SB 90 NON-CONTRACT HOSPITAL RATE & PAYMENT CHANGES

REGULAR POLICY CHANGE NUMBER: 74
IMPLEMENTATION DATE: 5/2011
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1604

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$94,377,000	$102,948,000
- STATE FUNDS	$47,188,500	$51,474,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	89.71 %	92.60 %
APPLIED TO BASE		
TOTAL FUNDS	$9,711,400	$7,618,200
STATE FUNDS	$4,855,700	$3,809,080
FEDERAL FUNDS	$4,855,700	$3,809,080

DESCRIPTION

Purpose:
This policy change estimates the costs due to the repeal of rate reductions for non-contract hospital inpatient services.

Authority:
SB 90 (Chapter 19, Statutes of 2011)

Background:
SB 90 repealed a number of rate and payment reductions for non-contract hospital inpatient services.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 the inpatient services of certain non-contract hospitals and exempted the inpatient services of non-contract Small and Rural Hospitals from the 10% payment reduction; and,
- ABX4 5 (Chapter 5, Statutes of 2009) 10% payment of certain non-contract Small and Rural Hospital inpatient services.

Reason for Change from Prior Estimate:
Costs for managed care plans were incorporated into FY 2011-12 managed care rates.

Methodology:
1. SB 90 was implemented in May 2011, retroactive to April 13, 2011.

2. The costs related to SB 90 repeal of rate reductions for managed care plans were incorporated into the FY 2011-12 managed care rates and budgeted in the each of the managed care plan policy changes.

SB 90 NON-CONTRACT HOSPITAL RATE & PAYMENT CHANGES

REGULAR POLICY CHANGE NUMBER: 74

FY 2011-12	TF	GF
Fee for Service (Lagged)	**$ 94,377,000**	**$47,188,500**
Managed Care	$ 66,037,000	$33,018,500
Total	$160,414,000	$80,207,000
FY 2012-13 and Annual		
Fee for Service	**$ 102,948,000**	**$51,474,000**
Managed Care	$ 62,995,000	$31,497,500
Total	$ 165,943,000	$82,971,500

Funding:

Title XIX 50/50 FFP (4260-101-0001/0890)

NF-B RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 75
IMPLEMENTATION DATE: 8/2011
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1021

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$53,494,000	$101,472,000
- STATE FUNDS	$26,747,000	$50,736,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$53,494,000	$101,472,000
STATE FUNDS	$26,747,000	$50,736,000
FEDERAL FUNDS	$26,747,000	$50,736,000

DESCRIPTION

Purpose:
This policy change estimates the cost of rate increases and rate add-ons for AB 1629 facilities.

Authority:
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)

Background:
AB 1629 requires 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 rural swing days. The Department collects QA fees from licensed NF-Bs as a means to enhance federal financial participation for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities. The sunset date of the fee program has been extended to July 31, 2013. The Department is proposing legislation to permanently extend the QA fee.

Reason for Change from Prior Estimate:
Estimates were updated to reflect changes in QA fee revenues in FY 2011-12 and FY 2012-13.

Methodology:
1. An overall rate increase up to 2.4% will be provided for the 2011-12 and 2012-13 rate years.

2. A rate increase of approximately 0.426% was provided to AB 1629 facilities in the 2011-12 rate year and a rate increase of 1.973% will be provided for the 2012-13 rate year. These rate adjustments are included in this policy change.

3. The rate increases of 0.426% in FY 2011-12 and 1.973% in FY 2012-13 increase the nursing facilities revenue upon which the QA fee is assessed resulting in increased QA fee collections. The increased QA fee collections allow for an additional rate increase to AB 1629 facilities. The separate rate adjustment funded by the QA fee increase is budgeted in the AB 1629 Rate Adjustments Due to QA Fee Increase policy change.

NF-B RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 75

4. 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. In order to implement the MDS 3.0 upgrade, the Department will reimburse facilities for the additional costs associated with formal staff training and increased data-entry workload, through a rate "add-on". The rate adjustment will be effective August 1, 2011. The rate increase for FY 2011-12 retroactive to October 1, 2010 will be $1.24, which includes additional start-up costs for IT and training related activities, and $0.51 for FY 2012-13.

5. Effective October 2009, the Occupation Safety and Health (Cal/OSHA) of the Department of Industrial Relations required all health care facilities to offer health care workers immunization from airborne diseases. In order to reimburse facilities for the costs associated with the mandate, facilities will receive a rate "add-on" effective August 1, 2011. The rate increase for FY 2011-12 retroactive to October 2009 will be $0.86, which includes additional start-up costs for IT and training related activities and $0.25 for FY 2012-13.

(In Thousands) FFS (lagged)	FY 2011-12	FY 2012-13
Rate Adjustment	$10,098	$59,711
Immunization Add-On	$11,440	$4,529
MDS Add-On	$16,494	$8,520
FFS Total	$38,032	$72,760
Managed Care	$15,462	$28,712
Total	**$53,494**	**$101,472**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER:	76
IMPLEMENTATION DATE:	8/2007
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1046

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$21,964,000	$53,267,000
- STATE FUNDS	$10,982,000	$26,633,500
PAYMENT LAG	0.8538	0.9260
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$18,752,900	$49,325,200
STATE FUNDS	$9,376,430	$24,662,620
FEDERAL FUNDS	$9,376,430	$24,662,620

DESCRIPTION

Purpose:
This policy change estimates the annual long-term care (LTC) rate adjustment for Nursing Facility-As (NF-A), Distinct Part Nursing Facility-Bs (DP/NF-Bs), Rural Swing Beds, Distinct Part (DP) Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, Intermediate Care Facility – Developmentally Disabled (ICF/DD), Intermediate Care Facility – Habilitative (ICF/DD-H), and Intermediate Care Facility – Nursing (ICF/DD-N) facilities. It also estimates the rate increases due to the assessment of Quality Assurance (QA) fees for ICF-DDs and Freestanding Pediatric Subacute facilities.

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)

Background:
Pursuant to the State Plan requirements, Medi-Cal rates for LTC facilities are adjusted after completion of an annual rate study.

ABX4 5 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 DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute facilities.

Effective June 1, 2011, AB 97 requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5. The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and is currently seeking approval to freeze Rural Swing Bed rates.

The Department elected to not implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on its access and utilization analyses. CMS has already approved the Department's request to not implement a rate freeze on DP Adult Subacute rates. The Department is

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 76

seeking approval to not freeze DP Pediatric Subacute rates.

Reason for Change from Prior Estimate:
The decrease in estimated costs was due to a lowered rate increase for DP Adult Subacute facilities in 2011-12 based on updated costs data and revised effective date of the Freestanding Pediatric Subacute QA fee program resulting in a shorter implementation period in FY 2011-12. Slight increases due to the addition of rate increases for DP Pediatric Subacute facilities and increase in add-on rates were not enough to offset the decrease.

Methodology:

1. No rate increase is assumed for NF-As, DP/NF-Bs, Rural Swing Beds, FS Pediatric Subacute, ICF/DD, ICF/DD-H and ICF/DD-N facilities during rate years 2011-12 and 2012-13.

2. However, DP Adult Subacute and DP Pediatric Subacute facilities will not be subject to any of the rate reductions that other Long Term Care facilities will be subjected to. The Department completed a “Monitoring Access to Medi-Cal Covered Services” study that determined reducing or freezing reimbursement rates for DP Adult Subacute and DP Pediatric Subacute facilities would negatively impact access to care. Therefore, the Department will be increasing reimbursement rates for these facility types under the “normal” rate setting process. It is estimated that the DP Adult Subacute facilities 2011-12 reimbursement rates may be increased by 3.96% and 2012-13 reimbursement rates may be increased by 7.08%. For DP Pediatric Subacute facilities, 2011-12 reimbursement rates may be increased by 4.61% and 2012-13 reimbursement rates may be increased by 4.25%.

3. ABX1 19 requires Freestanding Pediatric Subacute Care facilities to pay a QA fee beginning January 1, 2012. Effective October 1, 2011, the QA fee cap increased from 5.5% to 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.

4. 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 resulting in an add-on to the reimbursement rates for these facilities. The rate increase will be effective August 1, 2011. The rate increase for FY 2011-12 retroactive to October 1, 2010 will be $1.24 and $0.51 for FY 2012-13.

5. Effective October 2009, CalOSHA required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional cost will be effective August 1, 2011. The rate increase for FY 2011-12 retroactive to October 2009 will be $0.86 for the above-mentioned providers LTC providers, excluding ICF/DD-H and ICF/DD-N facilities, who will receive $1.55. For FY 2012-13, the add-on for the above-mentioned providers will be $0.25 excluding ICF/DD-H and ICF/DD-N facilities, who will receive $0.48.

6. The estimate 11-month impact of the August 1, 2011 rate increase for managed care plans in FY 2011-12 are not included in this policy change. They are included in each applicable managed care plan’s policy change. The estimated 11-month impact of the August 1, 2012 rate increase in FY 2012-13 for managed care plans is $5,970,000 and these costs are included in this policy change.

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(In Thousands)

Fee-for-Service	**FY 2011-12**	**FY 2012-13**
DP Adult Subacute Rate Increase 2011-12	$11,348	$12,380
DP Pediatric Subacute Rate Increase 2011-12	$923	$1,007
FS Pediatric Subacute QAF Rate Adjustment 2011-12	$2,239	$4,478
Immunization Add-On 2011-12	$5,144	$468
MDS Add-On 2011-12	$2,310	$210
DP Adult Subacute Rate Increase 2012-13		$21,113
DP Pediatric Subacute Rate Increase 2012-13		$891
FS Pediatric Subacute QAF Rate Adjustment 2012-13		$4,245
Immunization Add-On 2012-13		$1,555
MDS Add-On 2012-13		$950
Total FFS Cost	$21,964	$47,297
Managed care	$0	$5,970
Total Cost	**$21,964**	**$53,267**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 77
IMPLEMENTATION DATE: 8/2011
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1508

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$21,963,000	$74,049,000
- STATE FUNDS	$10,981,500	$37,024,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$21,963,000	$74,049,000
STATE FUNDS	$10,981,500	$37,024,500
FEDERAL FUNDS	$10,981,500	$37,024,500

DESCRIPTION

Purpose:
This policy change estimates the cost of the rate adjustments for freestanding skilled nursing facilities (NF-Bs) funded by the Quality Assurance Fee (QAF).

Authority:
AB 1629 (Chapter 875, Statutes of 2004)
ABX1 19 (Chapter 4, Statutes of 2011)

Background:
AB 1629 requires the Department to collect a Quality Assurance (QA) Fee from NF-Bs, including adult subacute days and excluding rural swing bed days. The Department collects QA fees from licensed NF-Bs as a means to enhance federal financial participation for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities. The sunset date has been extended to July 31, 2013. The Department is proposing legislation to permanently extend the fee.

To determine the QAF assessment, the Department uses two-year old data as the base revenues and applies growth and trending adjustments to project the actual revenues expected for the fiscal year. The incremental increase in the QAF revenues from year to year is used to adjust 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 effective October 1, 2011, is 6.0% of gross revenues. Changes in the amount of licensing and certification fees for NF-Bs assessed by the California Department of Public Health (CDPH) affect the amount of QAF that can be collected and remain within the federal safe harbor limit.

The rate year 2011-12 rate increase due to changes in the QAF is estimated to be 0.426%. A rate increase of 1.973% will be provided for the 2012-13 rate year. These rate increases are budgeted in the NF-B Rate Changes policy change.

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 77

Reason for Change from Prior Estimate:
Estimates were updated to reflect changes in QA fee revenues in FY 2011-12 and FY 2012-13.

Methodology:

1. The impact of the QAF-funded rate increase for rate year 2010-11 is now fully reflected in the Medi-Cal base estimate so is not included in this policy change.

2. The rate increase for rate year 2011-12 will be implemented in March 2012, retroactive to August 1, 2011.

3. The amounts shown are based upon the full year QAF increase, adjusted for an August 1 effective date and payment lags.

4. The General Fund amount shown here is equal to the QAF revenue deposited in the State's General Fund, on an accrual basis.

FY 2011-12

	TF	GF
FFS (lagged)	$15,381,000	$7,690,500
Managed care	$6,582,000	$3,291,000
Total:	**$21,963,000**	**$10,981,500**

FY 2012-13

	TF	GF
FFS (lagged)	$52,648,000	$26,324,000
Managed care	$21,401,000	$10,700,500
Total:	**$74,049,000**	**$37,024,500**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 78
IMPLEMENTATION DATE: 10/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 88

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$48,367,000	$13,885,000
- STATE FUNDS	$24,183,500	$6,942,500
PAYMENT LAG	0.9788	0.8946
% REFLECTED IN BASE	96.95 %	22.19 %
APPLIED TO BASE		
TOTAL FUNDS	$1,443,900	$9,665,200
STATE FUNDS	$721,960	$4,832,590
FEDERAL FUNDS	$721,960	$4,832,590

DESCRIPTION

Purpose:
This policy change estimates 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.

Authority:
Section 1833 of the Social Security Act

Background:
The Department implemented the PPS for FQHCs and RHCs included in the Benefits Improvement and Protection Act of 2000. Clinics have been given the choice of a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate adjustment is the percentage increase in the MEI and is effective October 1st of each year.

Reason for Change from Prior Estimate:
Updated data for the number of visits and dollars became available.

Methodology:
1. Estimated FY 2010-11 FQHC/RHC expenditures are $1,504,816,166. Estimated annual expenditures for FY 2011-12 are $1,576,525,175 and expenditures without the MEI increase are estimated to be $1,570,244,198. Estimated annual expenditures for FY 2012-13 are $1,694,776,118 and estimated expenditures without the MEI are $1,689,706,997.

2. Assume utilization will increase 11.7% per year based on the average percent increase of visits over the past three years.

3. The MEI increase effective October 1, 2010 is 1.2%.

4. The MEI increase effective October 1, 2011 is 0.4%.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 78

5. The MEI increase effective October 1, 2012 is estimated to be 0.6%. This is based on estimated sustainable growth rate and conversion factor for Medicare payments to physicians in 2012 from the Centers for Medicare & Medicaid Services.

6. For FY 2011-12, an estimated utilization increase of 9.20% is assumed on top of the average expenditures for FY 2010-11. A 0.4% increase of each month's expenditures from October 2011 through June 2012 is summed to find the MEI impact in FY 2011-12.

7. For FY 2012-13, an estimated utilization increase of 11.52% is assumed on top of the estimated average expenditures for FY 2011-12. An annualized 0.4% MEI for the October 2011 increase and nine months of the 0.6% MEI increase for October 2012 are summed to find the MEI impact in FY 2012-13.

FY 2011-12:	
2010 Increase	$43,657,000
2011 Increase	$4,711,000
	$48,367,000
FY 2012-13:	
2011 Increase:	$6,281,000
2012 Increase:	$7,604,000
	$13,885,000

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 79
IMPLEMENTATION DATE: 7/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1612

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$24,044,000
- STATE FUNDS	$0	$12,022,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$24,044,000
STATE FUNDS	$0	$12,022,000
FEDERAL FUNDS	$0	$12,022,000

DESCRIPTION

Purpose:
This policy change estimates the increase in payments and the offset of General Fund (GF) of the Medi-Cal reimbursement rate for emergency medical air transportation services.

