2010-11, all payments will be made in Fiscal Year 2010-11. In subsequent demonstration years, payments are expected to be made in March of the same fiscal year and September of the subsequent fiscal year.

BTR—DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 218

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional funding due to the FMAP increase is included in this policy change.

(In Thousands)	<u>TF</u>	<u>FF</u>	<u>ARRA FF</u>	<u>IGT</u>
FY 2010-11				
DY 2010-11	<u>\$1,006,880</u>	<u>\$ 503,440</u>	<u>\$ 88,167</u>	<u>\$ 415,273</u>
Total	\$1,006,880	\$ 503,440	\$ 88,167	\$ 415,273
FY 2011-12				
DY 2011-12	<u>\$ 650,000</u>	<u>\$ 325,000</u>	<u>\$ -</u>	<u>\$ 325,000</u>
Total	\$ 650,000	\$ 325,000	\$ -	\$ 325,000

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 219
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1571

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$306,550,000	\$74,064,000
- STATE FUNDS	\$0	-\$202,136,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$306,550,000	\$74,064,000
STATE FUNDS	\$0	-\$202,136,000
FEDERAL FUNDS	\$306,550,000	\$276,200,000

DESCRIPTION

The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below:

State Only Medical Programs
California Children 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 & Development (OSHPD)
<ul style="list-style-type: none"> • Song-Brown HealthCare Workforce Training • Steven M. Thompson Physician Corps Loan Repayment Program • Mental Health Loan Assumption Program
University of California
California State University
California Community Colleges

The annual limit the State-Only programs may claim for DSHP is \$400 million each Demonstration Year for a five year total of \$2 billion. In addition to the above programs, proposed trailer bill language will allow the DPHs to voluntarily provide excess CPEs as necessary for the State to claim the full \$400

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 219

million.

This PC budgets the additional FFP received for CPEs using programs in other departments under the BTR. In FY 2010-11, the FFP for other departments is offset against General Fund in a statewide budget control section, except for \$6,220,000 in ADAP FFP which is offset against the CDPH budget. In FY 2011-12, the FFP is offset against General Fund expenses in Item 4260-101-0001, except for ADAP. The \$74,064,000 FFP for ADAP is offset against the CDPH budget.

The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the MH/UCD & BTR—MIA-LTC and MH/UCD & BTR—BCCTP policy changes. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR—CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF savings are reflected in that estimate.

The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's FMAP by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 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. This policy change and the Department's State-Only Programs policy changes include additional federal funds due to the FMAP increase in FY 2010-11 of \$13,046,000 for DHCS programs and \$41,370,000 for other programs.

(In Thousands)

	Total DSHP		Included in this PC	
	FFP	FFP	FFP	FFP
	FY 2010-11	FY 2011-12	FY 2010-11	FY 2011-12
CCS	\$ 53,000	\$ 70,800		
GHPP	\$ 26,000	\$ 35,200		
MIA-LTC	\$ 13,600	\$ 17,000		
BCCTP	\$ 850	\$ 800		
DHCS Total	\$ 93,450	\$ 123,800		
ADAP	\$ 68,349	\$ 74,064	\$ 68,349	\$ 74,064
Co. Mental Health	\$ 23,585	\$ 30,100	\$ 23,585	\$ 30,100
DDS	\$ 5,731	\$ 7,314	\$ 5,731	\$ 7,314
EWC	\$ 4,414	\$ 15,059	\$ 4,414	\$ 15,059
PCTC	\$ 710	\$ 907	\$ 710	\$ 907
OSHPD	\$ 6,077	\$ 7,755	\$ 6,077	\$ 7,755
Univ. of Calif.	\$ 10,460	\$ 13,350	\$ 10,460	\$ 13,350
CSUS/Comm. Colleges	\$ 92,026	\$ 117,448	\$ 92,026	\$ 117,448
Miscellaneous Programs	\$ 95,198	\$ 10,203	\$ 95,198	\$ 10,203
Other Programs	\$ 306,550	\$ 276,200	\$ 306,550	\$ 276,200
Grand Total	\$ 400,000	\$ 400,000	\$ 306,550	\$ 276,200

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 220
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1572

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$139,898,000	\$238,693,000
- STATE FUNDS	\$0	\$30,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$139,898,000	\$238,693,000
STATE FUNDS	\$0	\$30,000,000
FEDERAL FUNDS	\$139,898,000	\$208,693,000

DESCRIPTION

This policy change budgets the federal funds for the revised Health Care Coverage Initiative (HCCI) of the Low Income Health Program (LIHP) which is effective November 1, 2010, through December 31, 2013, under the California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010.

The Low Income Health Program (LIHP) consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE will cover eligibles with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those with family incomes above 133% through 200% of Federal Poverty Level. Both are elective programs at the local government level and will be statewide. The LIHP HCCI replaces the HCCI program under the section 1115(a) Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD) which expired on August 31, 2010 and was extended until October 31, 2010.

Local government CPEs and IGTs are used to obtain the federal funding for the LIHP. The Department will use the current cost claiming protocol as the basis for the new cost claiming protocol to be submitted to CMS for approval. The MCE program is not subject to a federal funding cap while HCCI funding is subject to a cap of \$180 million each full demonstration year. No GF will be expended for this program. Federal funding will be provided through the Health Care Support Fund (HCSF), Item 4260-601-7503.

The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's FMAP by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 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 additional federal funding of \$24,898,000 in FY 2010-11 and \$8,693,000 in FY 2011-12 due to ARRA is budgeted in this policy change.

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 220

The estimated Health Care Coverage Initiative payments on a cash basis are:

FY 2010-11	TF	FFP	IGT	ARRA
2010-11	\$ 139,898,000	\$115,000,000	\$ 0	\$24,898,000
FY 2011-12				
2010-11	\$ 73,693,000	\$ 65,000,000	\$ 0	\$ 8,693,000
2011-12	\$ 165,000,000	\$135,000,000	\$30,000,000	\$ 0
Total	\$ 238,693,000	\$200,000,000	\$30,000,000	\$ 8,693,000

ANTI-FRAUD ACTIVITIES FOR PHARMACY AND PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 221
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1474

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$2,012,000
- STATE FUNDS	\$0	-\$1,006,000
PAYMENT LAG	1.0000	0.8130
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,635,800
STATE FUNDS	\$0	-\$817,880
FEDERAL FUNDS	\$0	-\$817,880

DESCRIPTION

In January 2012, the Department will expand its anti-fraud activities for pharmacy and physician services. This policy change budgets the savings resulting from the implementation of these anti-fraud activities.

Pharmacy Services Activities

The Department will use data mining techniques to identify providers and beneficiaries involved in suspicious activities related to abuse of prescriptions, institute a beneficiary lock-in program, apply administrative sanctions to providers found to be involved in unnecessary claiming, and address fraud related to medically unnecessary incontinence supplies.

Physicians Services Activities

The Department will conduct rapid response and compliance-focused sweeps of suspicious associations of providers and organized groups, targeting clinics involved in networks of fraud; provide statewide group training classes for providers; and identify providers with billing irregularities and provide training to ensure the type and level of services provided adhere to current medical practices and Medi-Cal statutes and regulations.

Savings are estimated to be \$13.8 million annually and will be phased in over 12 months. Budgeted amounts are preliminary, and will be updated in the November 2011 Estimate when additional information is available.

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 222
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1573

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$503,137,000	\$461,952,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$503,137,000	\$461,952,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$503,137,000	\$461,952,000

DESCRIPTION

This policy change budgets the federal funds for one component of the revised Safety Net Care Pool (SNCP) under the California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR). SNCP payments to DPHs are for uncompensated care provided to individuals with no source of third party coverage for the services they received.

Effective for dates of service on or after November 1, 2010, based on the Special Terms and Conditions of the BTR, a new SNCP was established to support the provision of services to the uninsured. The SNCP is to be distributed through the certified public expenditures (CPEs) of designated public hospitals (DPHs) for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

The Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration MH/UCD was extended for two months, until October 31, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the new BTR demonstration. This policy change budgets the SNCP for the DPHs for the two-month extension for the prior demonstration and for the BTR. SNCP funding for the State-Only Funded Programs under the BTR is budgeted in the BTR—Designated State Health Programs policy change.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional federal funding due to ARRA is \$88,155,000. This is included in this policy change.

