

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 136
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1232

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$87,157,000	\$212,509,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$87,157,000	\$212,509,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$87,157,000	\$212,509,000

DESCRIPTION

Purpose:

This policy change estimates the federal match for transportation and day care costs of Intermediate Care Facility - Developmentally Disabled (ICF-DD) beneficiaries for the California Department of Developmental Services (CDDS).

Authority:

Interagency Agreement (IA)

Background:

Federal financial participation (FFP) will be paid to the CDDS for the transportation and day care costs of ICF-DD beneficiaries. On April 15, 2011, Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain the federal match for the active treatment and transportation costs and reimbursement for these costs retroactive to July 1, 2007.

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 FFP for FY 2011-12 and FY 2012-13.

The General Fund is in the CDDS budget on an accrual basis, the federal funds in the Department's budget are on a cash basis.

Reason for Change from Prior Estimate:

Delay in implementation difficulties obtaining prior year data.

Methodology:

1. The following estimates have been provided by CDDS.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 136

CASH BASIS (In Thousands)	TF	CDDS GF	FFP Regular	FFP ARRA	Total FFP	IA #
FY 2011-12	\$157,535	\$70,378	\$78,768	\$8,389	\$87,157	07-65896
FY 2012-13	\$384,725	\$172,216	\$192,362	\$20,147	\$212,509	07-65896

Funding:

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

HEALTHY FAMILIES - CDMH

REGULAR POLICY CHANGE NUMBER: 142
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 89

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$18,513,000	\$21,099,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$18,513,000	\$21,099,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$18,513,000	\$21,099,000

DESCRIPTION

Purpose:

This policy change estimates Title XXI federal financial participation (FFP) for additional services provided to eligible, severely emotionally disturbed, children who have exhausted Healthy Families mental health benefits.

Authority:

Welfare and Institution Code, section 5600.3

Background:

The estimates below were provided by the California Department of Mental Health (CDMH) and the Department. Effective July 1, 2012, the CDMH Health Families mental health program and associated federal funding will be shifted to the Department.

Reason for Change from Prior Estimate:

Projections were revised based on additional actual expenditures.

Methodology:

Not applicable.

CASH BASIS

	<u>DHCS FFP</u>	<u>County Match</u>	<u>IA #</u>
FY 2011-12	\$18,513,000	\$9,968,000	02-25271
FY 2012-13	\$21,099,000	\$11,361,000	

Funding:

Title XXI 100% FFP (4260-113-0890)

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 145
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1526

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$40,368,000	\$11,418,000
- STATE FUNDS	\$16,935,000	\$5,709,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,368,000	\$11,418,000
STATE FUNDS	\$16,935,000	\$5,709,000
FEDERAL FUNDS	\$23,433,000	\$5,709,000

DESCRIPTION

Purpose:

This policy change estimates the federal match provided to the California Department of Developmental Services (CDDS) for increased administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).

Authority:

Interagency agreement (IA)

Background:

The CDDS will make supplemental payments to Medi-Cal providers that are licensed as ICF-DDs, ICF-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center (RC) consumers. The services and transportation are arranged for and paid by the local RCs, which will bill CDDS on behalf of the ICF-DDs. On April 15, 2011, a State Plan Amendment (SPA) was approved for CDDS to provide payment, retroactive to July 1, 2007, to the ICF-DDs, so that they can reimburse the RCs for arranging the services.

On April 8, 2011, the Department entered into an interagency agreement with CDDS for the reimbursement of administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.

ICF-DDs are subject to a Quality Assurance Fee (QAF) based upon their Medi-Cal revenues, with the revenue used to increase rates for the ICF-DDS.

Reason for Change from Prior Estimate:

Revised figures were given after the estimate was finalized.

Methodology:

1. The following estimates have been provided by CDDS.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 145

FY 2011-12 (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursement	Total Funds	DHCS GF	Total FFP
<u>\$8,074</u>	<u>\$32,294</u>	<u>\$40,368</u>	<u>\$16,935</u>	<u>\$23,433</u>

FY 2012-13 (In Thousands)

ICF-DD Admin Fee	QA Fee Reimbursement	Total Funds	DHCS GF	Total FFP
<u>\$2,284</u>	<u>\$9,134</u>	<u>\$11,418</u>	<u>\$5,709</u>	<u>\$5,709</u>

Funding:

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

MINOR CONSENT SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 146
 IMPLEMENTATION DATE: 7/2003
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 103

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$7,620,000	\$0
- STATE FUNDS	\$7,620,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,620,000	\$0
STATE FUNDS	\$7,620,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the costs of settlement payments related to incorrect claiming of services provided to minor consent eligibles.