Authority:
AB 2173 (Chapter 547, Statutes of 2010)
AB 215 (Chapter 392, Statutes of 2011)
Government Code, Section 76000.10

Background:
AB 2173 imposed an additional penalty of $4 upon every conviction involving a vehicle violation, except certain parking offenses, effective January 1, 2011. The bill requires the county treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Air Medical Transportation Act (EMATA) Fund.

AB 215 eliminated the county's administrative costs by allowing the counties to remit their collections to the State under an existing process established in current law. This change in remittance procedures increases the frequency of county remission of funds from quarterly to monthly.

After payment of the Department's administrative costs, 20% of the remaining EMATA funds will be used to offset the State's portion of the Medi-Cal reimbursement rate for emergency medical air transportation services. The remaining 80% of the fund will be matched with federal funds and used to augment the rate for medical emergency Medi-Cal air medical transportation services.

Upon federal approval, the Department will implement a two-phased approach to distribute EMATA funds to emergency air medical transportation providers. In the initial phase, the Department will provide supplemental payments for Medi-Cal air medical transportation services provided to Medi-Cal beneficiaries from January 6, 2012 to June 30, 2012. For the second phase, effective from July 1, 2012 to January 1, 2018, the Department will provide for annual rate augmentations to air medical transportation rates.

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 79

Reason for Change from Prior Estimate:
The change is due to revised penalty collections.

Methodology:

1. Assume $5,855,000 in annual collections of penalties was received based on actual collections in calendar year 2011. Twenty percent of this amount will be used to offset the FY 2011-12 GF costs of emergency air medical transportation services. This transaction, however, will occur in FY 2012-13.

   $5,855,000 x 20% = $1,171,000

2. The remaining 80 percent will be matched with federal funds and paid as supplemental payments in FY 2012-13 to fee-for-service air medical transportation providers.

   $5,855,000 - $1,171,000 = $4,684,000 x 2 = $9,368,000

3. Assume $10,396,000 in annual collections of penalties in calendar year 2012 based on collections received from June 30, 2011 to December 31, 2011. Twenty percent of this amount will be used to offset the FY 2012-13 GF costs of emergency air medical transportation services in FY 2012-13.

   $10,396,000 x 20% = $2,079,000

4. Beginning July 1, 2012 and each year thereafter until January 1, 2018, the rates for medical emergency Medi-Cal air medical transportation services will be augmented based on penalties collected from most vehicle violation convictions. Based on anticipated collections, the annual rate augmentation is expected to be $12,476,000 for FFS providers, and $4,158,000 to managed care providers.

   FFS: $12,476,000 annual rate augmentation x 0.8431 payment lag = $10,518,000 TF

   Managed Care: $4,158,000 annual rate augmentation

   $10,518,000 + $4,158,000 = $14,676,000 ($7,338,000 EMATA Fund)

(In Thousands)

FY 2012-13	TF	GF	FFP	EMATA
GF Offset	$0	-$3,250	$0	$3,250
Supp. Payment for FY 2011-12	$9,368	$0	$4,684	$4,684
Rate Augmentation	$14,676	$0	$7,338	7,338
Total:	**$24,044**	**-$3,250**	**$12,022**	**$15,272**

Funding:
Title XIX FFP (4260-101-0890)
Title XIX GF (4260-101-0001)
EMATA Fund (4260-101-3168)

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 80
IMPLEMENTATION DATE: 10/2006
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 96

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$5,681,000	$12,437,000
- STATE FUNDS	$2,840,500	$6,218,500
PAYMENT LAG	0.7727	0.8916
% REFLECTED IN BASE	74.95 %	36.50 %
APPLIED TO BASE		
TOTAL FUNDS	$1,099,600	$7,041,400
STATE FUNDS	$549,810	$3,520,700
FEDERAL FUNDS	$549,810	$3,520,700

DESCRIPTION

Purpose:
This policy change estimates the annual rate increase for hospice services and hospice room and board rates.

Authority:
Sections 1902(a)(13) and 1814(i)(1)(C)(ii) of the federal Social Security Act

Background:

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 rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

2. **Hospice Room and Board**
   The Department ties each hospice facility's room and board rate to 95% of the individual facility's affiliated nursing facility rate and included Intermediate Care Facility – Developmentally Disabled (ICF/DDs), Intermediate Care Facility – Habilitative (ICF/DD-Hs), & Intermediate Care Facility – Nursing (ICF/DD-Ns). This policy change assumes hospice room and board rates were increased with the adoption of AB 1629 (Chapter 875, Statutes of 2004) and its related State Plan Amendments. Annual increases are effective August 1st of each year.

Pursuant to ABX4 5 (Chapter 5, Statutes of 2009), hospice room and board rates were frozen to 2008-09 levels for rate years 2009-10 and 2010-11. AB 97 (Chapter 3, Statutes of 2011) allows the Department to decide whether to implement further rate freezes for long-term care facilities (LTCs), effective June 1, 2011. The Department removed the rate freeze for certain LTCs. Hospice room and board rates will increase based on the nursing facility rate increases.

Reason for Change from Prior Estimate:

- Estimate changes are due to the use of updated utilization data for hospice services and the addition of hospice room and board rate increases in FY 2011-12 and FY 2012-13.

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 80

- FY 2010-11 hospice service increases totaling $1.379 million are now fully reflected in the Medi-Cal base estimate and no longer included as FY 2011-12 costs.

Methodology:

1. Total actual expenditures for hospice services in FY 2010-11 were $67,943,000.

2. This policy change estimates the annual rate increases for hospice services effective October 1, 2011 and October 1, 2012.

3. The estimated weighted increase for hospice service rates is 2.93% in FY 2011-12 and 2.85% for FY 2012-13.

4. Effective June 1, 2011, AB 97 allows the Department to implement rate freezes at the 2008-09 levels for all LTCs other than Freestanding Skilled Nursing and Freestanding Adult Subacute Nursing Facilities.

   The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on Nursing Facility Level A and Distinct Part (DP) Nursing Facility Level B rates and is currently seeking approval to freeze Rural Swing Bed rates.

   The Department elected to not implement the rate freeze for all LTC facility types based on its access and utilization analyses. CMS has already approved the Department's request to not implement a rate freeze on DP Adult Subacute rates. The Department is seeking approval to not freeze DP Pediatric Subacute rates.

   Hospice room and board rates will continue at 95% of the facility rates, whether frozen or unfrozen.

5. The weighted increase for hospice room and board rates for FY 2011-12 and FY 2012-13 is estimated to be 4.27%.

	FY 2011-12	FY 2012-13
FY 2010-11 Hospice Services	(In Base)	(In Base)
FY 2011-12 Hospice Services	$1,537,000	$2,049,000
FY 2011-12 Room & Board	$4,144,000	$4,521,000
FY 2012-13 Hospice Services		$1,538,000
FY 2012-13 Room & Board		$4,329,000
TOTAL	**$5,681,000**	**$12,437,000**

Funding:

Title XIX 50/50 FFP (4260-101-0001/0890)

10% PYMT REDUCTION RESTORATION FOR AB 1629 FAC.

REGULAR POLICY CHANGE NUMBER: 81
IMPLEMENTATION DATE: 12/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1617

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$192,568,000
- STATE FUNDS	$0	$96,284,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$192,568,000
STATE FUNDS	$0	$96,284,000
FEDERAL FUNDS	$0	$96,284,000

DESCRIPTION

Purpose:
This policy change estimates the cost of a one-time payment to AB 1629 facilities to restore the 10% payment reduction for these facilities.

Authority:
ABX1 19 (Chapter 4, Statutes of 2011)

Background:
Under ABX1 19, the 10% payment reduction for AB 1629 facilities will end July 31, 2012. ABX1 19 requires the Department to:

- Provide a one-time supplemental payment in FY 2012-13 that is equivalent to the reduction applied from June 1, 2011, through July 31, 2012,
- Provide a rate increase of up to 2.4% in rate year 2012-13 if it is not provided in the 2011-12 rate year.
- Hold harmless in rate year 2012-13 any facility from rates that are less than the rates that were on file on May 31, 2011.

This policy change includes the impact of the one-time supplemental payment equivalent to the reduction applied for fee-for-service (FFS) and managed care providers.

Reason for Change from Prior Estimate:
Implementation of the payment reduction was delayed due to a Fiscal Intermediary backlog, which results in a lower amount needed to pay back the providers.

Methodology:
1. The annual amount of the reduction for AB 1629 facilities is estimated to be $310,522,000 for FFS providers and $89,061,000 for managed care providers, as shown in the 10% Payment Reduction for LTC Facilities policy change.

10% PYMT REDUCTION RESTORATION FOR AB 1629 FAC.

REGULAR POLICY CHANGE NUMBER: 81

2. Implementation of the 10% reduction began April 2012 for FFS resulting in three months of payment reductions.

3. The estimated cost of the one-time payment is $192,568,000 TF ($96,284,500 GF).

4. The supplemental payment is assumed to be made in December 2012.

5. The increase in revenues due to the one time payment will increase the amount of Quality Assurance (QA) fee collected. It is shown here for informational purposes, as the revenues are not part of the Medi-Cal budget.

   $192,568,000 increased payments - $11,554,000 more QA fee collection = $181,014,000 FY 2012-13 net costs

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

REGULAR POLICY CHANGE NUMBER: 82
IMPLEMENTATION DATE: 1/2011
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1563

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$46,643,000
- STATE FUNDS	$0	$23,321,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$46,643,000
STATE FUNDS	$0	$23,321,500
FEDERAL FUNDS	$0	$23,321,500

DESCRIPTION

Purpose:
This policy change estimates the transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund). Additionally, the policy change estimates the supplemental payments expected to be made to freestanding nursing facilities (NF-Bs) through the Special Fund in FY 2012-13.

Authority:
SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code, section 14126.022

Background:
SB 853 implemented a quality and accountability payments program for NF-Bs. Supplemental payments will begin in rate year 2012-13 and will be paid through the 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, and the savings achieved from setting the professional liability insurance cost category at the 75th percentile. On an ongoing basis, there will be no net impact to the 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. The California Department of Public Health (CDPH) administrative costs will be reimbursed from the Special Fund by the Department.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. Administrative costs as well as supplemental payments are eligible for an FFP match.

2. In FY 2011-12 $4,250,000 and in FY 2012-13 $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.

QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

REGULAR POLICY CHANGE NUMBER: 82

3. In FY 2011-12 and FY 2012-13, $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.

4. In FY 2012-13, supplemental payments are estimated to be $46,643,000 TF ($23,321,500 Special Fund).

(In Thousands)	FY 2011-12		FY 2012-13	
	TF	SF	TF	SF
Supplemental Payments	$0	$0	$46,643	$23,322
Transfer from GF *	$0	$4,250	$0	$24,750
Transfer to Special Fund**	$0	($4,250)	$0	($24,750)
Total:	**$0**	**$0**	**$46,643**	**$23,322**

Funding:
100% General Fund (4260-605-0001)*
SNF Quality & Accountability (less funded by GF) (4260-698-3167)**
SNF Quality & Accountability (4260-605-3167)
Title XIX FFP (4260-101-0890)

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER:	83
IMPLEMENTATION DATE:	7/2011
ANALYST:	Randolph Alarcio
FISCAL REFERENCE NUMBER:	1185

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$9,644,000	-$9,107,000
- STATE FUNDS	-$4,822,000	-$4,553,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$9,644,000	-$9,107,000
STATE FUNDS	-$4,822,000	-$4,553,500
FEDERAL FUNDS	-$4,822,000	-$4,553,500

DESCRIPTION

Purpose:
This policy change budgets the retroactive adjustments to dental managed care rates impacting fiscal years prior to FY 2011-12.

Authority:
Welfare and Institutions (W&I) Code, section 14301(a)

Background:
Section 14301(a) of W&I Code authorizes the Department to determine the rates of payment annually for services provided for Medi-Cal beneficiaries enrolled in a prepaid health plan and to implement the new annual rates through an amendment to the contract.

In the event there is any delay in a determination of rate changes, the amendment may not be processed in time to permit payment of new rates commencing July 1. The payment to contractors shall continue at the current rates. Those continued payments shall constitute interim payments only. Upon final approval of the revised rates, the Department shall make retroactive adjustments for those months for which interim payments were made.

Reason for Change from Prior Estimate:
The total retroactive adjustments increase due to updated eligible months. Because of delay on internal accounting processes, the retroactive adjustments are expected to complete in FY 2012-13.

Methodology:
1. Sacramento Geographic Managed Care (GMC) dental rates have changes that are retroactive to July 2009. The prior rate of $10.51 for all eligibles has changed to $10.91 for those under 21 years of age 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. Prepaid Health Plan (PHP) dental rates have changes that are retroactive to July 2009. The prior

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 83

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. The Program of All-Inclusive Care for the Elderly (PACE) retroactive rate adjustments are reflected in the PACE (Other M/C) policy change.

4. The Senior Care Action Network (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. All retroactive adjustments for the period of July 2009 through December 2009 were made in FY 2011-12.

7. It is assumed that retroactive adjustments for the period of January 2010 through February 2011 will be completed in FY 2012-13.

FY 2011-12	**TF**	**GF**
July – Dec 09	$5,973,000	$2,986,500
Jan 10 – Feb 11	$3,671,000	$1,835,500
Total	**$9,644,000**	**$4,822,000**
FY 2012-13	**$9,107,000**	**$4,553,500**

		Existing Rate	New Rate	Change	Eligible Months	Dental Retro Rate Adjustment
GMC	July-Dec. 2009					
	<21	$10.51	$10.91	$0.40	753,844	$301,538
	21+	$10.51	$2.52	($7.99)	402,009	($3,212,052)
	January-Dec. 2010					
	<21	$10.51	$11.16	$0.65	1,578,868	$1,026,264
	21+	$10.51	$2.58	($7.93)	847,539	($6,720,984)
	January-Feb. 2011					
	<21	$10.51	$11.83	$1.32	269,251	$355,411
	21+	$10.51	$2.91	($7.60)	145,047	($1,102,357)
PHP	July-Dec. 2009					
	<21	$10.51	$10.91	$0.40	1,160,905	$464,362
	21+	$10.51	$2.52	($7.99)	441,380	($3,526,626)
	January-Dec. 2010					
	<21	$10.51	$11.16	$0.65	2,539,055	$1,650,386
	21+	$10.51	$2.58	($7.93)	922,945	($7,318,954)
	January-Feb. 2011					
	<21	$10.51	$11.83	$1.32	443,479	$585,392
	21+	$10.51	$2.91	($7.60)	164,916	($1,253,362)
Total Dental Retroactive Adjustments						**($18,751,000)**

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 83

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

SB 90 PRESERVING CONTRACT HOSPITALS

REGULAR POLICY CHANGE NUMBER:	84
IMPLEMENTATION DATE:	7/2011
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1607

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$34,974,000	-$34,974,000
- STATE FUNDS	-$17,487,000	-$17,487,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	79.46 %	69.74 %
APPLIED TO BASE		
TOTAL FUNDS	-$7,183,700	-$10,583,100
STATE FUNDS	-$3,591,830	-$5,291,570
FEDERAL FUNDS	-$3,591,830	-$5,291,570

DESCRIPTION

Purpose:
This policy change estimates the savings from expected lower rates of growth in contract hospital negotiated rates.