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 222

The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs is:

(Dollars in thousands)	<u>Accrual</u>	
	State-Only Funded Programs	Due to DPHs
<u>Demonstration Year</u>		
2010-11	\$400,000	\$565,422
2011-12	\$400,000	\$436,000

The estimated payments to the DPHs on a cash basis budgeted in this policy change are:

(Dollars in Thousands)	<u>Cash</u>	
	FY 2010-11	FY 2011-12
Demonstration Year		
2010-11	\$503,137	\$62,285
2011-12		\$399,667
Total	\$503,137	\$461,952

COPAYMENT FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 223
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1574

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,653,000	-\$55,839,000
- STATE FUNDS	-\$2,326,500	-\$27,919,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,653,000	-\$55,839,000
STATE FUNDS	-\$2,326,500	-\$27,919,500
FEDERAL FUNDS	-\$2,326,500	-\$27,919,500

DESCRIPTION

The Health Trailer Bill of 2011 implemented mandatory copayments of \$5 for all dental visits. This copayment will be applied to dental services in both the fee-for-service and managed care settings. 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.

Assumptions:

- The legislation was enacted March 24, 2011, and the copayment will be implemented June 1, 2011.
- There are approximately 3,886,600 affected visits under the Delta Dental contract.
- The copayment is assumed to reduce the number of dental visits by 8%.
- The average payment for a dental visit is assumed to be \$120.52.
- Annual savings would be:

3,886,600 visits x 92% x \$5 =	\$17,878,000
3,886,600 visits x 8% x \$120.52 =	<u>\$37,473,000</u>
Total	\$55,351,000

- Annual dental managed care savings are estimated at \$488,000.

COPAYMENT FOR DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 223

	<u>TF</u>	<u>GF</u>
Total FY 2010-11 Savings:		
FFS	\$ 4,612,000	\$ 2,306,000
Managed Care	\$ 41,000	\$ 20,500
Total FY 2010-11	\$ 4,653,000	\$ 2,326,500
FY 2011-12 Savings:		
FFS	\$55,351,000	\$27,675,500
Managed Care	\$ 488,000	\$ 244,000
Total FY 2011-12	\$55,839,000	\$27,919,500

COPAYMENT FOR EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 224
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1525

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$66,610,000
- STATE FUNDS	\$0	-\$33,305,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$66,610,000
STATE FUNDS	\$0	-\$33,305,000
FEDERAL FUNDS	\$0	-\$33,305,000

DESCRIPTION

The Health Trailer Bill of 2011 implemented mandatory copayments of \$50 for emergency use of the emergency rooms at the point of service. This copayment will be implemented in both the fee-for-service and managed care settings and will not apply to those who are FFACT beneficiaries. 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.

Assumptions:

- The legislation was enacted March 24, 2011, and the copayment will be implemented November 1, 2011.
- There are approximately 1,410,000 fee-for-service (FFS) emergency visits annually. Total expenditures for emergency ER visits in 2008 were approximately \$202,434,000.
- It is assumed that there will be an 8% reduction in the number of emergency visits once the copayment is implemented. The average cost of an emergency visit is \$143.57.
- The savings from the copayment is estimated to be:

 $1,410,000 \text{ emergency visits} \times 92\% \text{ to pay copayment} \times \$50 \text{ copayment} = \$64,860,000 \text{ annual savings}$
- The savings from the reduction in the number of emergency visits are estimated to be:

 $1,410,000 \text{ emergency visits} \times 8\% \times \$143.57 = \$16,195,000 \text{ annual savings}$

Total Annual FFS Savings: $\$64,860,000 + \$16,195,000 = \$81,055,000$ (\$40,527,500 GF)
- The managed care savings are estimated to be \$39,986,000 TF (\$19,993,000 GF) annually.

COPAYMENT FOR EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 224

Total Annual Savings:	TF	GF
FFS	\$81,055,000	\$40,527,000
Managed Care	\$39,986,000	\$19,993,000
Total Annual	\$121,041,000	\$60,520,000
FY 2011-12 Savings:	TF	GF
FFS (Lagged)	\$39,953,000	\$19,976,000
Managed Care	\$26,657,000	\$13,329,000
Total FY 2011-12	\$66,610,000	\$33,305,000

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 225
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1524

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	-\$126,967,000
- STATE FUNDS	\$0	-\$63,483,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$126,967,000
STATE FUNDS	\$0	-\$63,483,500
FEDERAL FUNDS	\$0	-\$63,483,500

DESCRIPTION

The Health Trailer Bill of 2011 implemented mandatory copayments of \$50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented in both the fee-for-service and managed care settings and will not apply to those who are FFACT beneficiaries. 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.

Assumptions:

- The legislation was enacted March 24, 2011, and the copayment will be implemented November 1, 2011.
- There are approximately 2,879,000 fee-for-service (FFS) non-emergency visits annually. Total expenditures for non-emergency ER visits in 2008 were approximately \$362,581,000.
- It is assumed that there will be an 8% reduction in the number of non-emergency visits once the copayment is implemented. The average cost of a non-emergency visit is \$125.94.
- The savings from the copayment is estimated to be:

$$2,879,000 \text{ non-emergency visits} \times 92\% \text{ to pay copayment} \times \$50 \text{ copayment} = \$132,434,000$$
 annual savings
- The savings from the reduction in the number of non-emergency visits is estimated to be:

$$2,879,000 \text{ non-emergency visits} \times 8\% \times \$125.94 = \$29,007,000$$
 annual savings

$$\text{Total Annual FFS Savings: } \$132,434,000 + \$29,007,000 = \$161,441,000 \text{ } (\$80,720,500 \text{ GF})$$
- The managed care savings is estimated to be \$71,085,000 TF (\$35,542,500 GF) annually.

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 225

Total Annual Savings:	TF	GF
FFS	\$161,441,000	\$80,720,000
Managed Care	\$71,085,000	\$35,542,500
Total Annual	\$232,526,000	\$116,262,500
FY 2011-12 Savings:	TF	GF
FFS (Lagged)	\$79,577,000	\$39,788,500
Managed Care	\$47,390,000	\$23,695,000
Total FY 2011-12	\$126,967,000	\$63,483,500

COPAYMENTS FOR HOSPITAL INPATIENT DAYS

REGULAR POLICY CHANGE NUMBER: 226
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1517

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$271,294,000
- STATE FUNDS	\$0	-\$128,653,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$271,294,000
STATE FUNDS	\$0	-\$128,653,000
FEDERAL FUNDS	\$0	-\$142,641,000

DESCRIPTION

The Health Trailer Bill of 2011 implemented mandatory copayments of \$100 per hospital inpatient day up to a maximum of \$200 per admission. This copayment will be implemented in both the fee-for-service and managed care settings and will not apply to those who are FPACT beneficiaries. 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.