Authority:

Not applicable

Background:

On June 17, 2002, the Department, Los Angeles County, and the U.S. Department of Justice executed a settlement agreement concerning an audit by the federal Office of the Inspector General relating to the incorrect claiming of FFP for services (especially mental health services) provided to minor consent eligibles from 1993 to 1999. The terms of the settlement include payment of \$73.3 million plus interest, of which Los Angeles County paid \$6.8 million. The balance of \$66.5 million plus interest is being withheld from California's Medicaid payments over a ten year period beginning with the first "adjustment" made on July 1, 2003. The final payment will be made in FY 2011-12.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

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

Funding:

100% State GF (4260-101-0001)

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 147
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1340

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$7,248,000	\$5,203,000
- STATE FUNDS	\$3,624,000	\$2,601,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,248,000	\$5,203,000
STATE FUNDS	\$3,624,000	\$2,601,500
FEDERAL FUNDS	\$3,624,000	\$2,601,500

DESCRIPTION

Purpose:

This policy change estimates the noncontract hospital inpatient cost settlements.

Authority:

Welfare and Institutions Code, section 14170

Background:

All noncontract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the noncontract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.

Reason for Change from Prior Estimate:

The changes are due to updated expenditures.

Methodology:

Payments are estimated to total \$7,248,000 for FY 2011-12 and \$5,203,000 for FY 2012-13.

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
Hospitals	\$7,248,000	\$5,203,000

Funding:

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

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 148
 IMPLEMENTATION DATE: 2/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1629

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$4,300,000	\$11,430,000
- STATE FUNDS	\$4,300,000	\$11,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,300,000	\$11,430,000
STATE FUNDS	\$4,300,000	\$11,430,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the reimbursement from California Department of Development Services (CDDS) to pay claims for CDDS consumers whose dental services are no longer covered by Medi-Cal.

Authority:

Interagency agreement (IA)

Background:

The Lanterman Act requires the CDDS to provide dental services to its clients. Because Medi-Cal no longer covers most dental services for adults 21 years of age and older, CDDS has entered into an IA with the Department to have the Medi-Cal dental fiscal intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of claims processing and benefits will be reimbursed by CDDS. Processing of CDDS claims started on January 12, 2012.

This policy change estimates the reimbursement of benefit costs. The reimbursement of administration costs are budgeted in the Other Administration CDDS Dental Services policy change.

Reason for Change from Prior Estimate:

Delta Dental will not bill the Department for January claims until the month of February.

Methodology:

1. Assume the reimbursements will begin in February 2012.
2. Assume the benefit costs will be \$11,430,000 annually.

CDDS DENTAL SERVICES
REGULAR POLICY CHANGE NUMBER: 148

	<u>Reimbursement</u>	<u>IA #</u>
FY 2011-12:	\$ 4,300,000	10-87244
FY 2012-13:	\$11,430,000	10-87244

Funding:

Reimbursement (4260-610-0995)

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 151
 IMPLEMENTATION DATE: 4/1998
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 111

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$510,000	\$1,463,000
- STATE FUNDS	-\$9,839,000	-\$9,838,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$510,000	\$1,463,000
STATE FUNDS	-\$9,839,000	-\$9,838,500
FEDERAL FUNDS	\$10,349,000	\$11,301,500

DESCRIPTION

Purpose:

This policy change estimates the annual rate change posted in the Federal Register and the technical adjustment in funding from Title XIX 50% federal financial participation (FFP) to Title XIX 100% FFP for services provided by Indian health clinics to Native Americans eligible for Medi-Cal.

Authority:

Public Law 93-638

Background:

Indian Health Services (IHS) annually issues revised reimbursement rates applicable to the Centers for Medicare and Medicaid Services (CMS). These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS. Notice of the rate change is given by the Director of IHS and is published in the federal register.

Reason for Change from Prior Estimate:

FY 2012-13 estimate changed to incorporate the anticipated rate increase based on a 10 year trend estimate.