Authority:
SB 90 (Chapter 19, Statutes of 2011)

Background:
SB 90 included a provision that required the amount of any Quality Assurance Fee supplemental payment for a contract hospital that converts to noncontract 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 noncontract status.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
This provision provided the California Medical Assistance Commission (CMAC) with increased leverage in negotiations with hospitals to reduce the expected rate of growth in the Selective Provider Contracting Program (SPCP). Based on additional data, CMAC estimates a savings of $34.974 million TF ($17.487 million GF) in FY 2011-12 from the lowered rate of growth in contract hospital negotiated rates.

(In Thousands)	GF	FF	TF
FY 2011-12 & FY 2012-13	($17,487)	($17,487)	($34,974)
Total	**($17,487)**	**($17,487)**	**($34,974)**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER:	85
IMPLEMENTATION DATE:	9/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1505

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	-$42,310,000
- STATE FUNDS	$0	-$21,155,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	-$42,310,000
STATE FUNDS	$0	-$21,155,000
FEDERAL FUNDS	$0	-$21,155,000

DESCRIPTION

Purpose:
This policy change estimates the savings due to the implementation of a reduction to radiology rates.

Authority:
SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code, section 14105.08

Background:
SB 853 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.

Reason for Change from Prior Estimate:
The change is due to updated data, retroactive savings spread over 44 months, and delay in implementation due to inadequate staffing and other workload priorities.

Methodology:
1. Implementation will begin in September 2012.

2. Rate reductions will be retroactive to October 1, 2010.

3. The rate reductions will apply to radiology services that are paid at reimbursement rates exceeding 80 percent of Medicare rates.

4. Based on 2010 Medi-Cal payment rate data, the rate reductions will result in an annual fee-for-service savings of $40,570,000. The 2010 Medi-Cal payment rate includes a 1% reduction to radiology services as required by AB 1183 (Chapter 758, Statutes of 2008).

5. 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.

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 85

6. The total recoupment of retroactive savings from October 1, 2010 to August 31, 2012 is estimated to be $77,759,000 and expected to occur over 44 months, beginning in October 2012.

Total recoupment of retroactive savings:
$40,570,000 /12 months * 23 months = $77,759,000
Monthly recoupment amount:
$77,759,000/44 months = $1,767,000

FY 2012-13	TF	GF
FY 2012-13 Savings (lagged)	$26,425,000	$13,212,500
Recoupment of Retro Savings	$15,885,000	$7,942,500
Total	**$42,310,000**	**$21,155,000**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER:	86
IMPLEMENTATION DATE:	2/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1597

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$77,205,000	-$76,878,000
- STATE FUNDS	-$38,602,500	-$38,439,000
PAYMENT LAG	0.8759	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$67,623,900	-$76,878,000
STATE FUNDS	-$33,811,930	-$38,439,000
FEDERAL FUNDS	-$33,811,930	-$38,439,000

DESCRIPTION

Purpose:
This policy change estimates the savings to non-AB 1629 long-term care (LTC) facilities due to the rate being frozen at 2008-09 levels for Distinct Part/Nursing Facility-Level B (DP/NF-B) and Rural Swing Bed providers.

DP Adult Subacute and DP Pediatric Subacute facilities will not be subject to the rate freeze.

Nursing Facility-Level A (NF-A), Freestanding Pediatric Subacute providers, Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (H) and ICF/DD-Nursing (N) provider rates are currently reimbursed at the 2008-09 rate levels and are not impacted by this policy.

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)
AB 97 (Chapter 3, Statutes of 2011)

Background:
Effective August 1 of each year, LTC rates are re-determined annually for the following facility types: NF-A, DP/NF-B, Rural Swing Bed, DP Adult Subacute, DP Pediatric Subacute, Freestanding Pediatric Subacute, and ICF-DD/H/N.

ABX4 5 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-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute providers, effective February 25, 2010.

Effective June 1, 2011, AB 97 requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5. The Department received approval from the Centers of Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and is currently seeking approval to freeze Rural Swing Bed rates.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 86

The Department elected to not implement the rate freeze for DP Adult Subacute and DP Pediatric Subacute facilities based on its access and utilization analyses. CMS has already approved the Department's request to not implement a rate freeze on DP Adult Subacute rates. The Department is seeking approval to not freeze DP Pediatric Subacute rate.

Reason for Change from Prior Estimate:
Decreased savings due to the exclusion of DP Adult and Pediatric Subacute facilities from the rate freeze.

Methodology:
1. Assume the rate freeze will begin June 1, 2011.

2. For DP/NF-Bs, the rate freeze will be implemented based on dates of service. For dates of services from 06/01/11 to 12/27/11, the Department will only implement the rate freeze to those DP/NF-Bs that have not been reimbursed prior to 12/28/11. For dates of service 12/28/11 and forward, the rate freeze will be implemented for all payments due to facilities after 12/28/11.

3. Rates are currently being paid at the 2010-11 level.

4. The same number of Medi-Cal days is assumed for FY 2011-12 and FY 2012-13, based on the FY 2009-10 rate study, as historically growth has been insignificant.

5. Savings due to the rate freeze is estimated to be:

(In Thousands)	**FY 2011-12**	**FY 2012-13**
Rate Freeze	**$77,205**	**$76,878**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER:	87
IMPLEMENTATION DATE:	4/2012
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1579

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$171,860,000	-$145,719,000
- STATE FUNDS	-$85,930,000	-$72,859,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$171,860,000	-$145,719,000
STATE FUNDS	-$85,930,000	-$72,859,500
FEDERAL FUNDS	-$85,930,000	-$72,859,500

DESCRIPTION

Purpose:
This policy change estimates the savings achieved, up to 10%, due to the implementation of provider payment reductions to nursing and subacute facilities reimbursed under AB 1629 (Chapter 875, Statutes of 2004) reimbursement methodology, Nursing Facility - A (NF-A), Distinct Part Nursing Facility - B (DP/NF-B), Freestanding Adult Subacute, Freestanding Pediatric Subacute, Intermediate Care Facility for the Developmentally Disabled (ICF/DD), ICF/DD - Nursing (N), and ICF/DD - Habilitative (H) providers based on AB 97 (Chapter 3, Statutes of 2011).

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)
ABX1 19 (Chapter 4, Statutes of 2011)

Background:
Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider 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%.

Effective June 1, 2011, AB 97 required the Department to reduce payments to long-term care facilities by up to 10% in FFS and the actuarial equivalent of that amount in managed care. However, ABX1 19 required the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% of rate year 2008-09 rates. Additionally, under ABX1 19, the 10% payment reduction for AB 1629 facilities will end July 31, 2012. A one-time supplemental payment will be made December 2012 to restore the reductions in FY 2011-12. For details on the supplemental payment, see the 10% Pymt Reduction Restoration for AB 1629 Fac. policy change.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 87

For the impact of court actions related to the implementation of AB 97, see the AB 97 Injunctions policy change.

Reason for Change from Prior Estimate:
Estimate changes due to updated FFS and managed care data, delay in implementation of payment reductions to AB 1629 facilities, and the recoupment of retroactive savings for certain LTCs in FY 2012-13.

Methodology:

1. Assume savings will be phased in beginning on April 1, 2012, and will be retroactive to June 1, 2011 for FFS providers and July 1, 2011 for managed care providers.

2. Assume Erroneous Payment Corrections (EPC) to recoup savings retroactive to June 1, 2011 will be implemented over several months beginning July 2012.

3. Assume that the recoupment process will take an average of 24 months to complete once EPCs are implemented. It is estimated that the Department will recoup retroactive savings of $13,285,000 in FY 2012-13.

4. For ICF/DDs, AB 1629, and Freestanding Pediatric Subacute facilities, the decrease in General Fund (GF) revenues due to the decrease in the amount of Quality Assurance (QA) fee collected is shown here for informational purposes, as the revenues are not part of the Medi-Cal budget.

   $134,619,000 reduced payments - $8,077,000 less QA fee collection = $126,542,000 FY 2011-12 net savings

   $106,414,000 reduced payments - $6,385,000 less QA fee collection = $100,029,000 FY 2012-13 net savings

Lagged Savings	**FY 2011-12**	**FY 2012-13**	**Annual**
ICF-DD	($0)	($31,980,000)	($38,123,000)
AB 1629 Facilities	($45,226,000)	($58,281,000)	($0)
Non AB 1629 Facilities	($36,682,000)	($41,282,000)	($41,987,000)
Managed Care	($89,952,000)	($891,000)	($891,000)
Retro savings	($0)	($13,285,000)	N/A
Total	**($171,860,000)**	**($145,719,000)**	**($81,001,000)**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER:	88
IMPLEMENTATION DATE:	12/2011
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1580

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	-$705,373,000	-$764,182,000
- STATE FUNDS	-$352,686,500	-$382,091,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-$705,373,000	-$764,182,000
STATE FUNDS	-$352,686,500	-$382,091,000
FEDERAL FUNDS	-$352,686,500	-$382,091,000

DESCRIPTION

Purpose:
This policy changes estimates the savings due to the implementation of up to a 10% provider payment reduction.

Authority:
AB 1183 (Chapter 758, Statutes of 2008)
AB 97 (Chapter 3, Statutes of 2011)

Background:
AB 97 requires the Department to implement a 10% provider payment reduction, which will affect all services except hospital inpatient and outpatient services, critical access hospital, federal rural referral centers and FQHCs/RHCs, services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (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.

Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and fee-for-service (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 retroactive to July 1, 2011.

For the impact of court actions related to the implementation of AB 97, see the AB 97 Injunctions policy change.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 88

Reason for Change from Prior Estimate:
Estimate changes due to updated FFS and managed care data and recoupment of retroactive savings for certain providers in FY 2011-12 and FY 2012-13.

Methodology:
1. Assume implementation of the payment reductions will be phased in beginning December 2011.

2. Assume Erroneous Payment Corrections (EPC) to recoup FFS savings retroactive to June 1, 2011 will be implemented over several months beginning May 2012.

3. Assume that the recoupment process will take an average of 24 months to complete once EPCs are implemented. It is estimated that the Department will recoup retroactive savings of $1,962,000 in FY 2011-12 and $13,201,000 in FY 2012-13.

(In Thousands)

Lagged Savings	**FY 2011-12**	**FY 2012-13**	**Annual**
FFS	($485,339)	($532,909)	($534,262)
Managed Care	($218,072)	($218,072)	($218,072)
Retro savings	($1,962)	($13,201)	N/A
Total	**($705,373)**	**($764,182)**	($752,334)

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 89
IMPLEMENTATION DATE: 7/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1073

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$1,751,299,000	$1,719,634,000
- STATE FUNDS	$582,851,500	$596,991,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,751,299,000	$1,719,634,000
STATE FUNDS	$582,851,500	$596,991,000
FEDERAL FUNDS	$1,168,447,500	$1,122,643,000

DESCRIPTION

Purpose:
This policy change estimates the payments to Disproportionate Share Hospitals (DSHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code, sections 14166.6 and 14166.16
Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The 2011-12 and 2012-13 DSH allotments are estimated to be $1,122,651,686.

- 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 Omnibus Budget Reconciliation Act (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 (GF) each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the $160.00.

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 89

The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010.

The 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.

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

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

(In Thousands)

FY 2011-12	**TF**	**GF****	**FF**	**IGT***
DSH 2009-10	$776	$388	$388	$0
DSH 2010-11	$174,364	$1,330	$139,057	$33,977
DSH 2011-12	$1,576,159	$8,614	$1,029,003	$538,542
	$1,751,299	**$10,332**	**$1,168,448**	**$572,519**
FY 2012-13				
DSH 2011-12	$143,287	$783	$93,546	$48,958
DSH 2012-13	$1,576,347	$8,708	$1,029,097	$538,542
	$1,719,634	**$9,491**	**$1,122,643**	**$587,500**

Funding:
Demonstration DSH Fund (4260-601-7502)
MIPA Fund (4260-606-0834)*
Title XIX 50/50 GF/DSH (4260-101-0001/7502)**
Title XIX 100% FFP (4260-101-0890)

BTR—DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER:	90
IMPLEMENTATION DATE:	3/2011
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1570

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$975,000,000	$1,375,000,000
- STATE FUNDS	$487,500,000	$687,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$975,000,000	$1,375,000,000
STATE FUNDS	$487,500,000	$687,500,000
FEDERAL FUNDS	$487,500,000	$687,500,000

DESCRIPTION

Purpose:
This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the 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.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare and Institutions Code, section 14166.77
California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR)

Background:
The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010. The BTR establishes the DSRIP. AB 1066 provides the authority for the Department to implement the new payment methodologies under the BTR to determine DSRIP payments to public hospitals.

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 in Care

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 IGTs.

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:

BTR—DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 90

(In Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	$ 1,006,880	$ 591,601
2011-12	$ 1,300,000	$ 650,000
2012-13	$ 1,400,000	$ 700,000

Reason for Change from Prior Estimate:
There is no material change.

Methodology:

1. For DY 2010-11, all payments were 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.

2. DSRIP payments are estimated to be:

(In Thousands)

		TF	FF	IGT
FY 2011-12				
	DY 2011-12	**$975,000**	**$487,500**	**$487,500**
FY 2012-13				
	DY 2011-12	$325,000	$162,500	$162,500
	DY 2012-13	$1,050,000	$525,000	$525,000
		$1,375,000	**$687,500**	**$687,500**

Funding:
DSRIP IGT (4260-601-3172)
Title XIX FFP (4260-101-0890)

BTR—LOW INCOME HEALTH PROGRAM - MCE

REGULAR POLICY CHANGE NUMBER: 91
IMPLEMENTATION DATE: 7/2011
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1578

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$225,294,000	$2,325,678,000
- STATE FUNDS	$21,500,000	$581,864,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$225,294,000	$2,325,678,000
STATE FUNDS	$21,500,000	$581,864,000
FEDERAL FUNDS	$203,794,000	$1,743,814,000

DESCRIPTION

Purpose:
This policy change budgets the federal funds for the Medicaid Coverage Expansion (MCE) component of the Low Income Health Program (LIHP) under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
Section 1115(a) Medicaid Demonstration

Background:
The LIHP is effective November 1, 2010, through December 31, 2013, under the BTR and 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 are statewide. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (CI) which expired on August 31, 2010, and was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

Local government CPEs and IGTs are used to obtain the federal funding for the LIHP. The Department has used the CI cost claiming protocol for the MH/UCD as the basis for the new cost claiming protocol submitted to the Centers for Medicare and Medicaid Services (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.

Reason for Change from Prior Estimate:
The interim payment amounts were adjusted from the prior estimate to align with total projected costs.

BTR—LOW INCOME HEALTH PROGRAM - MCE

REGULAR POLICY CHANGE NUMBER: 91

Methodology:

1. 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 $13,900,000 in FY 2011-12 due to ARRA is budgeted in this policy change.