Assumptions:

1. The legislation was enacted March 24, 2011, and the copayment will be implemented November 1, 2011.
2. There are approximately 782,500 FFS hospital inpatient admissions annually. Of the admissions, 165,900 are for 1 day stay, and the remaining 616,600 are for 2 or more days stay.
3. It is assumed that there will be a 5% reduction in FFS hospital inpatient costs once the copayment is implemented. This savings is estimated to be \$235,634,000 TF (\$104,857,000 GF) annually.
4. The FFS savings from the copayment is estimated to be:

165,900 admissions for 1 day stay x .95 to pay copayment x \$100 copayment = \$15,760,000
 616,600 admissions for 2 or more days stay x .95 to pay copayment x \$200 copayment = \$117,154,000

\$15,760,000 + \$117,154,000 = \$132,914,000 TF (\$62,589,000 GF) annual FFS savings

Total Annual FFS Savings: \$132,914,000 + \$235,634,000 = \$368,548,000 TF (\$167,431,000 GF)

COPAYMENTS FOR HOSPITAL INPATIENT DAYS**REGULAR POLICY CHANGE NUMBER: 226**

5. The managed care savings is estimated to be \$177,324,000 TF (\$88,662,000 GF) annually.

Total Annual Savings:	TF	GF
FFS	\$368,548,000	\$167,431,000
Managed Care	\$177,324,000	\$88,662,000
Total Annual	\$545,872,000	\$256,093,000
FY 2011-12 Savings:	TF	GF
FFS (Lagged)	\$153,078,000	\$69,545,000
Managed Care	\$118,216,000	\$59,108,000
Total FY 2011-12	\$271,294,000	\$128,653,000

PHARMACY COPAYMENTS

REGULAR POLICY CHANGE NUMBER: 229
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1520

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	-\$256,786,000
- STATE FUNDS	\$0	-\$128,393,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$256,786,000
STATE FUNDS	\$0	-\$128,393,000
FEDERAL FUNDS	\$0	-\$128,393,000

DESCRIPTION

The Health Trailer Bill of 2011 requires mandatory copayments of \$3 per prescription for preferred drugs and \$5 per prescription for non-preferred drugs. This copayment will be implemented in both the fee-for-service and managed care settings and will not apply to those who are FFACT beneficiaries. 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.

Assumptions:

1. Legislation was enacted March 24, 2011, and the copayment will be implemented November 1, 2011.
2. There are approximately 30,881,000 fee-for-service (FFS) prescriptions annually. There are 1,450,000 non-preferred prescriptions and 29,431,000 preferred prescriptions.
3. It is assumed that there will be a 5% reduction in the number of prescriptions once the copayment is implemented. The average cost of a prescription is \$96.

$30,881,000 \times .05\% = 1,544,050$ reduced prescriptions

$1,544,050$ reduced prescriptions \times \$96 average cost = \$148,229,000 annual savings

4. It is assumed that 25% of the non-preferred prescriptions will switch to preferred drugs. The average savings for a prescription that switches from a non-preferred to a preferred drug is \$250.

$1,377,918$ non-preferred prescriptions \times 25% \times \$250 savings = \$86,120,000 annual savings

PHARMACY COPAYMENTS

REGULAR POLICY CHANGE NUMBER: 229

	Non-Preferred	Preferred	Total
Prescriptions	1,450,000	29,431,000	30,881,000
5% Reduction due to Copayment	-72,500	-1,471,550	-1,544,050
Remaining Prescriptions	1,377,500	27,959,450	29,336,950
25% Switch to Preferred Drugs	-344,375	344,375	0
Prescriptions after Switch	1,033,125	28,303,825	28,336,050

5. The FFS estimated savings from the copayment are: $\$5,166,000 + \$84,912,000 = \$90,078,000$

1,033,125 non-preferred prescriptions x \$5 copayment = \$5,166,000 annual savings
 28,303,825 preferred prescriptions x \$3 copayment = \$84,912,000 annual savings

6. It is assumed that there will be a loss of rebates of \$59,293,000 due to the reduction in prescriptions.

7. Total annual FFS savings are estimated to be:

$\$148,229,000 + \$86,120,000 + \$90,078,000 - \$59,293,000 = \$265,134,000$ (\$132,567,000 GF)

8. The annual managed care savings are estimated to be \$143,642,000 TF (\$71,821,000 GF).

Total Annual Savings:	TF	GF
FFS	\$265,134,000	\$132,567,000
Managed Care	\$143,642,000	\$ 71,821,000
Total Annual Savings	\$408,776,000	\$204,388,000
FY 2011-12 Savings:	TF	GF
FFS (Lagged)	\$161,025,000	\$ 80,512,000
Managed Care	\$95,761,000	\$ 47,880,500
Total FY 2011-12	\$256,786,000	\$128,392,500

HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 230
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1515

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$458,000
- STATE FUNDS	\$0	-\$229,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$458,000
STATE FUNDS	\$0	-\$229,000
FEDERAL FUNDS	\$0	-\$229,000

DESCRIPTION

The Health Trailer Bill of 2011 enacted a \$1,510 cap on hearing aids expenditures per beneficiary. 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 FFACT beneficiaries.

Assumptions:

1. Assume savings will begin on November 1, 2011.
2. Actual annual hearing aid expenditures for FY 2009-10 were \$20,186,000 for 24,762 unduplicated users.
3. Of the annual hearing aid expenditures amount, \$1,547,000 were associated with beneficiaries residing in long-term care and pregnant women, and \$2,015,000 were associated with beneficiaries under 21 years of age.
 $\$1,547,000 + \$2,015,000 = \$3,562,000$
4. Expenditures subject to cap are: $\$20,186,000 - \$3,562,000 = \$16,624,000$
5. The cap for expenditures relative to adults 21 years of age or older, not residing in a LTC facility or pregnant women is \$1,510.
6. Assume total FFS hearing aids expenditures below the \$1,510 cap were \$8,643,000 for 14,201 beneficiaries.
7. Assume that in average \$1,580 is spent annually per beneficiary at and above the \$1,510 expenditure cap.

HEARING AID CAP**REGULAR POLICY CHANGE NUMBER: 230**

	<u>Users</u>	<u>Expenditures</u>
Total unduplicated users	24,762	\$20,186,000
LTC, children, & pregnant women	5,510	\$3,562,000
Expenditures subject to cap	19,252	\$16,624,000
Below the \$1,510 cap for adults	14,201	\$8,642,000
Above the \$1,510 cap for adults	5,051	\$7,982,000

(In Thousands)	<u>TF</u>	<u>GF</u>	<u>FFP</u>
Annual FFS Expenditures	\$20,186	\$10,093	\$10,093
LTC, children, & pregnant women	-\$3,562	-\$1,781	-\$1,781
Expenditures Subject to Cap	\$16,624	\$8,312	\$8,312
FFS Expenditures < \$1,510 cap	-\$8,642	-\$4,321	-\$4,321
FFS Expenditures > \$1,510 cap	\$7,982	\$3,991	\$3,991
Allowable costs for > the \$1,510 cap	-\$7,617	-\$3,814	-\$3,814
Annual FFS savings due to cap	\$354	\$177	\$177
Annual Managed Care savings due to cap	\$432	\$216	\$216
Total Annual Savings	\$786	\$393	\$393
FY 2011-12			
FFS (lagged)	\$170	\$85	\$85
Managed Care	\$288	\$144	\$144
Total FY 2011-12	\$458	\$229	\$229

LIMIT ENTERAL NUTRITION TO TUBE FEEDING

REGULAR POLICY CHANGE NUMBER: 231
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1513

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$27,543,000
- STATE FUNDS	\$0	-\$13,771,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$27,543,000
STATE FUNDS	\$0	-\$13,771,500
FEDERAL FUNDS	\$0	-\$13,771,500

DESCRIPTION

The Health Trailer Bill of 2011 limited enteral nutrition products for adults to tube-fed only beneficiaries, 21 years of age or older. A product may be a benefit for a non-tube-fed adult beneficiary with a documented medical condition for which regular food cannot be consumed without causing risk to the health and/or life of the patient. Medical conditions may include, but are not limited to, malabsorption syndromes or inborn errors of metabolism. Pregnant women, beneficiaries in LTC facilities, and children eligible for EPSDT are exempt from this limitation.

Assumptions:

- The legislation was enacted March 24, 2011, and the limitation on enteral nutrition products will be implemented July 1, 2011.
- Fee-for-service expenditures for enteral nutrition products for adults, excluding pregnant women and those in LTC facilities, are approximately \$32,777,000 annually.
- Of this amount, expenditures for tube-fed adults are approximately \$3,885,000 annually.
- The FFS savings is estimated to be:

\$32,777,000
<u>-\$ 3,885,000</u>
\$28,892,000 (\$14,446,000 GF) annual FFS savings
- The managed care savings is estimated to be \$385,000 (\$192,500 GF) annually.