Methodology:

1. Currently, there are 49 Indian health clinics participating in Medi-Cal.
2. In fiscal year (FY) 2010-11, the Department spent \$19,677,000.
3. Recent changes posted in the Federal Register, Volume 76, Number 84, May 2, 2011, updated the per visit rate payable to Indian Health Clinics. As a result, effective calendar year 2011, the per rate visit payable to Indian Health Clinics has changed to \$294 from \$289, an increase of \$5.
4. The Department projects a total of \$20,017,000 will be spent on services provided by Indian Health Clinics in FY 2011-12 and FY 2012-13.

$$\$20,017,000 - \$19,677,000 = \$340,000$$

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 151

5. The FY 2011-12 budget includes an additional \$170,000 due to the increased rate for the period of January 2011 through June 2011. The annual rate increase for the additional \$5 is \$340,000.
6. The FY 2012-13 budget includes an additional \$374,000 due to the anticipated rate increase for the period of January 2012 through June 2012. The annual rate increase for the additional \$11 is \$749,000.

(In Thousands)	<u>FY 2011-12</u>	<u>FY 2012-13</u>
CY 2011 rate increase	\$340	\$340
CY 2012 rate increase	\$0	\$749
Retro Jan –June 2011 rate increase	\$170	\$0
Retro Jan –June 2012 rate increase	\$0	\$374
Total rate increase	<u>\$510</u>	<u>\$1,463</u>
FY 2010-11 Base expenditures	<u>\$19,677</u>	<u>\$19,677</u>
Total expenditures	\$20,187	\$21,140

Funding: (In Thousands)

FY 2011-12:		<u>TF</u>	<u>GF</u>	<u>FFP</u>
Title XIX 50/50 FFP	4260-101-0001/0890	-\$19,677	-\$9,839	-\$9,839
Title XIX FFP	4260-101-0890	\$20,187	\$0	\$20,187
Net Impact		\$510	-\$9,839	\$10,349*
FY 2012-13:		<u>TF</u>	<u>GF</u>	<u>FFP</u>
Title XIX 50/50 FFP	4260-101-0001/0890	-\$19,677	-\$9,839	-\$9,839
Title XIX FFP	4260-101-0890	\$21,140	\$0	\$21,140
Net Impact		\$1,463	-\$9,839	\$11,302*

*Totals may differ due to rounding.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 152
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1087

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change shifts the Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds from the Hospital Services, Physicians' Services and Unallocated Accounts to the Department's General Fund. This funding shift is identified in the management summary funding pages.

Authority:

California Tobacco Health Protection Act of 1988 (Proposition 99)
 AB 75 (Chapter 1331, Statutes of 1989)

Background:

The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments for FY 2011-12 and FY 2012-13. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

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

FY 2011-12

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

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 152

FY 2012-13

Hospital Services Account	\$58,946,000
Physicians' Services Account	\$105,000
Unallocated Account	<u>\$24,589,000</u>
Total CTPS/Prop. 99	\$83,640,000
GF	<u>-\$83,640,000</u>
Net Impact	\$0

Reason for Change from Prior Cycle:

There is no change.

Funding:

Proposition 99 Hospital Services Account (4260-101-0232)
Proposition 99 Physician Services Account (4260-101-0233)
Proposition 99 Unallocated Account (4260-101-0236)
Title XIX GF (4260-101-0001)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 153
 IMPLEMENTATION DATE: 7/1999
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 35

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$6,000,000	\$6,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$6,000,000	\$6,000,000
FEDERAL FUNDS	-\$6,000,000	-\$6,000,000

DESCRIPTION

Purpose:

This policy change estimates the cost of federal financial participation (FFP) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improperly claimed ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs).

Authority:

Title 42, Code of Federal Regulations, section 435.1009
 Welfare and Institutions Code, section 14053.3

Background:

Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for FFP. These ancillary services are to be county-funded. Because separate aid codes or other identifiers are not available to indicate a Medi-Cal beneficiary is residing in an IMD, repayment of the FFP is calculated retrospectively based on information on impacted beneficiaries provided by the California Department of Mental Health (CDMH). Effective July 1, 2012, CDMH Specialty Mental Health programs and associated funding will be shifted to the Department.