The estimated MCE payments on a cash basis are:

FY 2011-12		TF	FFP	IGT	ARRA
	2010-11	$180,294,000	$ 152,541,000	$ 0	$ 27,753,000
	2011-12	$ 45,000,000	$ 23,500,000	$ 21,500,000	$ 0
Total		**$225,294,000**	**$ 176,041,000**	**$ 21,500,000**	**$ 27,753,000**
FY 2012-13					
	2011-12	$ 592,295,000	$ 453,384,000	$138,911,000	$ 0
	2012-13	$1,733,383,000	$1,290,430,000	$442,953,000	$ 0
Total		**$2,325,678,000**	**$1,743,814,000**	**$581,864,000**	$ 0

Funding:

LIHP IGT Fund (4260-607-8502)
Title XIX FFP (4260-101-0890)

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 92
IMPLEMENTATION DATE: 11/2010
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1573

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$565,513,000	$390,166,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$565,513,000	$390,166,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$565,513,000	$390,166,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) for uncompensated care provided to individuals with no source of third party coverage for the services they receive.

Authority:
AB 1066 (Chapter 86, Statutes of 2011), Welfare and Institutions Code, section 14166.71
California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR)

Background:
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 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 estimates 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 Federal Medical Assistance Percentage (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 $78,671,000 for the DY 2010-11 payments and this is included in this policy change.

Reason for Change from Prior Estimate:
There is no change.

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 92

Methodology:
The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(In Thousands) Demonstration Year	State-Only Funded Programs	Due to DPHs
2010-11	$400,000	$565,422
2011-12	$400,000	$436,000
2012-13	$400,000	$386,000

The estimated payments to the DPHs on a cash basis are:

(In Thousands) Demonstration Year	FY 2011-12	FY 2012-13
2010-11	$165,846	
2011-12	$399,667	$36,333
2012-13		$353,833
Total	**$565,513**	**$390,166**

Funding:
Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 93
IMPLEMENTATION DATE: 7/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1071

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$384,035,000	$477,937,000
- STATE FUNDS	$192,017,500	$238,968,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$384,035,000	$477,937,000
STATE FUNDS	$192,017,500	$238,968,500
FEDERAL FUNDS	$192,017,500	$238,968,500

DESCRIPTION

Purpose:
This policy change estimates the funds for the private hospital Disproportionate Share Hospital (DSH) replacement payments.

Authority:
SB 1100 (Chapter 560, Statutes of 2005)
Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The payments are determined using the formulas and methodology that were previously 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.

Reason for Change from Prior Estimate:
The changes are due to additional actual payments.

Methodology:
1. SB 90 (Chapter 19, Statutes of 2011) reduces Medi-Cal DSH replacement payments to private hospitals by $60 million total fund (TF) ($30 million general fund (GF)) in FY 2010-11 and $150 million TF ($75 million GF) in FY 2011-12.

2. SB 335 (Chapter 286, Statutes of 2011) reduces Medi-Cal DSH replacement payments to private hospitals by $21 million TF ($10.5 million GF) in FY 2012-13 and $10.5 million TF ($5.25 million GF) in FY 2013-14.

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 93

3. 1.5 months of 2010-11 payments are assumed to be paid in FY 2011-12. The prorated FY 2010-11 SB 90 reductions, based on this payment, is $7,449,000 TF ($3,724,500 GF).

4. 11 months of 2011-12 payments are assumed to be paid in FY 2011-12 and one month is assumed to be paid in FY 2012-13. The prorated FY 2011-12 SB 90 reductions, based on these payments, are $137,500,000 TF ($68,750,000 GF) in FY 2011-12 and $12,500,000 TF ($6,250,000 GF) in FY 2012-13.

5. 11 months of 2012-13 payments are assumed to be paid in FY 2012-13 and one month is assumed to be paid in FY 2013-14. The prorated FY 2012-13 SB 335 reductions, based on these payments, are $19,250,000 TF ($9,625,000 GF) in FY 2012-13 and $1,750,000 TF ($875,000 GF) in FY 2013-14.

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

	TF	GF	FFP
2009-10	$12,000	$6,000	$6,000
2010-11	$61,759,000	$30,879,500	$30,879,500
SB 90	($7,449,000)	($3,724,500)	($3,724,500)
Net	$54,310,000	$27,155,000	$27,155,000
2011-12	$467,213,000	$233,606,500	$233,606,500
SB 90	($137,500,000)	($68,750,000)	($68,750,000)
Net	$329,713,000	$164,856,500	$164,856,500
Total FY 2011-12	**$384,035,000**	**$192,017,500**	**$192,017,500**
2011-12	$42,474,000	$21,237,000	$21,237,000
SB 90	($12,500,000)	($6,250,000)	($6,250,000)
Net	$29,974,000	$14,987,000	$14,987,000
2012-13	$467,213,000	$233,606,500	$233,606,500
SB 335	($19,250,000)	($9,625,000)	($9,625,000)
Net	$447,963,000	$223,981,500	$223,981,500
Total FY 2012-13	**$477,937,000**	**$238,968,500**	**$238,968,500**

Funding:
Title XIX 50/50 FFP (4260-101-001/0890)

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 94
IMPLEMENTATION DATE: 7/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1085

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$232,530,000	$302,844,000
- STATE FUNDS	$116,265,000	$151,422,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$232,530,000	$302,844,000
STATE FUNDS	$116,265,000	$151,422,000
FEDERAL FUNDS	$116,265,000	$151,422,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to private hospitals from the Private Hospital Supplemental Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code (W&I), section 14166.12
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (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 (Chapter 548, Statutes of 2007). 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 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 (CMAC).

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 94

Reason for Change from Prior Estimate:
The changes are due to:

- Revised estimate based on updated program expenditures,
- The delay of FY 2006-07 final reconciliation because of the complexity of hospital cost reports,
- FY 2005-06 and FY 2006-07 final stabilization payment will be paid out in FY 2012-13 to be consistent with GF savings budgeted in the Hospital Stabilization policy change.

Methodology:

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 in FY 2011-12 and $5,000,000 in FY 2012-13 and will generate $20,000,000 in FFP in FY 2011-12 and $5,000,000 in FFP in FY 2012-13. This includes the annual L.A. County IGT of $5,000,000 as specified in SB 474.

4. Stabilization funding for private hospitals is calculated based on the interim reconciliation and won't be paid out until the interim payout process is developed.

5. Distribution of the Private Hospital Supplemental Fund will be determined through negotiations with the CMAC. 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.

6. SB 87 (Chapter 33, Statutes of 2011) authorizes the transfer of $32,700,000 from the Private Hospital Supplemental Fund to the State General Fund in FY 2011-12.

7. SB 335 (Chapter 286, Statutes of 2011) reduces the Private Hospital Supplemental Fund by $17,500,000 in FY 2012-13 and $8,750,000 in FY 2013-14.

8. The Department is proposing the legislation to redirect the stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to GF. GF savings are budgeted in the Hospital Stabilization policy change.

9. The Department is proposing legislation that authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of CMAC under section 14165(b) of the W&I Code.

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 94

	TF	SF	FFP
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
Total	$337,432,000	$168,716,000	$168,716,000
Cash Expenditures in FY 2010-11	$201,620,000	$100,810,000	$100,810,000
FY 2010-11 Ending Balance	$135,812,000	$67,906,000	$67,906,000
FY 2011-12			
FY 2010-11 Ending Balance	$135,812,000	$67,906,000	$67,906,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
FY 2010-11 interest	$282,000	$141,000	$141,000
Est. 2005-06 Stabilization Transfer	$3,556,000	$1,778,000	$1,778,000
IGT	$40,000,000	$20,000,000	$20,000,000
Total	$416,450,000	$208,225,000	$208,225,000
Cash Expenditures to Hospitals	**$232,530,000**	**$116,265,000**	**$116,265,000**
Cash Expenditures to GF	$65,400,000	$32,700,000	$32,700,000
FY 2011-12 Ending Balance	$118,520,000	$59,260,000	$59,260,000
FY 2012-13			
FY 2011-12 Ending Balance	$118,520,000	$59,260,000	$59,260,000
Appropriation (from GF)	$236,800,000	$118,400,000	$118,400,000
Est. FY 2011-12 interest	$239,000	$119,500	$119,500
Est. 2006-07 Stabilization Transfer	$6,432,000	$3,216,000	$3,216,000
Est. 2008-09 Stabilization Transfer	$1,308,000	$654,000	$654,000
Est. 2010-11 Stabilization Transfer	$24,784,000	$12,392,000	$12,392,000
IGT	$10,000,000	$5,000,000	$5,000,000
Total	$398,083,000	$199,041,500	$199,041,500
Cash Expenditures to Hospitals	**$266,764,000**	**$133,382,000**	**$133,382,000**
Redirect Stabilization Fund to GF	**$36,080,000**	**$18,040,000**	**$18,040,000**
Cash Expenditures to GF	$35,000,000	$17,500,000	$17,500,000
FY 2012-13 Ending Balance	$60,239,000	$30,119,500	$30,119,500

Funding:

Private Hospital Supplemental Fund (4260-601-3097)
Title XIX FFP (4260-101-0890)

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 95
IMPLEMENTATION DATE: 11/2010
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1572

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$75,098,000	$301,431,000
- STATE FUNDS	$6,797,000	$78,370,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$75,098,000	$301,431,000
STATE FUNDS	$6,797,000	$78,370,000
FEDERAL FUNDS	$68,301,000	$223,061,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) of the Low Income Health Program (LIHP) under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
AB 342 (Chapter 723, Statutes of 2010)
AB 1066 (Chapter 86, Statutes of 2011)
Section 1115(a) Medicaid Demonstration (Waiver 11-W-00193/0)

Background:
The LIHP is effective November 1, 2010, through December 31, 2013, under the BTR and consists of two components, the Medicaid Coverage Expansion (MCE) and the 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 are statewide. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (CI) which expired on August 31, 2010, and was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

Local government certified public expenditures (CPEs) and intergovernmental transfers (IGTs) are used to obtain the federal funding for the LIHP. The Department has used the CI cost claiming protocol as the basis for the new cost claiming protocol submitted to the Centers for Medicare and Medicaid Services (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. Federal funding will be provided through the Health Care Support Fund (HCSF).

Reason for Change from Prior Estimate:
The interim payment amounts were adjusted from the prior estimate to align with total projected costs pursuant to the provisions of the Demonstration.

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 95

Methodology:

1. 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 $4,981,000 in FY 2011-12 due to ARRA is budgeted in this policy change.

The estimated HCCI payments on a cash basis are:

FY 2011-12	**TF**	**FFP**	**IGT**	**ARRA**
2010-11	$ 60,098,000	$ 50,847,000	$ 0	$ 9,251,000
2011-12	$ 15,000,000	$ 8,203,000	$ 6,797,000	$ 0
Total	**$ 75,098,000**	**$ 59,050,000**	**$ 6,797,000**	**$ 9,251,000**
FY 2012-13				
2011-12	$ 68,167,000	$ 53,412,000	$14,755,000	$ 0
2012-13	$233,264,000	$169,649,000	$63,615,000	$ 0
Total	**$301,431,000**	**$223,061,000**	**$78,370,000**	$ 0

Funding:

Health Care Support Fund (4260-601-7503)
LIHP IGT Fund (4260-607-8502)
Title XIX FFP (4260-101-0890)

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 96
IMPLEMENTATION DATE: 9/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1108

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$157,065,000	$71,004,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$157,065,000	$71,004,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$157,065,000	$71,004,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the California Children Services (CCS) Program and Genetically Handicapped Persons Program (GHPP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code, section 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the CCS and GHPP from the Safety Net Care Pool (SNCP) 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.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the BTR allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The CCS and GHPP programs are included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

Reason for Change from Prior Estimate:
The changes are due to the result of the final reconciliation for Demonstration Year (DY) 2008-09 and revised estimates based on updated program expenditures.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 96

Methodology:

1. 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 GF savings created will be used to support safety net hospitals under the MH/UCD and BTR.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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 August 31, 2010, resulting in additional $423.769 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.

3. In January 2012, the final reconciliations for CCS and GHPP for DY 2008-09 resulted in an overpayment of $12.533 million. The Department will conduct the final reconciliations for DY 2009-10 in FY 2012-13 and estimate that the Department will have to repay the federal government $15.967 million in FY 2012-13 as a result of the final reconciliations. The CCS and GHPP federal reimbursements are reduced by the final reconciliation amounts in this policy change.

4. Of the total DY 2008-09 final reconciliation of $13,436,000 for CCS, the regular FMAP amount is $11,993,000 and $1,443,000 is the ARRA amount in FY 2011-12. Of the total DY 2009-10 final reconciliation of $11,372,000, the regular FMAP amount is $10,796,000 and $576,000 is the ARRA amount in FY 2012-13.

5. Of the total DY 2008-09 final reconciliation of $903,000 for GHPP, the regular FMAP amount is $587,000 and $316,000 is the ARRA amount in FY 2011-12. Of the total DY 2009-10 final reconciliation $4,595,000 for GHPP, the regular FMAP amount is $3,993,000 and $602,000 is the ARRA amount in FY 2012-13.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 96

The estimated CCS/GHPP federal reimbursements are:

	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	$ 21,336,000	$ 42,294,000
FY 2009-10	$114,023,000	$ 41,073,000	$155,096,000
FY 2010-11	$ 59,959,000	$ 25,613,000	$ 85,572,000
FY 2011-12			
DSHP-BTR (DY 2010-11)	$ 56,158,000	$ 26,469,000	$ 82,627,000
DSHP-BTR (DY 2011-12)	$ 59,324,000	$ 27,647,000	$ 86,971,000
Total Claiming	$115,482,000	$ 54,116,000	$169,598,000
DY 2008-09 Final Reconciliation	($ 13,436,000)	$ 903,000	($ 12,533,000)
Total	**$102,046,000**	**$ 55,019,000**	**$157,065,000**
FY 2012-13			
DSHP-BTR (DY 2012-13)	$ 59,324,000	$ 27,647,000	$ 86,971,000
DY 2009-10 Final Reconciliation	($ 11,372,000)	($ 4,595,000)	($ 15,967,000)
Total	**$ 47,952,000**	**$ 23,052,000**	**$ 71,004,000**

Funding:
Health Care Support Fund (4260-601-7503)

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 97
IMPLEMENTATION DATE: 11/2010
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1571

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$150,341,000	$49,300,000
- STATE FUNDS	-$375,317,000	-$312,823,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$150,341,000	$49,300,000
STATE FUNDS	-$375,317,000	-$312,823,000
FEDERAL FUNDS	$525,658,000	$362,123,000

DESCRIPTION

Purpose:
This policy change estimates the additional federal financial participation (FFP) received for Certified Public Expenditures (CPEs) using programs in other departments under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

Authority:
SB 208 (Chapter 71, Statutes 2009), Welfare and Institutions Code, section 14182.3
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
The Centers for Medicare & Medicaid Services (CMS) approved the 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 (exceptions as noted):

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 97

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) · 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**
County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11.

* The DDS, EWC, and PCTP programs are approved DSHPs but the reimbursement protocols for these programs are still pending CMS approval.

** CMS approval to include the University of California (UC), California State University (CSU) and California Community Colleges (CCCs) programs as DSHPs is still pending.

The annual limit the State-Only programs may claim for DSHP is $400 million each Demonstration Year (DY) 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 million.

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures and delay in CMS approval on claiming protocols for UC, CSU, and CCCs.

Methodology:

1. The Department did not receive CMS approval to claim DY 6 in FY 2010-11. As a result, DY 6 and DY 7 will be claimed in FY 2011-12. DY 8 will be claimed in FY 2012-13.