LIMIT ENTERAL NUTRITION TO TUBE FEEDING

REGULAR POLICY CHANGE NUMBER: 231

Total Annual Savings:	TF	GF
FFS	\$28,892,000	\$14,446,000
Managed Care	\$ 385,000	\$ 192,500
Total Annual Savings	\$29,277,000	\$14,638,500
FY 2011-12 Savings:	TF	GF
FFS (Lagged)	\$27,158,000	\$ 13,579,000
Managed Care	\$ 385,000	\$ 192,500
Total FY 2011-12	\$27,543,000	\$ 13,771,500

ELIMINATE ADHC SERVICES

REGULAR POLICY CHANGE NUMBER: 235
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1472

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$423,474,000
- STATE FUNDS	\$0	-\$211,737,000
PAYMENT LAG	1.0000	0.8010
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$339,202,700
STATE FUNDS	\$0	-\$169,601,340
FEDERAL FUNDS	\$0	-\$169,601,340

DESCRIPTION

The Health Trailer Bill of 2011 eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program. This policy change budgets the savings due to the implementation of that legislation.

Assumptions:

1. Assume that savings will begin on July 1, 2011.
2. Expenditures for ADHC services are estimated to be \$390,766,000 in FY 2011-12.
3. Expenditures for ADHC services provided in an FQHC are estimated to be \$34,167,000 annually.
4. Assume savings due to the ADHC Onsite TAR reviews will be \$1,459,000 TF in FY 2011-12.
5. Total ADHC expenditures are estimated to be:

$$\text{FY 2011-12: } \$390,766,000 + \$34,167,000 - \$1,459,000 = \$423,474,000$$

6. ADHC savings are estimated to be:

$$\text{FY 2011-12 Savings: } \$423,474,000 \text{ TF } (\$211,737,000 \text{ GF})$$

ELIMINATION OF COUGH AND COLD PRODUCTS

REGULAR POLICY CHANGE NUMBER: 237
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1575

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$4,206,000
- STATE FUNDS	\$0	-\$2,103,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$4,206,000
STATE FUNDS	\$0	-\$2,103,000
FEDERAL FUNDS	\$0	-\$2,103,000

DESCRIPTION

The Health Trailer Bill of 2011 eliminated selected nonprescription cough and cold products as Medi-Cal benefits for adults and children.

Assumptions:

1. The legislation was enacted on March 24, 2011, and savings will begin on July 1, 2011
2. Fee-for-service expenditures for nonprescription cough and cold products for adults and children are estimated to be \$3,762,000 annually.
3. Managed care savings are estimated to be \$670,000 annually.
4. Annual savings are estimated to be: $\$3,762,000 + \$670,000 = \$4,432,000$ TF

Lagged Savings:

FY 2011-12 Savings:	<u>TF</u>	<u>GF</u>
FFS (Lagged)	\$3,536,000	\$1,768,000
Managed Care	\$ 670,000	\$ 335,000
Total FY 2011-12	\$4,206,000	\$2,103,000

COPAYMENTS FOR PHYSICIAN/FQHC/RHC OFFICE VISITS

REGULAR POLICY CHANGE NUMBER: 238
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Dee Britton
 FISCAL REFERENCE NUMBER: 1516

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$258,704,000
- STATE FUNDS	\$0	-\$129,352,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$258,704,000
STATE FUNDS	\$0	-\$129,352,000
FEDERAL FUNDS	\$0	-\$129,352,000

DESCRIPTION

The Health Trailer Bill of 2011 requires the Department to implement 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 will be implemented in both the fee-for-service and managed care settings and will not apply to those who are FPACT beneficiaries. The providers will collect the \$5 copayment from the beneficiaries at the time of service, and Medi-Cal will reimburse providers the appropriate rate minus the \$5 copayment.

Assumptions:

1. The legislation was enacted on March 24, 2011 and savings will begin on November 1, 2011.
2. In calendar year 2009, there were approximately 6,677,000 fee-for-service (FFS) physician office visits and 6,673,000 fee-for-service FQHC/RHC visits annually.
3. It is assumed that there will be an 8% reduction in the number of office visits once the copayment is implemented. The average cost of a FFS physician office visit is \$75.29, and the average cost of an FQHC/RHC visit is \$132.67. The weighted average cost of an office visit is \$103.97.
4. The annual savings from the copayment are estimated to be:

6,677,000 physician visits + 6,673,000 FQHC/RHC visits = 13,350,000 visits
 13,350,000 x 92% to pay copayment x \$5 copayment = \$61,410,000 annual savings.

COPAYMENTS FOR PHYSICIAN/FQHC/RHC OFFICE VISITS

REGULAR POLICY CHANGE NUMBER: 238

5. The annual savings from the reduction in the number of office visits are estimated to be:

13,350,000 visits x 8% x \$103.97 = \$111,040,000 annual savings

6. Total Annual FFS Savings: \$61,410,000 + \$111,040,000 = \$172,450,000 TF (\$86,225,000 GF)

7. The managed care savings are estimated to be \$256,000,000 TF (\$128,000,000 GF) annually.

	TF	GF
Total Annual Savings:		
FFS	\$172,450,000	\$86,225,000
Managed Care	\$256,000,000	\$128,000,000
Total Annual Savings	\$428,450,000	\$214,225,000
FY 2011-12 Savings:		
FFS (Lagged)	\$88,037,000	\$44,018,500
Managed Care	\$170,667,000	\$85,333,500
Total FY 2011-12	\$258,704,000	\$129,352,000

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 239
 IMPLEMENTATION DATE: 10/2011
 ANALYST: Dee Britton
 FISCAL REFERENCE NUMBER: 1519

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$82,082,000
- STATE FUNDS	\$0	-\$41,041,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$82,082,000
STATE FUNDS	\$0	-\$41,041,000
FEDERAL FUNDS	\$0	-\$41,041,000

DESCRIPTION

This policy change reflects the savings resulting from the implementation of an annual seven physician visit cap for Medi-Cal beneficiaries.

The Health Trailer Bill of 2011 caps the number of physician visits and clinic visits (including FQHCs/RHCs) allowed per Medi-Cal beneficiary at seven per year. The cap on the number of physician and clinic visits is for adults 21 years of age or older, except those who are FPACT beneficiaries. The cap applies in both the FFS and managed care settings.

Assumptions:

1. Legislation was enacted March 24, 2011, and savings will begin on October 1, 2011.
2. The annual physician visit cap is set at seven visits per beneficiary. All visits above the seven allowed will require a physician's certification to be paid by Medi-Cal.
3. In FY 2009-2010, the number of FFS beneficiaries with 8 or more physician visits was 342,000 and their total number of physician visits was 5,010,000. The average number of visits per beneficiary was 15.
4. Medi-Cal will pay for up to seven visits per beneficiary:
 $342,000 \text{ beneficiaries} \times 7 \text{ allowable visits} = 2,394,000 \text{ allowable visits}$
5. The number of visits above the cap is estimated to be:
 $5,010,000 \text{ total visits} - 2,394,000 \text{ allowable visits} = 2,616,000 \text{ visits above the cap}$
6. The average cost per visit is \$114.66. The total annual cost above the cap is estimated to be \$299,951,000.
 $2,616,000 \text{ visits above the cap} \times \$114.66 = \$299,951,000$

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 239

7. Assume that 85% of the visits above the cap will meet the physicians' certification requirement , and the remaining 15% will be eliminated.
8. FFS annual savings are estimated to be:
\$299,951,000 cost above the cap x 15% = \$44,992,000 TF (\$22,496,000 GF)
9. The managed care savings are estimated to be \$74,314,000 TF (\$37,157,000 GF) annually.

Total Annual Savings:	TF	GF
FFS	\$44,992,000	\$22,496,000
Managed Care	\$74,314,000	\$37,157,000
Total Annual Savings	\$119,306,000	\$59,653,000
FY 2011-12 Savings:	TF	GF
FFS (Lagged)	\$26,347,000	\$13,173,500
Managed Care	\$55,735,000	\$27,867,500
Total FY 2011-12	\$82,082,000	\$41,041,000

BTR—LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 240
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1576

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$59,571,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$59,571,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$59,571,000

DESCRIPTION

AB 1628 (Chapter 728, Statutes of 2010) authorizes the Department to claim federal funding for inpatient hospital services for certain inmates in the California Department of Corrections and Rehabilitation (CDCR) 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 with family incomes at or below 133% of the Federal Poverty Level determined eligible by the Department for either the Medi-Cal program or the Low Income Health Program (LIHP) operated by the counties. The LIHP is established under the California Bridge to Reform section 1115(a) Demonstration (BTR). This policy change budgets the federal funds for the inpatient hospital payments covered under the LIHP. See Medi-Cal Inpatient Hospital Costs for CDCR Inmates policy change for the Medi-Cal covered costs.