Reimbursement to the Department for the cost of these services from CDMH and the providers, for years before FY 2012-13, is budgeted in the Reduction in IMD Ancillary Services Costs policy change.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

Not Applicable

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 153

Services Rec'd	FY 2011-12 Repayment	FY 2012-13 Repayment
10/01/08-09/30/09	\$6,000,000	\$0
10/01/09-09/30/10	\$0	\$6,000,000
Total:	\$6,000,000	\$6,000,000

Funding:

GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

REDUCTION IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER: 154
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1422

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change reflects the General Fund (GF) reimbursement from the California Department of Mental Health (CDMH) for improperly claimed Medi-Cal funding for ancillary services for Medi-Cal beneficiaries residing in Institutions for Mental Diseases (IMDs). The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.

Authority:

Title 42, Code of Federal Regulations, section 435.1009
 Welfare and Institutions Code, section 14053.3

Background:

Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for federal financial participation (FFP). These ancillary services are to be county-funded. Because separate aid codes or other identifiers are not available to indicate if a Medi-Cal beneficiary is residing in an IMD, the claims are not easily identifiable. Repayment of the FFP is required by the Centers for Medicare & Medicaid Services (CMS) and is calculated retrospectively based on beneficiaries' dates of residence in an IMD as provided by CDMH.

The Department is developing a process, in collaboration with CDMH, to stop inappropriate billings for ancillary services, and has released instructions to the provider community via a memorandum and the Medi-Cal provider bulletin. In addition, the Department anticipates utilizing a three-step approach as outlined below:

1. The Department and CDMH have developed one list of IMD facilities, which has been distributed to IMD facilities and which will be published in the Medi-Cal Provider Manual. Outreach will be conducted to help ensure that expenses for ancillary services are billed to the appropriate entity.
2. The Department will publish policy guidance through an All County Welfare Director's Letter (ACWDL) or similar instruction that will instruct providers that claims for ancillary services shall not be submitted to Medi-Cal.

REDUCTION IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER: 154

3. The Department will establish an indicator on the Medi-Cal Eligibility Data System (MEDS) that would assist providers to identify beneficiaries who are residents of an IMD and preclude inappropriate billings for ancillary services.

Reason for Change from Prior Estimate:

Due to the transfer of CDMH programs to the Department, reimbursements from CDMH in FY 2012-13 were deleted from this policy change.

Methodology:

1. In FY 2011-12, the Department expects to collect 50% of costs for FY 2007-08 and FY 2008-09.
2. Effective July 1, 2012, CDMH programs and its associated funding will be shifted to the Department therefore reimbursements from CMDH will no longer exist. Beginning FY 2012-13 forward, the Department will attempt to collect reimbursements directly from the counties or conduct an Erroneous Payment Correction (EPC) process once the Department can identify providers that received inappropriate Medi-Cal reimbursement for services to IMD residents.

Dates of Service	FY 2011-12
FY 2007-08	\$ 6,000,000
FY 2008-09	\$ 6,000,000
Total:	\$12,000,000 GF

Funding:

GF (4260-101-0001)

Reimbursement GF (4260-610-0995)

CLPP FUNDS

REGULAR POLICY CHANGE NUMBER: 155
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Jade Li
 FISCAL REFERENCE NUMBER: 1633

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change appropriates Childhood Lead Poisoning Prevention (CLPP) Funds for blood lead tests performed by the Medi-Cal program and estimates the technical adjustment in funding from 100% State GF to CLPP funds.

Authority:

Health and Safety Code § 105305,105310,124075

Background:

Medi-Cal provides blood lead tests to children who are at risk for lead poisoning, and

- are full-scope beneficiaries under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit of the Medi-Cal Program, or
- are pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The state share of cost for the lead testing component are paid by Medi-Cal on a fee-for-service (FFS) basis and are funded by the CLPP Funds. The expenditures are in Medi-Cal's FFS base trends, and this policy change adjusts the CLPP funding.

The CLPP Funds receive revenues from a fee accessed on entities formerly or presently engaged in commerce involving lead products, and collected by the Board of Equalization. CLPP funds appropriated in the Medi-Cal Local Assistance Estimate were previously shown in the EPSDT Screens and the CHDP Gateway - Preenrollment policy changes.