2. The FFP for other departments is offset against General Fund expenses in Item 4260-101-0001, except for $76,277,000 in FY 2010-11 and $74,064,000 in FY 2011-12 in ADAP FFP which are offset against the CDPH budget. In FY 2012-13, of the $65,000,000 ADAP FFP available, $15,700,000 is offset against 4260-101-0001 and $49,300,000 is offset against the CDPH budget.

3. 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–

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 97

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.

4. In FY 2011-12, on a cash basis, the Department will claim DSHPs for FY 2010-11 and FY 2011-12 for the programs that have been approved by CMS. In FY 2012-13, on a cash basis, the Department will claim DSHPs for FY 2010-11, FY 2011-12, and FY 2012-13.

The estimated BTR DSHP federal reimbursements are as follows:

(In Thousands)	**Total DSHP (Accrual Basis)**			**Included in this PC (Cash Basis)**	
	FFP FY 2010-11	FFP FY 2011-12	FFP FY 2012-13	**FFP FY 2011-12**	**FFP FY 2012-13**
CCS	$56,158	$59,324	$59,324		
GHPP	$26,469	$27,647	$27,647		
MIA-LTC	$17,020	$17,589	$17,589		
BCCTP	$1,097	$1,178	$1,178		
DHCS Total	$100,744	$105,737	$105,737		
ADAP	$76,277	$74,064	$65,000	$150,341	$65,000
Co. Mental Health	$18,272	$20,067	$20,067	$38,339	$20,067
DDS	$69,106	$88,124	$88,124	$157,230	$88,124
EWC	$1,469	$5,796	$5,796	$7,265	$5,796
PCTP	$709	$907	$907	$1,616	$907
OSHPD	$3,243	$6,980	$6,980	$10,223	$6,980
Univ. of Calif.	$2,018	$2,575	$2,575	$0	$7,168
CSU/Comm. Colleges	$21,486	$29,362	$29,362	$0	$80,210
CMSP	$106,676	$53,969	$0	$160,646	$0
Miscellaneous Programs	$0	$12,419	$75,453	$0	$87,872
Other Programs	$299,257	$294,262	$294,263	**$525,658**	**$362,123**
Grand Total	$400,000	$400,000	$400,000	**$525,658**	**$362,123**

Funding:
Title XIX GF/FFP (4260-101-0001/0890)

MANDATORY SPD ENROLLMENT INTO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 98
IMPLEMENTATION DATE: 6/2011
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1498

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$96,141,000	-$303,007,000
- STATE FUNDS	$48,070,500	-$151,503,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
The policy change estimates the costs for the mandatory enrollment of Seniors and Persons with Disabilities (SPD) into a managed care plan.

Authority:
Senate Bill 208 (Chapter 714, Statutes of 2010)
Assembly Bill 342 (Chapter 723, Statutes of 2010)

Background:
Beginning June 1, 2011, enrollment into a managed care plan became mandatory for Seniors and Persons with Disabilities (SPDs) residing in a Two Plan and Geographic Managed Care (GMC) county and who are not dually eligible for Medicare. Prior to June 1, 2011, only SPDs in County Organized Health System counties were required to enroll in the managed care plan. This change is included in the California Bridge to Reform section 1115(a) Demonstration (BTR).

Reason for Change from Prior Estimate:
This policy change is 100% reflected in the base regression for FY 2011-12 and FY 2012-13.

Methodology:
1. Mandatory enrollment of SPDs into Medi-Cal managed care plans in Two-Plan and GMC counties began 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 per member per month (PMPM), excluding services that will not be capitated under mandatory enrollment.

4. Assume the managed care average monthly payments will be $474.40 PMPM, and the managed care plans will provide at least an equivalent scope of services.

MANDATORY SPD ENROLLMENT INTO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 98

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., Long Term Care (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.

8. Mandatory enrollment of California Children Services (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.

12. Assume all Fee-For-Service (FFS) lagged savings for the Designated Public Hospitals are budgeted as 100% Federal Funds.

13. The total capitation costs for SPDs transitioning into Managed Care:

	FY 2011-12			FY 2012-13		
(In Thousands)	TF	GF	FFP	TF	GF	FFP
MC Cost	$1,202,685	$601,342	$601,342	$1,945,916	$972,958	$972,958
DPH Savings (lagged)	-$54,236	$0	-$54,236	-$114,113	$0	-$114,113
FFS Savings (lagged)	-$1,068,486	-$534,243	-$534,243	-$2,248,096	-$1,124,048	-$1,124,048
Total	$79,963	$67,099	$12,863	-$416,293	-$151,090	-$265,203

14. The Managed Care percent in Base for FY 2011-12 will be 100% and 100.00% for FY 2012-13.

15. The FFS percent in Base for FY 2011-12 will be 100% and 100% for FY 2012-13.

MANDATORY SPD ENROLLMENT INTO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 98

16. The remaining costs are now part of the Base Regressions:

(In Thousands)	FY 2011-12 TF	FY 2012-13 TF
MC Cost	$730,030	$1,459,437
DPH Savings (lagged)	-$30,622	-$85,140
FFS Savings (lagged)	-$603,267	-$1,677,304
Total	**$96,141**	**-$303,007**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

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

REGULAR POLICY CHANGE NUMBER: 99
IMPLEMENTATION DATE: 5/2008
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1078

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$77,407,000	$70,703,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$77,407,000	$70,703,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$77,407,000	$70,703,000

DESCRIPTION

Purpose:
This policy change estimates the payments to the Designated Public Hospitals (DPHs) for the uncompensated costs of their physician and non-physician practitioner professional services.

Authority:
Medi-Cal Hospital/Uninsured Care Demonstration (MH/UCD)
California Bridge to Reform Demonstration (BTR)

Background:
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, pursuant to State Plan Amendment (SPA) 05-023, DPHs received reimbursement based on certified public expenditures (CPEs) for their uncompensated costs incurred for physician and non-physician practitioner professional services. The reimbursement is 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.

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

Methodology:
1. Payments for 2009-10 were made in FY 2010-11; Payments for 2010-11 dates of service July 1, 2010 through May 30, 2011 were made in FY 2010-11; the June 2011 dates of service and FY 2011-12 payments are expected to be made in FY 2011-12. Payments for 2012-13 are expected to be made in FY 2012-13.

2. The estimated cost of 2011-12 DPHs' physician and non-physician practitioner professional services will not increase by the Consumer Price Index U.S. City Average pending completion of preliminary reconciliation of prior estimated payments from 2005-06 through 2010-11.

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

REGULAR POLICY CHANGE NUMBER: 99

3. Reconciliation of the first program year 2005-06 is anticipated to be completed during FY 2012-13 upon conclusion of the Physician/Non-Physician Practitioner time studies that are a required component of the reconciliation process.

(In Thousands)	Estimated Expenditures		
FY 2011-12	**TF**	**FFP**	**ARRA**
2010-11	$ 6,704	$ 5,893	$811
2011-12	$ 70,703	$ 70,703	
Total	**$ 77,407**	$ 76,596	$811
FY 2012-13	**$ 70,703**	$ 70,703	

Funding:
Title XIX FFP (4260-101-0890)

MH/UCD—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 100
IMPLEMENTATION DATE: 10/2007
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1152

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$2,725,000	$159,300,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,725,000	$159,300,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$2,725,000	$159,300,000

DESCRIPTION

Purpose:
This policy estimates the funds for the reconciliation of Designated Public Hospital (DPH) interim payments to their finalized hospital inpatient costs.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code, section 14166.4
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
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 MH/UCD and BTR, each DPH's fiscal year interim per diem rate, comprised of 100% 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.

MH/UCD—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 100

Reason for Change from Prior Estimate:
The final reconciliation for FY 2006-07 will be paid in FY 2012-13 because of pending cost reporting issues from DPHs.

Methodology:

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.

3. The final reconciliation for 2005-06 is expected to be completed by June 2012. When reconciled with the tentative settlement of $42,891,000, there is an expected payout of $6,890,000, of which $4,165,000 was paid in December 2010.

4. The final reconciliation for 2006-07 is expected to be completed by December 2012 and is estimated to be $67,400,000. There are no plans to issue a tentative settlement for 2006-07.

5. The final reconciliation for 2007-08 is expected to be completed by June 2013 and is estimated to be $91,900,000. There are no plans to issue a tentative settlement for 2007-08.

FY 2011-12	**FFP**
2005-06 Final Reconciliation	**$2,725,000**
FY 2012-13	
2006-07 Final Reconciliation	$67,400,000
2007-08 Final Reconciliation	$91,900,000
Total	**$159,300,000**

Funding:
Title XIX FFP (4260-101-0890)

MH/UCD—SOUTH LA PRESERVATION FUND

REGULAR POLICY CHANGE NUMBER: 101
IMPLEMENTATION DATE: 3/2009
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1219

	FY 2011-12	FY 2012-13
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

Purpose:
This policy change estimates the payments to hospitals from the South Los Angeles Medical Services Preservation (SLAMSP) Fund.

Authority:
SB 474 (Chapter 518, Statutes of 2007), Welfare and Institutions Code, section 14166.25
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Background:
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 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 created the 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.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. 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

MH/UCD—SOUTH LA PRESERVATION FUND

REGULAR POLICY CHANGE NUMBER: 101

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.

2. ABX3 5 (Chapter 20, Statutes of 2009) reduced the payments to DPHs and the SLAMSP Fund by 10%, effective July 1, 2009. The SLAMSP Fund allocation for 2009-10 was 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 and $22,500,000 is expected to be paid out in FY 2011-12.

3. The MH/UCD was extended to October 31, 2010. It is estimated that the SLAMSP funding allocation for the 60-day extension is $16.667 million which is expected to be paid in FY 2011-12. 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.

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

Fiscal Year	FY 2011-12
2009-10	$ 22,500,000
2010-11	$ 16,667,000
Total	**$ 39,167,000**

Funding:
South Los Angeles Medical Services Preservation Fund (4260-601-7504)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 102
IMPLEMENTATION DATE: 7/2006
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1153

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$17,549,000	$105,756,000
- STATE FUNDS	$17,549,000	$58,541,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$17,549,000	$105,756,000
STATE FUNDS	$17,549,000	$58,541,000
FEDERAL FUNDS	$0	$47,215,000

DESCRIPTION

Purpose:
This policy change estimates the cost of stabilization funding under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions (W&I) Code, section 14166.75
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration

Background:
Stabilization funding is provided 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 General Fund (GF) payments to the extent that the state-funded programs certified public expenditures (CPEs) are used for federal financial participation (FFP) from the Safety Net Care Pool (SNCP) and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, Private Hospitals, and Distressed Hospitals.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 102

Reason for Change from Prior Estimate:
The changes are due to:

- The delay of FY 2006-07 final reconciliation because of the complexity of hospital cost reports,
- FY 2005-06 and FY 2006-07 final stabilization payments to the Private Hospitals will be paid out in FY 2012-13 to be consistent with GF savings budgeted in the Hospital Stabilization policy change.

Methodology:

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.

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. 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. 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. Subject to the federal upper payment limit (UPL) rule, Private Hospitals are not able to receive 2009-10 (Demonstration Year (DY) 5) stabilization funding due to the implementation of the Hospital Quality Assurance Fee (QAF). The Department is proposing legislation to authorize 2009-10 stabilization funding to be paid to Private Hospitals using FY 2010-11 dates of service, while retaining 2009-10 methodology.

6. A total of $36,078,000 TF ($18,039,000 GF) will be transferred to the Private Hospital Supplemental Fund. This amount will be paid from the MH/UCD & BTR—Private Hospital Supplemental Payment policy change.

7. A total of $538,000 TF ($269,000 GF) will be transferred to the NDPH Supplemental Fund. This amount will be paid from the MH/UCD & BTR—NDPH Supplemental Payment policy change.

8. The MH/UCD was extended for 60 days to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 102

Demonstration (BTR) effective November 1, 2010. Stabilization Funding is not applicable under the BTR. Funding for the 60-day extension of the prior MH/UCD SNCP is included in the new BTR.

9. The Department is proposing legislation to redirect the final stabilization payments to the NDPHs and Private Hospitals that has not yet been paid for FY 2005-06 through FY 2009-10 to GF. GF savings are budgeted in the Hospital Stabilization policy change.

10. The Department is proposing legislation that authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of CMAC under section 14165(b) of the W&I Code.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 102

The estimated stabilization payments are:

FY 2011-12		
2005-06	**TF**	**GF**
DPHs*	$17,549,000	$17,549,000
Total FY 2011-12	**$17,549,000**	**$17,549,000**

FY 2012-13		
2005-06	**TF**	**GF**
Redirect to GF-Private	$7,022,000	$3,511,000
2006-07		
DPHs*	$777,000	$777,000
Redirect to GF-Private	$12,714,000	$6,357,000
2006-07 Total	$13,491,000	$7,134,000
2007-08		
Redirect to GF-NDPH	$1,614,000	$807,000
Distressed	$9,350,000	$4,675,000
2007-08 Total	$10,964,000	$5,482,000
2008-09		
DPHs*	$10,549,000	$10,549,000
Redirect to GF-Private	$2,586,000	$1,293,000
Distressed	$5,866,000	$2,933,000
2008-09 Total	$19,001,000	$14,775,000
2009-10		
Distressed	$6,298,000	$3,149,000
2010-11		
Redirect to GF-Private	$48,980,000	$24,490,000
Total FY 2012-13	**$105,756,000**	**$58,541,000**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)
GF (4260-101-0001)*

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 103
IMPLEMENTATION DATE: 9/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1072

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$1,949,000	$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	$1,949,000	$42,735,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$1,949,000	$42,735,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for Safety Net Care Pool (SNCP) payments to Designated Public Hospitals (DPHs) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code, section 14166.7
MH/UCD

Background:
Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions of the MH/UCD, a 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 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). SNCP funding for the Health Care Coverage Initiative and for state-only programs are included in other policy changes.

In 2007, SB 474 (Chapter 518, Statutes of 2007) 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 were claimed using the CPEs of the County of Los Angeles or its DPHs. Expenditures from this fund are budgeted in the MH/UCD – South LA Preservation Fund 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.

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 103

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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 MH/UCD 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 (BTR) 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 Pool.

Reason for Change from Prior Estimate:
The changes are due to the delay of final reconciliations for DY 2006-07 and DY 2008-09.

Methodology:
The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(In Thousands)

Demonstration Year	State-Only Funded Programs	Due to DPHs
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 on a cash basis are:

(In Thousands)

Demonstration Year	FY 2011-12	FY 2012-13
2005-06	$1,949	
2006-07		$35,918
2007-08		$6,817
Total	**$1,949**	**$42,735**

Funding:
Health Care Support Fund (4260-601-7503)

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 104
IMPLEMENTATION DATE: 7/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1576

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$75,223,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$75,223,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$75,223,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Low Income Health Program (LIHP) payments for California Department of Corrections and Rehabilitation (CDCR) inmates receiving hospital inpatient services at hospitals off the grounds of the correction facilities.

Authority:
AB 1628 (Chapter 729, Statutes of 2010)
SB 92 (Chapter 36, Statutes of 2011)

Background:
AB 1628 and SB 92 authorize the Department to claim federal funding for inpatient hospital services for certain inmates of 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 LIHP operated by the counties. The LIHP is established under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

See Medi-Cal Inpatient Hospital Costs for CDCR Inmates policy change for the Medi-Cal covered costs.