The CDCR will forward LIHP applications used by the participating counties to the Department which will apply the eligibility rules for the LIHP and determine eligibility. The CDCR will pay the hospitals under contract for covered inpatient services. The CDCR will provide paid claims data to the individual county programs for certification and attestation of the Certified Public Expenditures (CPEs) and allowable inpatient hospital services for reimbursement of federal funding at the usual FMAP.

Assumptions:

1. The CDCR will submit claims for inpatient hospital services beginning in July 2011.
2. California Prison Health Care Services estimates 800 inmates with inpatient admissions each month.
3. Applications for LIHP will be processed by the Department and no additional county administration costs will be incurred.
4. Assume the Department will process 600 applications from inmates per month, of which 35 will be Medi-Cal applications.

BTR—LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 240

5. California Prison Health Care Services estimates that 13 percent of the inmates are undocumented.
6. California Prison Health Care Services estimates that LIHP applications will comprise 90 percent of the total beneficiary applications, while Medi-Cal applications will be 10 percent of the total.
7. Legislation has been proposed to authorize CDCR to sign applications on behalf of inmates.
8. Assume each month 3 Medi-Cal applications from inmates will be denied because of excess assets. These applicants will be determined eligible for the LIHP.
9. The average monthly inmates potentially eligible for LIHP inpatient hospital services coverage are:

$800 \text{ inmates} \times 87\% \text{ documented} \times 90\% \text{ LIHP} + 3 \text{ denied Medi-Cal} = 629 \text{ potential inmate LIHP eligibles}$

10. Each month, the Department will be able to process:

$600 \text{ total applications} - 35 \text{ Medi-Cal applications} = 565 \text{ LIHP applications}$

11. Assume that all processed inmate LIHP applications will be approved.
12. The average cost per inpatient admission is estimated to be \$19,170.
13. The annual cost will be:

$565 \text{ inpatient admissions per month} \times 12 \text{ months} \times \$19,170 \text{ per inpatient stay} \times 50.00\% \text{ FMAP} = \$64,986,000 \text{ FFP}$

14. Assuming a one-month lag in the claiming process, the FY 2011-12 cost will be:

$565 \text{ inpatient admissions per month} \times 11 \text{ months} \times \$19,170 \text{ per inpatient stay} \times 50.00\% \text{ FMAP} = \mathbf{\$59,571,000 \text{ FFP}}$

ACCELERATED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 241
 IMPLEMENTATION DATE: 12/2010
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1577

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$1,071,028,000	-\$1,071,028,000
- STATE FUNDS	\$408,526,000	-\$507,599,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,071,028,000	-\$1,071,028,000
STATE FUNDS	\$408,526,000	-\$507,599,000
FEDERAL FUNDS	\$662,502,000	-\$563,429,000

DESCRIPTION

In FY 2010-11, the Department will accelerate budgeted payments to maximize federal funds under the American Recovery and Reinvestment Act of 2009 (ARRA). The increased Federal Medical Assistance Percentage (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%. Increased FMAP expires June 30, 2011, and for FY 2011-12 the federal participation will return to the base FMAP rate of 50%. To maximize federal funds, the following budgeted payments will be accelerated:

Checkwrites – The Department will temporarily suspend the one-week audit hold at the end of December 2010, March 2011 and June 2011, thereby accelerating 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 last checkwrite in June has been delayed into the next fiscal year since FY 2004-05, and the second-to-last checkwrite was scheduled to be delayed beginning in June 2011.)

This policy change budgets the savings from the suspensions of the one-week hold, and the savings from accelerating the last checkwrite in June 2011. The savings from no longer delaying the second-to-last checkwrite in June is reflected in a separate policy change, PC 152 Delay Checkwrite June 2011 to July 2011. Accelerating the payments into December and March will create a one-time GF savings in FY 2010-11 of \$15.1 million. Paying the two additional checkwrites in June will create a one-time cost in FY 2010-11 of \$331.7 million GF, but a one-time reduction in FY 2011-12 expenditures of \$382.6 million GF, and will result in a net GF savings of \$50.9 million.

COHS Capitation Payments – Accelerating COHS capitation payments in December 2010 and March 2011 will create one-time GF savings of \$13.3 million. Accelerating COHS capitation payments in June will create a one-time cost in FY 2010-11 of \$107.8 million GF, but a one-time reduction in FY 2011-12 expenditures of \$125.0 million GF, and will result in a net GF savings of \$17.2 million.

Safety Net Payments—Accelerating Safety Net payments in December will create one-time GF savings of \$2.5 million.

ACCELERATED PAYMENTS

REGULAR POLICY CHANGE NUMBER: 241

The total impact that is reflected in this policy change for the acceleration of budgeted payments to maximize federal funds under ARRA is a net GF cost of \$408.5 million GF in FY 2010-11 and a GF savings of \$507.6 million GF in FY 2011-12. Over the two-year period, the total GF savings is \$99.1 million.

The total impact of the acceleration of budgeted payments, including the impact of no longer delaying the second-to-last checkwrite in June and the impact of no longer deferring the June Two Plan and GMC capitation payments, is a GF cost of \$690.8 million in FY 2010-11 and a GF savings of \$835.2 million in FY 2011-12. Over the two year period, overall GF savings total \$144.4 million.

(In Thousands)

FY 2010-11	TF	GF	FFP
January Payments (to be paid in December)	\$0	(\$20,397)	\$20,397
April Payments (to be paid in March)	\$0	(\$10,573)	\$10,573
July Payments (to be paid in June)	\$1,071,028	\$439,496	\$631,532
Total	\$1,071,028	\$408,526	\$662,502
FY 2011-12			
July Payments (to be paid in June)	(\$1,071,028)	(\$507,599)	(\$563,429)
Difference over both FYs	\$0	(\$99,073)	\$99,073
Impact of Not Delaying June Two Plan & GMC Pmt (PC 68)	\$0	(\$27,520)	\$27,520
Impact of Second-to-Last June Checkwrite (PC 152)	\$0	(\$17,816)	\$17,816
Difference over both FYs	\$0	(\$144,409)	\$144,409

BTR—LOW INCOME HEALTH PROGRAM - MCE

REGULAR POLICY CHANGE NUMBER: 242
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1578

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,212,051,000
- STATE FUNDS	\$0	\$280,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,212,051,000
STATE FUNDS	\$0	\$280,000,000
FEDERAL FUNDS	\$0	\$932,051,000

DESCRIPTION

This policy change budgets the federal funds for the Medicaid Coverage Expansion (MCE) component of the Low Income Health Program (LIHP) which is effective November 1, 2010, through December 31, 2013, under the California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR).

The Low Income Health Program consists of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE will cover eligibles with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those with family incomes above 133% through 200% of Federal Poverty Level. Both are elective programs at the local government level and will be statewide. The LIHP HCCI replaces the HCCI program under the Medi-Cal Hospital/Uninsured Care Demonstration which expired on August 31, 2010, and was extended until October 31, 2010.

Local government CPEs and IGTs are used to obtain the federal funding for the MCE. The Department will use the current cost claiming protocol for the MH/UCD HCCI as the basis for the new cost claiming protocol to be submitted to CMS for approval. The MCE program is not subject to a federal funding cap while HCCI funding is subject to a cap of \$180 million each full demonstration year. No GF will be expended for this program.

The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's FMAP by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 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 additional federal funding of \$36,051,000 in FY 2011-12 is budgeted in this policy change.