The cost associated with the lead testing component for beneficiaries in Medi-Cal managed care plans is incorporated in the plans' capitation rates, and has not been identified. In order to achieve General Fund savings in managed care plans analogous to the savings achieved in FFS, CLPP Funds for the lead testing component in Medi-Cal managed care capitation will be budgeted once the costs are identified.

CLPP FUNDS

REGULAR POLICY CHANGE NUMBER: 155

Reason for Change from Prior Estimate:

The Department previously appropriated CLPP funds but did not draw these funds down. The Department will claim three years' CLPP funds in FY 2011-12 based on actual expenditures.

Methodology:

1. Funding for Medi-Cal and CHDP Gateway is at 50% State Funds.
2. The Department will claim the prior three years' expenditure in FY 2011-12. The estimated CLPP funds to be claimed in FY 2011-12 are:

	<u>Total Funds</u>	<u>CLPP Funds</u>
FY 2008-09	\$1,622,000	\$811,000
FY 2009-10	\$1,607,000	\$803,000
FY 2010-11	\$1,490,000	\$746,000
Total FY 2011-12	\$4,719,000	\$2,360,000

3. It is assumed that FY 2011-12 lead testing expenditures will be claimed in FY 2012-13 and will remain the same as the actual expenditures of FY 2010-11.

	<u>Total Funds</u>	<u>CLPP Funds</u>
Total FY 2012-13	\$1,490,000	\$746,000

Funding:

CLPP Fund (4260-111-0080)
General Fund (4260-101-0001)

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 156
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1621

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to implementation of a quality assurance fee (QAF) for hospitals from July 1, 2011 to December 31, 2013.

Authority:

SB 335 (Chapter 286, Statutes of 2011)

Background:

SB 90 (Chapter 19, Statutes of 2011) allows certain acute care hospital buildings that are classified as a Structural Performance Category-1 (SPC-1) building to receive an additional extension of up to seven years to meet the State's seismic requirements contingent upon a hospital QAF program being established in FY 2011-12 that includes \$320 million in fee revenue for health care coverage for children. The hospital QAF program established by SB 335 (Chapter 286, Statutes of 2011) meets the SB 90 children's health coverage funding requirement to satisfy this condition.

SB 335 establishes a hospital QAF program for the period beginning July 1, 2011 to December 31, 2013. The extension of the hospital QAF program is currently pending approval from the Centers for Medicare and Medicaid Services (CMS). It is anticipated that the State will receive 6 months of QAF payments from the hospitals in FY 2011-12 and 18 months in FY 2012-13. The remaining 6 months of QAF payments will be received in FY 2013-14.

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.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 156

Methodology:

Based on a model created to analyze SB 335, the estimated receipt of funds for children's health care coverage is:

(In Thousands)	<u>TF</u>	<u>GF</u>	<u>Hosp. QA Rev Fund</u>
FY 2011-12	\$0	-\$ 170,000	\$ 170,000
FY 2012-13			
2011-12	\$0	-\$ 170,000	\$ 170,000
2012-13	\$0	-\$ 387,000	\$ 387,000
Total	\$0	-\$ 557,000	\$ 557,000

Funding:

Title XIX GF (4260-101-0001)

Hospital Quality Assurance Revenue Fund (4260-611-3158)

OVERPAYMENTS - INTEREST RATE CHANGE

REGULAR POLICY CHANGE NUMBER: 157
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1636

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$1,556,000
- STATE FUNDS	\$0	-\$1,556,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,556,000
STATE FUNDS	\$0	-\$1,556,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION**Purpose:**

This policy change estimates the savings from additional revenue due to the increased interest rate applied to uncollected accounts receivables for overpayments made to Medi-Cal providers.

Authority:

Trailer bill language has been proposed to amend Section 14171 of the Welfare and Institutions Code.

Background:

The Department assesses interest on account receivables over 90 days old, for overpayments made to Medi-Cal providers, at a rate equal to the monthly average received on investments in the Surplus Money Investment Fund (SMIF). The current SMIF rate is 0.378%.

The Department has proposed legislation to change the interest rate to the rate authorized by the California Constitution or the SMIF rate, whichever is higher. As a result of the rate change, the Department anticipates receiving increased revenue.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. It is estimated the new SMIF rate will be implemented July 1, 2012.