CDCR/California Correctional Health Care Services (CCHCS) will forward applications to the Department for the purpose of determining LIHP eligibility. CDCR/CCHCS will pay the hospitals under contract for covered inpatient services. CDCR/CCHCS 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.

Reason for Change from Prior Estimate:
Delays in establishing LIHP programs and obtaining federal approvals.

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 104

Methodology:

1. CDCR/CCHCS will submit LIHP claims for inpatient hospital services beginning in October 2011.

2. Applications for LIHP will be processed by the Department and no additional county administrative costs will be incurred.

3. Assume the Department will process 500 applications per month for inmates with verified citizenship.

4. SB 92 authorizes CDCR/CCHCS to sign applications on behalf of inmates.

5. Of the estimated 500 mothly applications, it is assumed 75% in FY 2011-12 and 80% in FY 2012-13 are for LIHP:
   - FY 2011-12: 500 inmates x 75% LIHP = 375 potential inmate LIHP eligible
   - FY 2012-13: 500 inmates x 80% LIHP = 400 potential inmate LIHP eligible

6. Assume that 96% of processed inmate LIHP applications will be approved.

7. The average cost per inpatient admission is estimated to be $19,170.

8. The annual cost will be:
   - FY 2011-12: 360 inpatient admissions per month x 12 months x $19,170 per inpatient stay x 50.00% FMAP = $41,407,000 FFP
   - FY 2012-13: 384 inpatient admissions per month x 12 months x $19,170 per inpatient stay x 50.00% FMAP = $44,168,000 FFP

9. Assuming dates of service begin October 1, 2011, estimated FY 2011-12 costs incurred will be:
   360 inpatient admissions per month x 9 months x $19,170 per inpatient stay
   x 50.00% FMAP = $31,055,000 FFP

10. Assuming there will be no approved claiming protocol prior to July 2012, there will be no claims submitted for FY 2011-12 and $31,055,00 in claims for FY 2011-12 will be claimed in FY 2012-13.

The estimated payments for inmates on a cash basis are:

FY 2012-13		TF	FFP
	FY 2011-12	$31,055,000	$31,055,000
	FY 2012-13	$44,168,000	$44,168,000
		$75,223,000	**$75,223,000**

Funding:

Title XIX FFP (4260-101-0890)

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 105
IMPLEMENTATION DATE: 9/2007
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1154

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$43,468,000	$5,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$43,468,000	$5,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$43,468,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the federal funds for the Health Care Coverage Initiative (HCCI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD).

Authority:
SB 1448 (Chapter 76, Statutes of 2006)
California section 1115 (a) Medi-Cal Hospital/Uninsured Care Demonstration

Background:
Under the 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 HCCI counties at an amount equal to the applicable Federal Medical Assistance Percentage of their Certified Public Expenditures (CPEs) for health care services provided to eligible low-income uninsured persons. The HCCI counties will submit their CPEs to the Department for verification and submission for federal financial participation (FFP).

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 Section 1115(a) Medicaid 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. The HCCI has been replaced by a modified program under the BTR which is reflected in the Low Income Health Program policy changes.

Reason for Change from Prior Estimate:
Updated claims information.

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

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 105

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	$180,000,000

2. Final payments for DY 2007-08 through DY 2009-10 under the MH/UCD HCCI are expected to be paid in FY 2011-12 and FY 2012-13.

The estimated HCCI payments on a cash basis are:

FY 2011-12	**TF**	**FFP**
2007-08	$ 28,297,000	$ 28,297,000
2008-09	$ 4,509,000	$ 4,509,000
2009-10	$ 10,662,000	$ 10,662,000
Total	**$ 43,468,000**	**$ 43,468,000**
FY 2012-13		
2009-10	**$ 5,000,000**	**$ 5,000,000**

Funding:
Health Care Support Fund (4260-601-7503)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 106
IMPLEMENTATION DATE: 7/2010
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1459

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$31,111,000	-$9,187,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$31,111,000	-$9,187,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$31,111,000	-$9,187,000

DESCRIPTION

Purpose:
This policy change estimates the savings from the federal flexibilities policies which allows the claiming of unused Safety Net Care Pool (SNCP) federal funds to offset State General Fund expenditures.

Authority:
Welfare and Institutions Code, section 14166.221
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Background:
Under the 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, The Centers for Medicare and Medicaid Services (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 SNCP.

Reason for Change from Prior Estimate:
Final reconciliations are expected to be completed in FY 2012-13.

Methodology:
1. The Department may claim these funds using the certified public expenditures from Designated Public Hospitals, the Coverage Initiative Program, and State-Only funded programs, including Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), County Mental Health Services for the Uninsured (CMHS), and AIDS Drug Assistance Program (ADAP).

2. 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

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 106

would distribute those funds in conformity with the payment schedule for Hospital QAF payments. $135.083 million of the total $420 million was applied to this policy change and paid in FY 2010-11.

3. Interim claims resulted in reductions to the General Fund of $137.784 million in FY 2010-11 and are expected to result in additional reductions to the General Fund of $31.111 million from the County Mental Health Services for the Uninsured in FY 2011-12. The final reconciliation is expected to begin in FY 2012-13.

4. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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 federal financial participation (FFP) for FY 2010-11 and FY 2011-12. The additional FFP due to these changes in FMAP is budgeted in the Federal Flex. & Stabilization – SNCP ARRA policy change.

The General Fund savings resulting from the federal flexibilities are expected to be:

FY 2011-12	TF	FFP
CMHS	$31,111	$31,111
FY 2012-13		
Final Reconciliation (EAPC, CMSP, & ADAP)	($9,187)	($9,187)

Funding:
Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 107
IMPLEMENTATION DATE: 7/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1076

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$6,250,000	$5,236,000
- STATE FUNDS	$3,125,000	$2,618,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,250,000	$5,236,000
STATE FUNDS	$3,125,000	$2,618,000
FEDERAL FUNDS	$3,125,000	$2,618,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions (W&I) Code, section 14166.17
Medi-Cal Hospital/Uninsured Care Section 1115(a) Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
As part of the MH/UCD and the BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, supplemental reimbursements will be available to NDPHs.

Payments to the NDPHs will be from the NDPH Supplemental Fund 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).

Reason for Change from Prior Estimate:
The changes are due to revised estimate based on updated program expenditures.

Methodology:
1. The State Funds (SF) item includes the annual General Fund (GF) appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated.

2. SB 1100 requires that $1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 107

3. Distribution of the NDPH Supplemental Fund will be determined through negotiations with the California Medical Assistance Commission (CMAC).

4. The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010.

5. The Department is proposing legislation to redirect the stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to the GF. GF savings are budgeted in the Hospital Stabilization policy change.

6. The Department is proposing legislation that authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of CMAC under section 14165(b) of the W&I Code.

It is assumed NDPH supplemental payments will be made on a cash basis as follows:

	TF	SF	FFP
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	$5,616,000	$2,808,000	$2,808,000
Cash Expenditures in FY 2010-11	$2,274,000	$1,137,000	$1,137,000
FY 2010-11 Ending Balance	$3,342,000	$1,671,000	$1,671,000
FY 2011-12			
FY 2010-11 Ending Balance	$3,342,000	$1,671,000	$1,671,000
Appropriation (GF)	$3,800,000	$1,900,000	$1,900,000
FY 2010-11 Interest Earned	$6,000	$3,000	$3,000
Total	$7,148,000	$3,574,000	$3,574,000
Cash Expenditures in FY 2011-12	**$6,250,000**	**$3,125,000**	**$3,125,000**
FY 2011-12 Ending Balance	$898,000	$449,000	$449,000
FY 2012-13			
FY 2011-12 Ending Balance	$898,000	$449,000	$449,000
Appropriation (GF)	$3,800,000	$1,900,000	$1,900,000
Est. FY 2011-12 Interest Earned	$4,000	$2,000	$2,000
Est. 2007-08 Stabilization Transfer	$538,000	$269,000	$269,000
Total	$5,240,000	$2,620,000	$2,620,000
Cash Expenditures in FY 2012-13	**$4,698,000**	**$2,349,000**	**$2,349,000**
Redirect Stabilization Fund to GF	**$538,000**	**$269,000**	**$269,000**
FY 2012-13 Ending Balance	$4,000	$2,000	$2,000

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 107

Funding:
NDPH Supplemental Fund (4260-601-3096)
Title XIX FFP (4260-101-0890)

MH/UCD—DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 108
IMPLEMENTATION DATE: 7/2006
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1070

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$2,248,000	$0
- STATE FUNDS	$1,124,000	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$2,248,000	$0
STATE FUNDS	$1,124,000	$0
FEDERAL FUNDS	$1,124,000	$0

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments made from the Distressed Hospital Fund.

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code, section 14166.23
Medi-Cal Hospital/Uninsured Care Section 1115(a) Demonstration (MH/UCD)

Background:
As part of MH/UCD, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, the Distressed Hospital Fund, 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 9SB 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 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.

Reason for Change from Prior Estimate:
There is no change.

MH/UCD—DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 108

Methodology:

1. Contract hospitals that meet the following requirements, as determined by CMAC, are eligible for distressed funds:
   a. The hospital serves a substantial volume of Medi-Cal patients.
   b. The hospital is a critical component of the Medi-Cal program's health care delivery system.
   c. The hospital is facing a significant financial hardship.

2. The MH/UCD 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 (BTR), effective November 1, 2010. No additional funding for the Distressed Hospital Fund was included in the BTR.

3. The final payment from the PSFs will be made in FY 2011-12 depleting any remaining accumulated interest and fund balance.

4. The stabilization funding amounts to the Distressed Hospital Fund will be determined following the completion of the final reconciliations of the interim Medicaid inpatient hospital payment rates, interim Disproportionate Share Hospital payments, and interim Safety Net Care Pool payments for each fiscal year under the MH/UCD and paid in FY 2012-13. The stabilization payments are reflected in the MH/UCD- Stabilization Funding policy change.

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

FY 2010-11	**TF**	**SF**	**FFP**
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
Estimated Interest Earned in Distressed Fund	$ 40,000	$ 20,000	$ 20,000
Distressed Funds Available	$ 8,272,000	$ 4,136,000	$ 4,136,000
Cash Expenditures in FY 2010-11	$ 6,050,000	$ 3,025,000	$ 3,025,000
FY 2010-11 Ending Balance	$ 2,222,000	$ 1,111,000	$ 1,111,000
FY 2011-12			
FY 2010-11 Ending Balance	$ 2,222,000	$ 1,111,000	$ 1,111,000
Transfer from Prior Supplement Funds	$ 20,000	$ 10,000	$ 10,000
Estimated Interest Earned in Distressed Fund	$ 6,000	$ 3,000	$ 3,000
Distressed Funds Available	$ 2,248,000	$ 1,124,000	$ 1,124,000
Cash Expenditures in FY 2011-12	**$ 2,248,000**	**$ 1,124,000**	**$ 1,124,000**
FY 2011-12 Ending Balance	$ -	$ -	$ -

Funding:

Distressed Hospital Fund (4260-601-8033)
Title XIX FFP (4260-101-0890)

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 109
IMPLEMENTATION DATE: 7/2012
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1622

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$190,000,000
- STATE FUNDS	$0	$95,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$190,000,000
STATE FUNDS	$0	$95,000,000
FEDERAL FUNDS	$0	$95,000,000

DESCRIPTION

Purpose:
This policy change estimates the funding for the Low Income Health Program (LIHP) Medicaid Coverage Expansion (MCE) Out-of-Network Emergency Care Services Fund that was created to reimburse out-of-network hospitals for providing certain services to LIHP MCE enrollees.

Authority:
SB 335 (Chapter 286, Statutes of 2011)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
SB 335 establishes the LIHP MCE Out-of-Network Emergency Care Services Fund, effective July 1, 2011 to December 31, 2013. Moneys shall be allocated from the fund by the Department to be matched with federal funds in accordance with the Special Terms and Conditions for the BTR. The Department shall disburse moneys from the fund to the LIHPs solely for the purposes of funding the out-of-network hospital emergency care services for emergency medical conditions and required poststabilization care provided by private hospitals and non-designated public hospitals that are outside the LIHP coverage network. This program is currently pending approval from the Centers for Medicare and Medicaid Services (CMS).

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. IGTs will total $20 million and will generate $20 million in FFP in FY 2011-12 and FY 2012-13.

2. $75 million will be transferred from the Hospital Quality Assurance Revenue Fund (HQARF) and will generate $75 million in FFP in FY 2011-12 and FY 2012-13.

3. IGT funds are to be used in their entirety before HQARF funds are used.

4. LIHPs will provide utilization data to the Department within 60 days of the end of each fiscal year.

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 109

The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations. As a result, payments for a fiscal year are paid during the subsequent fiscal year.

5. The LIHP MCE Out-of-Network Emergency Care Services Fund is being established. IGTs will be deposited into and paid from the Reimbursement Fund until the new LIHP MCE fund is established.

(In Thousands)

FY 2012-13	**TF**	**IGT**	**HQARF**	**FF**
2011-12	**$190,000**	**$20,000**	**$75,000**	**$95,000**

Funding:
Reimbursement Fund (4260-610-0995)
Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-101-0890)

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 110
IMPLEMENTATION DATE: 9/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1079

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$33,737,000	-$14,493,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$33,737,000	-$14,493,000
FEDERAL FUNDS	$33,737,000	$14,493,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the Medically Indigent Adult Long-Term Care (MIA-LTC) program claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code, section 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for the MIA-LTC 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.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the new demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The MIA-LTC program is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

Reason for Change from Prior Estimate:
The changes are due to the result of the final reconciliation for Demonstration Year (DY) 2008-09 and revised estimates based on updated program expenditures.

Methodology:
1. The FFP received for the MIA-LTC program will be deposited in the Health Care Support Fund, Item 4260-601-7503. The General Fund savings created will be used to support safety net hospitals

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 110

under the MH/UCD and BTR.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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 August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the MIA-LTC programs.

3. In January 2012, the final reconciliation for DY 2008-09 resulted in an overpayment of $872,000. The Department will conduct the final reconciliation for DY 2009-10 in FY 2012-13 and estimate it will have to repay the federal government $3.096 million in FY 2012-13. The MIA-LTC federal reimbursements are reduced by the final reconciliation amounts in this policy change.

4. Of the total DY 2008-09 final reconciliation of $872,000, the regular FMAP amount is $796,000 and $76,000 is the ARRA amount in FY 2011-12. Of the total DY 2009-10 final reconciliation of $3,096,000, the regular FMAP amount is $2,544,000 and $552,000 is the ARRA amount in FY 2012-13.

The MIA-LTC federal reimbursements are:

	FFP
FY 2005-06	$ 12,834,000
FY 2006-07	$ 7,328,000
FY 2007-08	$ 14,743,000
FY 2008-09	$ 23,160,000
FY 2009-10	$ 28,147,000
FY 2010-11	$ 11,386,000
FY 2011-12	
DSHP-BTR (DY 2010-11)	$ 17,020,000
DSHP-BTR (DY 2011-12)	$ 17,589,000
Total Claiming	$ 34,069,000
DY 2008-09 Final Reconciliation	($ 872,000)
Total	**$ 33,737,000**
FY 2012-13	
DSHP-BTR (DY 2012-13)	$ 17,589,000
DY 2009-10 Final Reconciliation	($ 3,096,000)
Total	**$ 14,493,000**

Funding:
Health Care Support Fund (4260-601-7503)
GF (4260-101-0001)

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER:	111
IMPLEMENTATION DATE:	9/2005
ANALYST:	Jennifer Hsu
FISCAL REFERENCE NUMBER:	1084

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$2,439,000	-$988,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$2,439,000	-$988,000
FEDERAL FUNDS	$2,439,000	$988,000

DESCRIPTION

Purpose:
This policy change reflects the federal reimbursement received by the Department for a portion of the State-Only Breast and Cervical Cancer Treatment Program (BCCTP) claims based on the certified public expenditures (CPEs).