BTR—LOW INCOME HEALTH PROGRAM - MCE

REGULAR POLICY CHANGE NUMBER: 242

The estimated MCE payments on a cash basis are:

FY 2011-12	TF	FFP	IGT	ARRA
2010-11	\$ 298,051,000	\$262,000,000	\$ 0	\$36,051,000
2011-12	\$ 914,000,000	\$634,000,000	\$280,000,000	\$ 0
Total	\$1,212,051,000	\$896,000,000	\$280,000,000	\$36,051,000

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 243
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Dee Britton
 FISCAL REFERENCE NUMBER: 1580

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$815,123,000
- STATE FUNDS	\$0	-\$407,561,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$815,123,000
STATE FUNDS	\$0	-\$407,561,500
FEDERAL FUNDS	\$0	-\$407,561,500

DESCRIPTION

This policy changes budgets the savings due to the implementation of a 10% provider payment reduction, which will be effective July 1, 2011 and retroactive to June 1, 2011.

AB 97 (Chapter 2, Statutes of 2011) requires the Department to implement a 10% provider payment reduction, which will affect all services except contracted acute hospital inpatient services, critical access hospital, federal rural referral centers and FQHCs/RHCs, services provided through the Breast and Cervical Cancer Treatment and Family PACT programs and hospice services. Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services and payments funded by certified public expenditure and intergovernmental transfer are exempt. Managed care savings also exempt payments to AHF, PACE and SCAN.

Effective March 1, 2009, as required by the Health Trailer Bill of 2008, pharmacy and LTC provider payments were reduced by 5% and FFS provider payments were reduced by 1%. Managed care providers payments were reduced by an actuarially equivalent reduction. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers. Therefore, this policy change budgets a 10% payment reduction for FFS providers receiving fully restored payments and an additional 9% or 5% payment reduction for FFS providers whose payments are currently reduced by 1% or 5%.

Managed care provider payments will be reduced by the actuarial equivalent amount of the FFS payment reductions.

Lagged Savings	FY 2011-12	Annual
FFS	\$570,649,000	\$554,970,000
Managed Care	\$244,474,000	\$225,668,000
Total	\$815,123,000	\$780,638,000

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 245
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Laura Swift
 FISCAL REFERENCE NUMBER: 1579

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$402,985,000
- STATE FUNDS	\$0	-\$201,492,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$402,985,000
STATE FUNDS	\$0	-\$201,492,500
FEDERAL FUNDS	\$0	-\$201,492,500

DESCRIPTION

This policy change budgets the savings due to the Health Trailer Bill of 2011's requirement for a 10% provider payment reduction to nursing and subacute facilities reimbursed under the AB 1629 reimbursement methodology, NF-A, DP/NF-B, DP/NF Adult and Pediatric Subacute, Freestanding Pediatric Subacute, Rural Swing Bed, and ICF-DD/N/H providers.

Effective March 1, 2009, as required by the Health Trailer Bill of 2008, pharmacy and LTC provider payments were reduced by 5% and FFS provider payments were reduced by 1%. Managed care providers payments were reduced by an actuarially equivalent reduction. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers. Therefore, this policy change budgets a 10% payment reduction for FFS providers receiving fully restored payments and an additional 9% or 5% payment reduction for FFS providers whose payments are currently reduced by 1% or 5%.

Assumptions

1. Assume savings will begin on July 1, 2011, and will be retroactive to June 1, 2011.
2. This policy change only budgets the savings due to the payment reductions for FFS providers. The decrease in GF revenues due to the decrease in the amount of QA fee collected is shown here for informational purposes, as the revenues are not part of the Medi-Cal budget.

\$201,493,000 GF reduced payments - \$22,229,000 less QA fee collection = \$179,264,000 FY 2011-12 net GF savings

\$209,270,000 GF reduced payments - \$23,077,000 less QA fee collection = \$186,193,000 Annual net GF savings

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 245

Lagged Savings	FY 2011-12	Annual
ICF-DD	\$40,322,000	\$40,108,000
AB 1629 Facilities	\$310,973,000	\$324,494,000
Non AB1629 Facilities	\$51,690,000	\$53,938,000
Total	\$402,985,000	\$418,540,000

SAVINGS FROM ATTRITION IN MSSP

REGULAR POLICY CHANGE NUMBER: 246
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1419

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$5,000,000
- STATE FUNDS	\$0	-\$2,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$5,000,000
STATE FUNDS	\$0	-\$2,500,000
FEDERAL FUNDS	\$0	-\$2,500,000

DESCRIPTION

This policy change budgets savings due to the reduction to the Multipurpose Senior Services Program (MSSP).

Currently, the MSSP is designed to evaluate the effects of providing a comprehensive array of social and health services to persons 65 or older who are "at risk" of long-term care. The program provides services under a federal home and community-based services waiver to an average of 16,335 clients in 11,789 client slots, at \$4,285 per year per client slot.

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.

Assumptions:

1. Beginning in FY 2011-12, assume that MSSP sites will not fill slots that become open due to attrition.
2. Savings are estimated to be **\$5,000,000 in FY 2011-12.**

LOMELI V. SHEWRY

REGULAR POLICY CHANGE NUMBER: 248
 IMPLEMENTATION DATE: 11/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1583

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$336,000
- STATE FUNDS	\$0	\$168,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$336,000
STATE FUNDS	\$0	\$168,000
FEDERAL FUNDS	\$0	\$168,000

DESCRIPTION

The Department finalized a settlement of the *Lomeli, et al., v. Shewry* 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. Benefit costs for eligible medical services during the retroactive coverage period may qualify individuals for reimbursement.

Assumptions:

1. The Department expects to receive claims beginning August 2011. Costs are expected to begin in November 2011.
2. Assume there will be 1,000 Medi-Cal claims per month, of which 60% will be eligible for retroactive coverage.
3. Of those, assume 33% will file a claim for dental services and 67% will file a claim for medical services.
4. It is estimated that 18% of dental claims will be approved.
5. It is estimated that 28% of medical claims will be approved.
6. Assume the average cost is \$533.74 for dental claims and \$202.98 for medical claims.

	<u>TF</u>	<u>GF</u>
Dental Costs	\$ 152,000	\$ 76,000
Medical Costs	\$ 184,000	\$ 92,000
Total Cost	\$ 336,000	\$ 168,000

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 249
 IMPLEMENTATION DATE: 2/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1585

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$128,000,000
- STATE FUNDS	\$0	-\$64,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$128,000,000
STATE FUNDS	\$0	-\$64,000,000
FEDERAL FUNDS	\$0	-\$64,000,000

DESCRIPTION

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 January 2012.

Assumptions:

1. Rebates are invoiced quarterly.
2. Assume invoicing will begin in January 2012, retroactive to April 2010.
3. Assume rebates will be received beginning in February 2012.
4. The Department estimates \$128,000,000 TF (\$64,000,000 GF) will be collected in FY 2011-12.

<u>FY 2011-12</u>	
Retroactive payments	\$ 64,000,000
FY 2011-12	\$ 64,000,000
Total	\$128,000,000

TRANSFER OF MCO TAX TO GENERAL FUND

REGULAR POLICY CHANGE NUMBER: 250
 IMPLEMENTATION DATE: 2/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1586

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

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.

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. This policy change budgets the reimbursement to the General Fund from the MCO Tax Fund. A reimbursement of \$89.9 million is expected in FY 2010-11 for FY 2009-10 capitation payments. Beginning in FY 2011-12, a payment reconciliation will be completed on the previous year.

	<u>FY 2010-11</u>
January 2009 - June 2010	\$ 89,900,000
July 2010 - September 2010	\$ 18,600,000
October 2010 – December 2010	\$ 18,600,000
January 2011 - March 2011	\$ 20,000,000
Total MCO Tax	\$147,100,000
GF	-\$147,100,000
Total	\$0

	<u>FY 2011-12</u>
April 2011 – June 2011	\$ 21,000,000
July 2011 - September 2011	\$ 22,400,000
October 2011 – December 2011	\$ 22,400,000
January 2012 - March 2012	\$ 22,400,000
FY 2010-11 Reconciliation	\$ 11,400,000
Total MCO Tax	\$99,600,000
GF	-\$99,600,000
Total	\$0

MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER: 251
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1587

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$10,000,000
- STATE FUNDS	\$0	-\$9,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$10,000,000
STATE FUNDS	\$0	-\$9,500,000
FEDERAL FUNDS	\$0	-\$500,000

DESCRIPTION

This policy change reflects the savings resulting from recovery of overpayments related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles. 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. UMASS will assist the Department in auditing the invoices received from CMS to pay the Medicare premiums.

Payment to the contractor is contingent upon recovery from CMS and Medicare providers. The contract costs are budgeted in the Medicare Recovery Project Contract policy change.

Assumptions:

1. Assume the contractor will begin auditing invoices and providing findings to the Department on July 1, 2011.
2. Assume recovery of overpayments will begin January 1, 2012.
3. Assume that 90% of recoveries will be from CMS Medicare Premiums and 10% will be from provider overpayments.
4. Annual savings are estimated to be \$20,000,000 TF.
5. FY 2011-12 savings are estimated to be:
 $\$20,000,000 / 12 \text{ months} = \$1,666,667 \times 6 \text{ months} = \mathbf{\$10,000,000 \text{ TF}}$

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 252
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1588

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$346,000,000
- STATE FUNDS	\$0	\$173,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$346,000,000
STATE FUNDS	\$0	\$173,000,000
FEDERAL FUNDS	\$0	\$173,000,000

DESCRIPTION

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 IGTs of \$277 million and \$554 million in increased capitation rates. Because the SPD enrollment transition will occur over a period of time beginning June 1, 2011, the initial IGT is estimated to be \$173 million for the period June 1, 2011 through June 30, 2012. This policy change budgets the increase in capitation payments due to the public hospital IGTs.

FY 2011-12

	<u>IGT</u>	<u>FFP</u>	<u>TF</u>
Total	\$173,000	\$173,000	\$346,000

SHIFT OF HEALTHY FAMILIES CHILDREN TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 253
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1511

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$258,762,000
- STATE FUNDS	\$0	\$90,566,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$258,762,000
STATE FUNDS	\$0	\$90,566,700
FEDERAL FUNDS	\$0	\$168,195,300

DESCRIPTION

Legislation has been proposed to shift all Healthy Families Program (HFP) eligibles to the Medi-Cal Program. Beginning January 2012, a six-month transition of eligibles will take place. Children over 150% of the federal poverty level will continue to be required to pay a premium for coverage. Administrative costs associated with this change are budgeted separately. This policy change budgets the cost to the Medi-Cal program. The savings to the Healthy Families Program is reflected in the Managed Risk Medical Insurance Board (MRMIB) budget.

Assumptions:

- As of January 1, 2012, 891,700 eligibles will be transferred to Medi-Cal over a 6 month period. A State Plan amendment will be submitted to allow these eligibles to be determined presumptively eligible for Medi-Cal.
- Distribution of these eligibles among counties is based upon their current enrollment in the HFP.
- These new eligibles will be enrolled in managed care plans in those counties that have County Organized Health Systems, Geographic Managed Care, or the Two Plan Model. In other counties they will participate in the Fee-For-Service system.
- Eligibles will be transferred to Medi-Cal as follows:

	Eligibles	Phase-In
In Medi-Cal managed care counties		
Able to enroll in same health plan	387,366	Jan. – Feb. 2012
Unable to enroll in same health plan	454,734	March – April 2012
Not in Medi-Cal managed care counties	49,600	March - June 2012
	891,700	

SHIFT OF HEALTHY FAMILIES CHILDREN TO MEDI-CAL**REGULAR POLICY CHANGE NUMBER: 253**

5. The weighted average monthly cost of benefits for these eligibles under the Medi-Cal program is estimated to be \$74.38, including managed care capitation payments, fee-for-service costs, managed care carve-outs, FQHC wrap-around payments and dental payments (excludes CCS).
6. Premiums in FY 2011-12 for those over 150% of FPL are estimated to be \$74,704,000.
7. Included in the 891,700 eligibles are an estimated 6,144 CCS-HFP eligibles that will be shifted to CCS-Medi-Cal. The cost for these eligibles is currently budgeted in the Family Health Estimate. CCS-HFP is funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under Medi-Cal. The GF reimbursement from the counties for CCS-Medi-Cal in the amount of \$6.2 million in FY 2011-12 is included in the 4260-610-0995 Reimbursement line in the Management Summary.
8. Enhanced federal funding under Title XXI is available for these eligibles on Medi-Cal. These costs are budgeted in Item 4260-113 at 65% FFP.
9. This policy change includes caseload growth for the period of January 1, 2012 through June 30, 2012.

(In Thousands)

FY 2011-12	TF	GF	Reimbursement from Counties
Other Services	\$289,116	\$101,191	
Premiums	\$ 74,704	(\$ 26,147)	
Net	\$ 214,412	\$ 75,044	
CCS	\$ 44,350	\$ 9,314	\$6,209
Total	\$ 258,762	\$ 84,358	\$6,209

IHSS PROVIDER TAX

REGULAR POLICY CHANGE NUMBER: 254
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1591

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	\$332,500,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$332,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$332,500,000

DESCRIPTION

This policy change budgets the Title XIX federal funds associated with supplementary payments to IHSS providers for services provided to Medi-Cal beneficiaries. AB 1612 (Chapter 725, Statutes of 2010) mandates that IHSS providers be taxed at the State sales tax rate. The IHSS provider tax will allow additional federal funding to be matched with funds from the sales tax collected. 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.

The Department will provide the federal funds for the supplementary payments for services provided retroactive to October 1, 2010, and upon approval of a SPA that was submitted to CMS in December 2010.

Estimated Costs:

	FY 2011-12
FY 2010-11	\$142,500,000
FY 2011-12	\$190,000,000
Total	\$332,500,000

RECOUPMENT OF MEDICARE PROVIDER OVERPAYMENTS

REGULAR POLICY CHANGE NUMBER: 255
 IMPLEMENTATION DATE: 4/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1593

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	-\$41,000,000	\$0
- STATE FUNDS	-\$20,500,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$41,000,000	\$0
STATE FUNDS	-\$20,500,000	\$0
FEDERAL FUNDS	-\$20,500,000	\$0

DESCRIPTION

This policy change budgets the savings from the recoupment of overpayments made to Medi-Cal/Medicare providers for services that had 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 incorrectly. 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.

Assumption:

1. Assume the recovery of overpaid claims for October 2005 through May 2009 will be completed in FY 2010-11.
2. Providers will be notified of the EPC and adjustments will be made to recoup the overpayments.
3. Savings are estimated to be **\$41,000,000 TF (\$20,500,000 GF) in FY 2010-11.**

ADHC TRANSITION

REGULAR POLICY CHANGE NUMBER: 256
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Irene Gen
 FISCAL REFERENCE NUMBER: 1594

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$50,000,000
- STATE FUNDS	\$0	\$25,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$50,000,000
STATE FUNDS	\$0	\$25,000,000
FEDERAL FUNDS	\$0	\$25,000,000

DESCRIPTION

This policy change budgets the costs associated with transitioning current Adult Day Health Care (ADHC) program participants into other services appropriate to their needs in order to minimize the risks of institutionalization.

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 utilize \$50 million TF (\$25 million GF) to help transition existing ADHC enrollees to other appropriate Medi-Cal services. The funds may be used for assessment, placement, and the provision of services.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 259
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1597

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	-\$83,555,000
- STATE FUNDS	\$0	-\$41,777,500
PAYMENT LAG	1.0000	0.8750
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$73,110,600
STATE FUNDS	\$0	-\$36,555,310
FEDERAL FUNDS	\$0	-\$36,555,310

DESCRIPTION

This policy changes budgets the savings due to implementation of the Health Trailer Bill of 2011's requirement to freeze rates at the 2008-09 levels for DP/NF-B, DP/NF Adult and Pediatric Subacute, Freestanding Pediatric Subacute, and Rural Swing Bed providers. Because NF-A, and ICF-DD/N/H provider rates are currently reimbursed at the 2008-09 rate levels, these providers are not impacted by this policy.