Authority:
SB 1100 (Chapter 560, Statutes of 2005), Welfare and Institutions Code, section 14166.22
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool (SNCP) funding established by 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 federal poverty level (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 Planning, Access, Care, and Treatment (Family PACT) providers.

The MH/UCD was extended for two months until October 31, 2010. Effective November 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved a new five-year demonstration, the BTR. The Special Terms and Conditions of the new demonstration allow the State to claim federal financial participation (FFP) using the CPEs of approved Designated State Health Programs (DSHP). The BCCTP is included in the list of DSHP. Funding for the two-month extension of the prior MH/UCD SNCP is included in the BTR. This policy change includes the impact of the BTR.

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 111

Reason for Change from Prior Estimate:
The changes are due to the result of the final reconciliation for Demonstration Year (DY) 2008-09 and revised estimates based on updated program expenditures.

Methodology:

1. The FFP received for the BCCTP will be deposited in the Health Care Support Fund, Item 4260-601-7503. The General Fund savings created will be used to support safety net hospitals under the MH/UCD and BTR.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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 August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the BCCTP program.

3. In January 2012, the final reconciliation for Demonstration Year (DY) 2008-09 resulted in an additional FFP of $164,000. The Department will conduct the final reconciliation for the BCCTP for DY 2009-10 in FY 2012-13 and estimate that the Department will have to repay the federal government $190,000 in FY 2012-13 as a result of the reconciliations. The BCCTP federal reimbursements are reduced by the final reconciliation amounts in this policy change.

4. Of the total DY 2008-09 final reconciliation of $164,000, the regular FMAP amount is $125,000 and $39,000 is the ARRA amount in FY 2011-12. Of the total DY 2009-10 final reconciliation of $190,000, the regular FMAP amount is $170,000 and $20,000 is the ARRA amount in FY 2012-13.

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 111

The BCCTP federal reimbursements are:

	FFP
FY 2005-06	$ 591,000
FY 2006-07	$ 291,000
FY 2007-08	$ -
FY 2008-09	$ 1,211,000
FY 2009-10	$ 2,137,000
FY 2010-11	$ 1,095,000
FY 2011-12	
DSHP-BTR (DY 2010-11)	$ 1,097,000
DSHP-BTR (DY 2011-12)	$ 1,178,000
Total Claiming	$ 2,275,000
DY 2008-09 Final Reconciliation	$ 164,000
Total	**$ 2,439,000**
FY 2012-13	
DSHP-BTR (DY 2012-13)	$ 1,178,000
DY 2009-10 Final Reconciliation	($ 190,000)
Total	**$ 988,000**

Funding:
Health Care Support Fund (4260-601-7503)
GF (4260-101-0001)

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

REGULAR POLICY CHANGE NUMBER: 112
IMPLEMENTATION DATE: 7/2011
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1460

	FY 2011-12	FY 2012-13
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

Purpose:
This policy change estimates the final reconciliations of the certified public expenditures (CPEs) that were used to claim the additional Safety Net Care Pool (SNCP) federal funds that were available due to the increased Federal Medical Assistance Percentage (FMAP) under the American Recovery and Reinvestment Act of 2009 (ARRA).

Authority:
Welfare and Institutions Code, section 14166.221
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Background:
Under ARRA, the 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 Safety Net Care Pool (SNCP) federal funds allotment under the MH/UCD will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP.

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 (BTR) effective November 1, 2010. Under the new demonstration, this federal flexibility funding is no longer applicable. Funding for the two-month extension of the prior MH/UCD SNCP is included in the new BTR demonstration.

Reason for Change from Prior Estimate:
The actual overpayment as result of the final reconciliation for Demonstration Year (DY) 2008-09 was less than the estimated amount.

Methodology:
1. The Department may claim these funds using certified public expenditures from Designated Public

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

REGULAR POLICY CHANGE NUMBER: 112

Hospitals, the Coverage Initiative Program, and State-Only funded programs, including Breast and Cervical Cancer Treatment (BCCTP), Medically Indigent Adults/Long Term Care (MIA-LTC), California Children's Services (CCS), Genetically Handicapped Persons (GHPP), County Medical Services Program, County Mental Health Services for the Uninsured, and AIDS Drug Assistance Program.

2. AB 1653 (Chapter 218, Statutes of 2010) allowed 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. $284.917 million of the total $420 million was applied to this policy change and paid in FY 2010-11.

3. In FY 2010-11, the Department claimed SNCP ARRA of $2.519 million for FY 2008-09, $86.939 million for FY 2009-10, and $49.395 million in FY 2010-11, for a total of $138.853 million.

4. In January 2012, the final reconciliation for DY 2008-09 resulted an overpayment of $13.241 million. The Department will conduct the final reconciliation for DY 2009-10 in FY 2012-13 and estimates it will have to repay the federal government $19.253 million in FY 2012-13.

5. This policy change is for informational purposes only because all CPEs being used are in the Department'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 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 final reconciliations are as follows:

	FFP FY 2011-12	FFP FY 2012-13
CCS	($13,436,000)	($11,372,000)
GHPP	$903,000	($4,595,000)
MIA LTC	($872,000)	($3,096,000)
BCCTP	$164,000	($190,000)
Grand Total	($13,241,000)	($19,253,000)

Funding:
Not Applicable

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 113
IMPLEMENTATION DATE: 7/2005
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1161

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$0
- STATE FUNDS	-$443,735,000	-$449,298,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	-$443,735,000	-$449,298,500
FEDERAL FUNDS	$443,735,000	$449,298,500

DESCRIPTION

Purpose:
This policy change estimates the technical adjustment in funding from 50% federal financial participation (FFP) to 100% FFP to reimburse Designated Public Hospitals (DPHs).

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR),

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, based on SPA 05-021, DPHs no longer received the California Medical Assistance Commission (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' two years prior 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.

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 113

includes the additional FFP due to ARRA on a date-of-service basis. In FY 2011-12 the increase due to ARRA is $41,775,000, on a cash basis.

	Expenditures	GF to FF shift
FY 2011-12	**$ 887,470,000**	**$ 443,735,000**
FY 2012-13	**$ 898,597,000**	**$ 449,298,500**

Funding:
Title XIX GF/FFP (4260-101-0001/0890)

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 114
IMPLEMENTATION DATE: 7/2009
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1162

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$34,087,000	$87,825,000
- STATE FUNDS	$17,043,500	$43,912,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$0
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$0

DESCRIPTION

Purpose:
This policy change estimates the cost of increases in payments to Designated Public Hospitals (DPHs) due to interim rate growth.

Authority:
Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Background:
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, based on SPA 05-021, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs 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 California Medical Assistance Commission (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.

Reason for Change from Prior Estimate:
The changes are due to updated program expenditures.

Methodology:
1. The DPHs received an increase in their interim per diem rates for dates of service on or after July 1, 2010, of 7.08%.

2. The DPHs received an increase in their interim per diem rates for dates of services on or after July 1, 2011, of 6.37%.

3. An additional cost of $34,087,000 is estimated to occur in FY 2011-12.

4. An additional cost of $87,825,000 is estimated to occur in FY 2012-13.

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 114

5. 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% FFP. The full adjustment is shown in the MH/UCD & BTR—DPH Interim Rate policy change.

6. The additional costs for FY 2011-12 and FY 2012-13 are fully incorporated into the base trends.

The estimated additional costs for DPH interim rates are:

	GF	FF	TF
FY 2011-12	$ 17,043,500	$ 17,043,500	**$ 34,087,000**
FY 2012-13	$ 43,912,500	$ 43,912,500	**$87,825,000**

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 115
IMPLEMENTATION DATE: 7/2011
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1475

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$1,958,501,000	$7,827,754,000
- STATE FUNDS	$972,169,000	$3,961,827,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$1,958,501,000	$7,827,754,000
STATE FUNDS	$972,169,000	$3,961,827,000
FEDERAL FUNDS	$986,332,000	$3,865,927,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments hospitals will receive from the quality assurance fee (QAF) program.

Authority:
AB 1383 (Chapter 627, Statutes of 2009)
SB 90 (Chapter 19, Statutes of 2011)
SB 335 (Chapter 286, Statutes of 2011)

Background:
AB 1383 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) created by AB 188 (Chapter 645, Statutes of 2009). This fund is used to provide supplemental payments to private and non-designated public hospitals (NDPHs), grants to designated public hospitals (DPHs), 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) and SB 208 (Chapter 714. Statutes of 2010) revised 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 DPHs for the State's use while the bill is in effect. In exchange, a portion of federal flexibility funding was allocated to the DPHs 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. SB 208 compressed the timeframe for collection of the QAF and distribution of supplemental payments, allowed accumulation of fees in the HQARF in order to make managed care payments, and altered the priority of payments.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 115

SB 90 extended the QAF program established by AB 1383, for the period of January 2011 through June 2011. The extension provided for supplemental payments to private hospitals, increased payments to managed health care, and mental health plans if enough fees were collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

SB 335 creates a new QAF program for the period July 2011 through December 2013. This 30-month program was modeled on the original QAF program and two-quarter extension. This program provides for supplemental payments to private hospitals, grants to DPHs and NDPHs, increased payments to managed health care, and mental health plans if enough fees are collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

Reason for Change from Prior Estimate:
The changes are due to revised payment calculation pursuant to SB 335 and delay in implementation because of pending CMS approval.

Methodology:

1. The first QAF program was effective April 2009 through December 2010; with a two-quarter extension through June 2011. An additional 30-month QAF program is effective for the time period July 2011 through December 2013.

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, $1.9 billion in FY 2010-11, $2.6 billion in FY 2011-12, $2.8 billion in FY 2012-13, and $1.5 billion in FY 2013-14.

3. First payment to the hospitals occurred in October 2010.

4. The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's Federal Medical Assistance Percentage (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 $25,326,000 due to ARRA, for SB 90 managed care payments in FY 2011-12, is budgeted in this policy change.

5. California's FMAP returned to 50% as of July 1, 2011. All fee-for-service (FFS) payments made in FY 2011-12 and FY 2012-13 including payments for the original QAF and the two-quarter extension will be made at the current FMAP.

6. In FY 2011-12, $2,187,000 in grants will be paid to DPHs from the HQARF pursuant to AB 1383 and $34,300,000 in grants will be paid to DPHs and NDPHs pursuant to SB 335. In FY 2012-13, $95,900,000 in grants will be paid to DPHs and NDPHs from the HQARF pursuant to SB 335. These hospital grants do not receive a federal match.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 115

Payments to the hospitals are estimated to be:

FY 2011-12	TF	SF(HQARF)	FF	ARRA FF
AB 1383	$37,303,000	$19,745,000	$17,558,000	$0
SB 90*	$398,428,000	$173,888,000	$199,214,000	$25,326,000
SB 335**	$1,522,770,000	$778,536,000	$744,234,000	$0
Total	**$1,958,501,000**	**$972,169,000**	**$961,006,000**	**$25,326,000**
FY 2012-13				
SB 335**	**$7,827,754,000**	**$3,961,827,000**	**$3,865,927,000**	

Funding:
Hospital Quality Assurance Revenue Fund (4260-601-3158)
Hospital Quality Assurance Revenue Fund (4260-610-3158)*
Hospital Quality Assurance Revenue Fund (4260-611-3158)**
Title XIX FFP (4260-101-0890)

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 116
IMPLEMENTATION DATE: 11/2011
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1140

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$120,000,000	$195,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$120,000,000	$195,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$120,000,000	$195,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to freestanding, non-hospital based clinics.

Authority:
AB 959 (Chapter 162, Statutes of 2006)

Background:
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 will be retroactive to July 1, 2006, pending an approved State Plan Amendment. Since facilities must submit cost reports and the Department must certify expenditures before federal financial participation (FFP) can be claimed, supplemental payments for services provided during a fiscal year will not be issued until the completion of audited cost reports.

Reason for Change from Prior Estimate:
Supplemental payments for FY 2008-09, FY 2009-10, and FY 2010-11 will be paid in FY 2012-13.

Methodology:
1. Supplemental payments for freestanding, non-hospital based clinics are expected to begin in FY 2011-12.

2. Supplemental payments to freestanding, non-hospital based clinics are expected to total between $60,000,000 and $66,000,000 annually.

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 116

3. Supplemental payments are lagged 18 months pending the completion of cost report audits.

Program payment amounts are estimated to be:

	FY 2011-12
Freestanding Outpatient Clinics for FY 2006-07	$60,000,000
Freestanding Outpatient Clinics for FY 2007-08	$60,000,000
Total FFP	**$120,000,000**

	FY 2012-13
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
Total FFP	**$195,000,000**

Funding:
Title XIX 100% FFP (4260-101-0890)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 117
IMPLEMENTATION DATE: 4/2004
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 78

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$202,834,000	$173,507,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$202,834,000	$173,507,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$202,834,000	$173,507,000

DESCRIPTION

Purpose:
This policy change estimates the outpatient supplemental payments based on certified public expenditures (CPEs) for providing outpatient hospital care to Medi-Cal beneficiaries.

Authority:
AB 915 (Chapter 747, Statutes of 2002)

Background:
A supplemental reimbursement program was created for publicly owned or operated hospital outpatient departments. Hospitals now receive outpatient supplemental payments based on CPEs 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 federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

Reason for Change from Prior Estimate:
There is no material change.

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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 was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. Payments of $202,834,000 are expected to be made in FY 2011-12 based on CPE claims and adjusting for the change in the FMAP.

3. Payments of $173,507,000 are expected to be made in FY 2012-13 based on CPE claims.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 117

Estimated costs are as follows:

	Regular FFP	FY 2011-12 ARRA	Total FFP
FY 2009-10	$1,360,000	$315,000	$1,676,000
FY 2010-11	$168,453,000	$32,705,000	$201,158,000
	$169,813,000	$33,020,000	**$202,834,000**

	Regular FFP	FY 2012-13 ARRA	Total FFP
FY 2011-12	$173,507,000	**$0**	**$173,507,000**

Funding:
Title XIX FFP (4260-101-0890)

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 118
IMPLEMENTATION DATE: 7/1991
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 82

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$172,243,000	$111,214,000
- STATE FUNDS	$46,981,000	$45,343,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$172,243,000	$111,214,000
STATE FUNDS	$46,981,000	$45,343,500
FEDERAL FUNDS	$125,262,000	$65,870,500

DESCRIPTION

Purpose:
This policy change estimates the Medi-Cal reimbursement for debt services incurred from the financing of capital construction projects.

Authority:
SB 1732 (Chapter 1635, Statutes of 1988), SB 2665 (Chapter 1310, Statutes of 1990), and SB 1128 (Chapter 757, Statutes of 1999).

Background:
SB 1732 and SB 2665 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.

SB 1128 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 Welfare and Institutions Code.