Effective August 1 of each year, long term care (LTC) rates are re-determined annually for the following facility types: NF-A, DP/NF-B, Rural Swing Bed, DP/NF Adult and Pediatric Subacute, Freestanding Pediatric Subacute and ICF-DD/N/H. The amendments to the Budget Act of 2009 eliminated rate increases for these facilities effective August 1, 2009. 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 DP/NF-B, DP/NF adult and Pediatric Subacute, Freestanding Pediatric Subacute and Rural Swing Bed providers, effective February 25, 2010. Therefore, only these providers received a rate increase in FY 2010-11 and FY 2011-12.

Assumptions

1. Assume the rate freeze will begin July 1, 2011.
2. The cost of the August 1, 2010 and the August 1, 2011 rate increases for DP/NF-Bs, DP Adult and Pediatric Subacute, FS Pediatric Subacute and Rural Swing Bed providers are estimated to be \$83,555,000 TF in FY 2011-12.
3. Savings due to the rate freeze is estimated to be:
 $\$83,555,000 \times .875 \text{ payment lag} = \mathbf{\$73,111,000 \text{ TF } (\$36,556,000 \text{ GF}) \text{ FY 2011-12}}$

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 260
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1600

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$64,000,000	\$64,000,000
- STATE FUNDS	\$27,597,000	\$32,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$64,000,000	\$64,000,000
STATE FUNDS	\$27,597,000	\$32,000,000
FEDERAL FUNDS	\$36,403,000	\$32,000,000

DESCRIPTION

This policy change budgets the revenue and payments for a supplemental reimbursement program for nondesignated public hospitals (NDPHs). This program was established by AB 113 (Chapter 20, Statutes of 2011) and is funded by intergovernmental transfers (IGTs). The IGTs are deposited into the Medi-Cal Inpatient Payment Adjustment (MIPA) Fund, Item 4260-606-0834. The payments to NDPHs will be made once a year, beginning in June 2011.

AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This PC also reflects the portion of the nine percent that is used to offset GF costs of Medi-Cal children's health services.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional funding due to the FMAP increase is included in this policy change.

(in thousands)

	<u>TF</u>	<u>GF</u>	<u>IGT</u>	<u>FF</u>	<u>ARRA</u>
FY 2010-11					
Payments to NDPHs	\$64,000	\$ -	\$27,597	\$32,000	\$4,403
Children's Services	\$ -	(\$2,685)	\$ 2,685	\$ -	\$ -
Total	\$64,000	(\$2,685)	\$30,282	\$32,000	\$4,403
FY 2011-12					
Payments to NDPHs	\$64,000	\$ -	\$32,000	\$32,000	\$ -
Children's Services	\$ -	(\$2,990)	\$ 2,990	\$ -	\$ -
Total	\$64,000	(\$2,990)	\$34,990	\$32,000	\$ -

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 261
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1601

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

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 which are budgeted in the Managed Care IGT policy change.

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.

This policy change budgets the decrease in Medi-Cal costs due to the collection of the county IGT administrative and processing fee.

Assumptions:

1. Assume legislation will be enacted July 1, 2011.
2. The total IGT amount budgeted for FY 2011-12 IGTs is \$170,852,000.

FY 2011-12 (In Thousands)

<u>FY 2011-12 IGT</u>	<u>20% Admin. & Processing Fee</u>	<u>Reimbursement to GF</u>	<u>Net Impact</u>
\$170,582	\$34,170	(\$34,170)	\$0

FY 2011-12 HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 263
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1603

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

This policy change budgets the funding for health care coverage for children in the Medi-Cal program due to implementation of a quality assurance fee (QAF) for hospitals in FY 2011-12.

SB 90 (Chapter 19, Statutes of 2011) 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.

The funding adjustment is reflected in the management summary. The estimated receipt of funds for children's health care coverage is:

	<u>TF</u>	<u>GF</u>	<u>Hosp. QA Rev Fund</u>
FY 2011-12	\$0	\$-320,000,000	\$ 320,000,000

SB 90 NON-CONTRACT HOSPITAL RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 264
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1604

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$160,414,000
- STATE FUNDS	\$0	\$80,207,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$160,414,000
STATE FUNDS	\$0	\$80,207,000
FEDERAL FUNDS	\$0	\$80,207,000

DESCRIPTION

SB 90 (Chapter 19, Statutes of 2011) repealed a number of rate reductions for non-contract hospital inpatient services. These include:

- ABX3 5 (Chapter 3, Statutes of 2008) 10% reduction of non-contract hospital inpatient payments;
- AB 1183 (Chapter 758, Statutes of 2008), the Budget Trailer Bill required additional rate reductions for non-contract hospitals; and
- AB 97 (Chapter 3, Statutes of 2011) imposed 10% reductions on those non-contract hospitals that were previously exempt.

SB 90 was effective on April 13, 2011, and is expected to be implemented in July 2011.

FY 2011-12	<u>TF</u>	<u>GF</u>
Fee for Service	\$ 94,377,000	\$47,188,500
Managed Care	\$ 66,037,000	\$33,018,500
Total	\$160,414,000	\$80,207,000

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 265
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1605

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage and are currently in the FFS program 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 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.

As a result, DPHs will reimburse the GF for the costs that are built into the managed care capitation rates that would not have been incurred had the SPDs remained in FFS.

Annual reimbursement is estimated to be \$150.3 million. Because the SPD enrollment transition will be phased-in beginning June 1, 2011, the initial GF reimbursement for the period June 1, 2011 through June 30, 2012 will be \$93,959,000, and will occur in FY 2011-12.

FY 2011-12	
Reimbursement from DPHs	\$93,959,000
GF	<u>-\$93,959,000</u>
Net Impact	\$0

ONE YEAR LOCK-IN FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 266
 IMPLEMENTATION DATE: 10/2011
 ANALYST: Calah Frazier
 FISCAL REFERENCE NUMBER: 1606

	FY 2010-11	FY 2011-12
FULL YEAR COST - TOTAL FUNDS	\$0	-\$5,300,000
- STATE FUNDS	\$0	-\$2,650,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$5,300,000
STATE FUNDS	\$0	-\$2,650,000
FEDERAL FUNDS	\$0	-\$2,650,000

DESCRIPTION

The Department will propose legislation to change the managed care enrollment policy to only allow managed care enrollees in Two-Plan and Geographic Managed Care counties to switch plans once a year. New beneficiaries will have a 60-day period from their initial enrollment date to switch plans after which they will be locked in for the balance of the one-year period.

Currently, managed care enrollees may switch plans monthly. Managed care plans are required to perform a health assessment each time a new beneficiary enrolls in their plan. By limiting the frequency of plan enrollment to once per year and requiring plans to share health records with other managed care plans for beneficiaries choosing to switch plans, costs associated with the health assessment will be reduced.

Every beneficiary affected by this policy will receive an annual notification letter on or before their one-year anniversary date. Beneficiaries choosing to switch plans will then receive an annual informing packet. These costs are budgeted under the Fiscal Intermediary/Health Care Options.

FY 2011-12	TF	GF
Benefit Savings	-\$5,300,000	-\$2,650,000
Mailing Costs	\$2,000,000	\$1,000,000
Net Impact	-\$3,300,000	-\$1,650,000

SB 90 PRESERVING CONTRACT HOSPITALS

REGULAR POLICY CHANGE NUMBER: 267
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Marc Lowry
 FISCAL REFERENCE NUMBER: 1607

	<u>FY 2010-11</u>	<u>FY 2011-12</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$81,320,000
- STATE FUNDS	\$0	-\$40,660,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$81,320,000
STATE FUNDS	\$0	-\$40,660,000
FEDERAL FUNDS	\$0	-\$40,660,000

DESCRIPTION

SB 90 (Chapter 19, Statutes of 2011) includes a provision that requires the amount of any Quality Assurance Fee supplemental payment for a contract hospital that converts to non-contract status be reduced by the amount by which that hospital's overall payment for services for Medi-Cal patients during the program period was increased by reason of it becoming a noncontract hospital. This provision will negate any financial benefit from a contract hospital converting to non-contract status. The California Medical Assistance Commission concludes that this provision will provide them with increased leverage in negotiations with hospitals to reduce the expected rate of growth in the program, resulting in savings of \$81.3 million (\$40.7 million GF) in FY 2011-12.