Reason for Change from Prior Estimate:
Revised based on additional actual expenditures.

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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 was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there were some expenditures made in FY 2011-12 that will receive the increased

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 118

ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as capital construction reimbursements, when Medi-Cal draws the federal funds in a subsequent fiscal year.

3. Retroactive payments for DP-NFs for the periods of FY 2004-05 through 2010-11, were made in FY 2011-12.

4. Two DP facilities have begun submitting annual claims in FY 2011-12.

FY 2011-12	Total Funds	GF	Regular FFP	ARRA FFP*	Total FFP
Hospitals	$93,962,000	$46,981,000	$46,981,000	$0	$46,981,000
DP-NFs	$78,281,000	$0	$24,919,000	$53,362,000	$78,281,000
Total	**$172,243,000**	$46,981,000	$71,900,000	$53,362,000	$125,262,000

FY 2012-13	Total Funds	GF	FFP
Hospitals	$90,687,000	$45,343,500	$45,343,500
DP-NFs	$20,527,000	$0	$20,527,000
Total	**$111,214,000**	$45,343,500	$65,870,500

Funding:
Title XIX 100% FFP (4260-101-0890)*
Capital Debt 50/50 FFP (4260-102-0001/0890)

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 119
IMPLEMENTATION DATE: 11/2012
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1458

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$0	$175,073,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$0	$175,073,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$0	$175,073,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement based on certified public expenditures for Specialty Mental Health (SMH) Services.

Authority:
ABX4 5 (Chapter 5, Statutes of 2009)

Background:
This program 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.

The supplemental payment amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the allowable costs of providing services to Medi-Cal beneficiaries. The non-federal share of costs used to draw down federal financial participation (FFP) for the supplemental payments will be expended from the public agency, and will not involve General Fund dollars.

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

Reason for Change from Prior Estimate:
Updated data used in the supplemental payment calculation became available.

Methodology:
The Department will submit an attachment to the State Plan Amendment to the Center of Medicare and Medicaid Services 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 2012-13. Annual payments are estimated to be $110,886,000.

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 119

	FFP - REGULAR	FFP - ARRA	FY 2012-13 TOTAL FFP
FY 2008-09 FFP	$52,108,000	$12,079,000	$64,187,000
FY 2009-10 FFP	$90,019,000	$20,867,000	$110,886,000
TOTAL FFP Payments	$142,127,000	$32,946,000	**$175,073,000**

Funding:
Title XIX 100% FFP (4260-101-0890)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 120
IMPLEMENTATION DATE: 6/2011
ANALYST: Jennifer Hsu
FISCAL REFERENCE NUMBER: 1600

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$93,432,000	$70,000,000
- STATE FUNDS	$44,514,000	$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$93,432,000	$70,000,000
STATE FUNDS	$44,514,000	$35,000,000
FEDERAL FUNDS	$48,918,000	$35,000,000

DESCRIPTION

Purpose:
This policy change estimates the revenue and payments for a supplemental reimbursement program for Nondesignated Public Hospitals (NDPHs).

Authority:
AB 113 (Chapter 20, Statutes of 2011)

Background:
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). 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 policy change also reflects the portion of the nine percent that is used to offset GF costs of Medi-Cal children's health services.

Reason for Change from Prior Estimate:
There is no material change.

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased ARRA FMAP as allowed by the federal government. The additional funding due to the FMAP increase is included in this policy change.

(In Thousands)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 120

FY 2011-12					
FY 2010-11	TF	GF	IGT	FF	ARRA
Payments to NDPHs	$32,000	$0	$13,798	$16,000	$2,202
Children's Services	$0	($1,324)	$1,324	$0	$0
Total	$32,000	($1,324)	$15,122	$16,000	$2,202
FY 2011-12					
Payments to NDPHs	$61,432	$0	$30,716	$30,716	$0
Children's Services	$0	($2,898)	$2,898	$0	$0
Total	$61,432	($2,898)	$33,614	$30,716	$0
Total 2011-12	**$93,432**	**($4,222)**	**$48,736**	**$46,716**	**$2,202**
FY 2012-13					
Payments to NDPHs	$70,000	$0	$35,000	$35,000	$0
Children's Services	$0	($3,322)	$3,322	$0	$0
Total 2012-13	**$70,000**	**($3,322)**	**$38,322**	**$35,000**	**$0**

Funding:
Medi-Cal Inpatient Payment Adjustment (MIPA) Fund (4260-606-0834)
Title XIX GF/FFP (4260-101-0001/0890)

IGT FOR NON-SB 1100 HOSPITALS

REGULAR POLICY CHANGE NUMBER: 121
IMPLEMENTATION DATE: 7/2006
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1158

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$12,760,000	$100,000,000
- STATE FUNDS	$6,380,000	$50,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$12,760,000	$100,000,000
STATE FUNDS	$6,380,000	$50,000,000
FEDERAL FUNDS	$6,380,000	$50,000,000

DESCRIPTION

Purpose:
This policy change estimates the Intergovernmental Transfers (IGTs) used to draw down federal financial participation (FFP) paid to non-SB 1100 hospitals.

Authority:
Welfare and Institutions Code, section 14164

Background:
This program provides general authority for the Department to accept 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.

Reason for Change from Prior Estimate:
Additional payment information became available.

Methodology:
Not applicable

	TF	IGT	FFP
FY 2011-12	**$12,760,000**	$6,380,000	$6,380,000
FY 2012-13	**$100,000,000**	$ 50,000,000	$50,000,000

IGT FOR NON-SB 1100 HOSPITALS

REGULAR POLICY CHANGE NUMBER: 121

Funding:
Title XIX FFP (4260-101-0890)
Reimbursement (4260-610-0995)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 122
IMPLEMENTATION DATE: 2/2006
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 104

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$67,130,000	$67,130,000
- STATE FUNDS	$33,565,000	$33,565,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$67,130,000	$67,130,000
STATE FUNDS	$33,565,000	$33,565,000
FEDERAL FUNDS	$33,565,000	$33,565,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to specific hospitals that provide trauma care to Medi-Cal beneficiaries, through the use of Intergovernmental Transfers (IGTs).

Authority:
Welfare and Institutions Code Sections 14164 and 14087.3

Background:
Under this program, Los Angeles and Alameda Counties 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 Department uses the funds to make enhanced payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
The non-federal match is paid by Los Angeles and Alameda Counties via Intergovernmental Transfer through the Special Deposit Fund (Local Trauma Centers).

	Special Deposit Fund	FFP	TF
FY 2011-12	$33,565,000	$33,565,000	**$67,130,000**
FY 2012-13	$33,565,000	$33,565,000	**$67,130,000**

Funding Table:
Local Trauma Centers Fund 50% (4260-601-0942142)
Title XIX 50% FFP (4260-101-0890)

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 123
IMPLEMENTATION DATE: 6/2002
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 86

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$40,678,000	$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	$40,678,000	$32,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$40,678,000	$32,000,000

DESCRIPTION

Purpose:
This policy change estimates federal financial participation (FFP) payments based on Certified Public Expenditures (CPE) to nursing facilities (NF) that are distinct parts (DP) of acute care hospitals.

Authority:
AB 430 (Chapter 171, Statutes of 2001)

Background:
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. This bill provides supplemental reimbursement to a DP-NF of an acute care hospital, as described above, for delivering services to Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:
The audit results from the Office of Inspector General were incorporated into this policy change.

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 123

3. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Interim payments, or recoupment of overpaid funds, are expected during the current fiscal year (represented below).

4. 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.

5. Based on a funding of historical data, an estimate of $40,678,000 FFP and $32,000,000 FFP will be available in FY 2011-12 and FY 2012-13, respectively.

	FISCAL YEAR 2011-12		
	FFP	**ARRA**	**Total FFP**
FY 2011-12	$41,123,000	$3,877,000	$45,000,000
FY 2007-08 Reconciliation	$1,705,000		$1,705,000
FY 2006-07 Reconciliation	-$665,000		-$665,000
FY 2005-06 Reconciliation	-$2,735,000		-$2,735,000
FY 2004-05 Reconciliation	-$2,627,000		-$2,627,000
Total	$36,801,000	$3,877,000	**$40,678,000**

	FISCAL YEAR 2012-13		
	FFP	**ARRA**	**Total FFP**
FY 2012-13	$32,000,000	$0	**$32,000,000**

Funding:
Title XIX FFP (4260-101-0890)

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 124
IMPLEMENTATION DATE: 1/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1038

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$7,500,000	$10,000,000
- STATE FUNDS	$3,750,000	$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$7,500,000	$10,000,000
STATE FUNDS	$3,750,000	$5,000,000
FEDERAL FUNDS	$3,750,000	$5,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental reimbursement to hospitals providing a disproportionate share of outpatient services.

Authority:
SB 2563 (Chapter 976, Statutes of 1988)

Background:
A supplemental program was created for hospitals providing a disproportionate share of outpatient services. 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. Since the Department accelerated 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, there will be one less quarterly payment in FY 2011-12.

Reason for Change from Prior Estimate:
There is no change.

Methodology:
1. In FY 2011-12 $7,500,000 and in FY 2012-13 $10,000,000 will be paid through PANs.

	FY 2011-12	FY 2012-13
Ongoing Annual Payment	$7,500,000	$10,000,000

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 125
IMPLEMENTATION DATE: 1/2005
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1039

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$6,000,000	$8,000,000
- STATE FUNDS	$3,000,000	$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$6,000,000	$8,000,000
STATE FUNDS	$3,000,000	$4,000,000
FEDERAL FUNDS	$3,000,000	$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the increase in reimbursement rates for outpatient services provided to Medi-Cal beneficiaries by Small and Rural Hospitals (SRHs).

Authority:
AB 2617 (Chapter 158, Statutes of 2000)

Background:
This program was created to provide SRHs with increased reimbursement rates. 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. Since the Department accelerated 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, there will be one less quarterly payment in FY 2011-12.

Methodology:
1. Reimbursements to SRHs providing outpatient services are assumed to be $8,000,000 when combined with federal matching funds.

2. In FY 2011-12 $6,000,000 and in FY 2012-13 $8,000,000 will be paid through Payment Action Notices (PANs).

	FY 2011-12	FY 2012-13
Ongoing Annual Payment	**$6,000,000**	**$8,000,000**

Reason for Change from Prior Estimate:
There is no change.

Funding:
Title XIX 50/50 FFP (4260-101-0001/0890)

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 126
IMPLEMENTATION DATE: 12/2010
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 1616

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$3,237,000	$4,000,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$3,237,000	$4,000,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$3,237,000	$4,000,000

DESCRIPTION

Purpose:
This policy change estimates the supplemental payments to state veterans' homes.

Authority:
AB 959 (Chapter 162, Statutes of 2006)

Background:
Under this program, 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 federal financial participation (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.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. 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 state veterans' homes began in FY 2010-11.

Reasons for Change from Prior Estimate:
Additional data became available for calculating the supplemental payments.

Methodology:
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (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. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 126

payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as state veterans' homes supplemental payments, and Medi-Cal draws the federal funds in a subsequent fiscal year.

Program payment amounts are estimated to be:

FY 2011-12	**FFP**	**ARRA**	**Total FFP**
State Veterans' Homes for FY 2010-11	$2,711,000	$526,000	**$3,237,000**
FY 2012-13			
State Veterans' Homes for FY 2011-12	$4,000,000	$0	**$4,000,000**

Funding:
Title XIX 100% FFP (4260-101-0890)

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER:	133
IMPLEMENTATION DATE:	12/2011
ANALYST:	Cang Ly
FISCAL REFERENCE NUMBER:	1488

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	$501,500,000	$468,775,000
- STATE FUNDS	$0	$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	$501,500,000	$468,775,000
STATE FUNDS	$0	$0
FEDERAL FUNDS	$501,500,000	$468,775,000

DESCRIPTION

Purpose:
This policy change estimates the cost of Medicaid incentive payments to qualified health care providers who adopt and use Electronic Health records (EHR) in accordance with the Health Information Technology for Economic and Clinical Health (HITECH) Act under the American Recovery and Reinvestment Act of 2009 (ARRA).

Authority:
American Recovery and Reinvestment Act of 2009 (ARRA), SB 945 (Chapter 433, Statutes of 2011)

Background:
The HITECH Act, a component of the ARRA, authorizes the outlay of federal money estimated to be $45 billion over 10 years between 2011 and 2021 for Medicaid incentives to qualified health care providers who adopt, implement, or upgrade and meaningfully use certified EHR technology in accordance with the HITECH Act's requirements. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011.

The Department will expand the current Medicaid Management Information Systems (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 20,000 to 22,000 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 EHR Incentive Payments Program. System costs are budgeted in the FI Estimate.

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 133

Reason for Change from Prior Estimate:
Delay in implementation of the EHR Incentive program resulted from a decision to abandon a Commercial Off-the-Shelf (COTS) solution developed by the vendor, in favor of a California specific solution which should accommodate the program's unique needs.

Methodology:

1. Payments to the providers began in December 2011.

2. Payments to professionals are a fixed amount for the first year of eligibility and a lesser fixed amount for eligibility years two through six. Payments to hospitals are fixed at a computed amount over four years.

3. Assume professionals will receive incentive payments over a six year period. The years do not have to be consecutive. The first eligibility year incentive payment is $21,250. Incentive payments for years two through six are $8,500 per eligible year. The maximum incentive payment for a professional over the six year period is $63,750.

4. Assume the aggregate hospital incentive payment amount is computed on a $2,000,000 base amount adjusted up or down depending on Medi-Cal discharges for the year. Hospital incentive payments will be made over a period of four years. The years do not have to be consecutive. Payments will be limited to 50 percent of the aggregate hospital incentive payment for the first eligibility year, 30 percent for the second eligibility year and 10 percent for the third and fourth payment eligibility years.

5. Assume for FY 2011-12 and FY 2012-13, the aggregate hospital incentive payment is $3,400,000. The first year eligibility incentive payment will average $1,700,000 and the second year eligible incentive payment will average $1,020,000.

6. Assume 10,000 eligible professionals will receive a first year eligibility incentive payment in FY 2011-12. Of the eligible hospitals, 170 will receive a first year incentive eligibility incentive payment in FY 2011-12.

   10,000 professionals x $21,250 = $212,500,000
   170 hospitals x $1,700,000 = $289,000,000

7. Assume 2,500 eligible professionals will receive a first year eligibility incentive payment and 2,500 will receive a second year eligibility incentive payment in FY 2012-13. Of the eligible hospitals, 130 will receive a first year eligibility incentive payment and 170 will receive a second year eligibility payment in FY 2012-13.

   2,500 professionals x $21,250 = $53,125,000
   2,500 professionals x $ 8,500 = $21,250,000

   130 hospitals x $1,700,000 = $221,000,000
   170 hospitals x $1,020,000 = $173,400,000

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 133

CASH BASIS	FFP
FY 2011-12	
Eligibility Year 1 Professional Payments	$212,500,000
Eligibility Year 1 Hospital Payments	$289,000,000
	$501,500,000
FY 2012-13	
Eligibility Year 1 Professional Payments	$53,125,000
Eligibility Year 2 Professional Payments	$21,250,000
Eligibility Year 1 Hospital Payments	$221,000,000
Eligibility Year 2 Hospital Payments	$173,400,000
	$468,775,000

Funding:
Title XIX 100% FFP (4260-101-0890)