FY 2012-13	<u>TF</u>	<u>GF</u>
Total Savings	\$1,556,000	\$1,556,000

Funding:

GF (4260-101-0001)

FI COST CONTAINMENT PROJECTS

REGULAR POLICY CHANGE NUMBER: 158
 IMPLEMENTATION DATE: 2/2013
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 124

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$1,572,000
- STATE FUNDS	\$0	-\$786,000
PAYMENT LAG	1.0000	0.6570
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,032,800
STATE FUNDS	\$0	-\$516,400
FEDERAL FUNDS	\$0	-\$516,400

DESCRIPTION

Purpose:

This policy change estimates the savings from Fiscal Intermediary (FI) projects that reduce Medi-Cal costs.

Authority:

Not applicable

Background:

The FI is implementing the following proposals to contain Medi-Cal costs, which are not yet fully reflected in the base estimate.

The Establish Controls for X0032 (Transportation) project returned an insignificant amount of savings and was closed in August 2011.

The Pharmacy Duplicates project reviews claims sent from providers to ensure claims are not duplicated. The FI is working closely with Audits and Investigations (A&I) to determine final recovery amounts.

Reason for Change from Prior Estimate:

The change is due to additional data.

Methodology:

<u>Project Number</u>	<u>Impl. Date</u>	<u>Title</u>	<u>FY 2012-13 Savings</u>
08-01	July-11	Establish Controls for X0032 (Transportation)	Insignificant
07-17	Feb-13	Pharmacy Duplicates	\$1,572,000
TOTAL			\$1,572,000

Funding:

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

ANTI-FRAUD ACTIVITIES FOR PHARMACY AND PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 159
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1474

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,013,000	-\$12,363,000
- STATE FUNDS	-\$1,006,500	-\$6,181,500
PAYMENT LAG	0.5730	0.8813
% REFLECTED IN BASE	7.20 %	1.10 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,070,400	-\$10,775,700
STATE FUNDS	-\$535,200	-\$5,387,830
FEDERAL FUNDS	-\$535,200	-\$5,387,830

DESCRIPTION

Purpose:

This policy change estimates the savings resulting from expanding anti-fraud activities for pharmacy and physician services.

Authority:

Welfare & Institutions Code, section 14123.25

Background:

In January 2012, the Department expanded its anti-fraud activities for pharmacy and physician services.

Pharmacy Services Activities

The Department will use data mining techniques to identify providers and beneficiaries involved in suspicious activities related to abuse of prescriptions, institute a beneficiary lock-in program, apply administrative sanctions to providers found to be involved in unnecessary claiming, and address fraud related to medically unnecessary incontinence supplies.

Physicians Services Activities

The Department will conduct rapid response and compliance-focused sweeps of suspicious associations of providers and organized groups, targeting clinics involved in networks of fraud; provide statewide group training classes for providers; and identify providers with billing irregularities and provide training to ensure the type and level of services provided adhere to current medical practices and Medi-Cal statutes and regulations.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Savings are estimated to be \$13,800,000 annually.
2. Savings will be phased in over 12 months.

**ANTI-FRAUD ACTIVITIES FOR PHARMACY AND
PHYSICIANS**
REGULAR POLICY CHANGE NUMBER: 159

3. Budgeted amounts are preliminary until actual data becomes available.

Funding:

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

FQHC/RHC AUDIT STAFFING

REGULAR POLICY CHANGE NUMBER: 160
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1437

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	-\$3,058,000	\$0
- STATE FUNDS	-\$1,529,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,058,000	\$0
STATE FUNDS	-\$1,529,000	\$0
FEDERAL FUNDS	-\$1,529,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the savings achieved through reconciliation audits of Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) providers.

Authority:

Welfare & Institutions Code, section 14170

Background:

The Department received three limited-term positions to perform audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines. Reconciliation audits consist of reconciling Managed Care, Children's Health and Disability Prevention, Medicare Crossover and Medicare Advantage plan visits and payments to assure the FQHC/RHC providers were paid an amount equal to their prospective payment system rate. In the past five years, the number of FQHC/RHC providers has increased an average of nine percent annually, while the number of audit staff has remained the same. It is anticipated that the new limited-term positions will generate increased cost savings for FY 2011-12.

Reason for Change from Prior Estimate:

The three limited-term positions will expire June 30, 2012.

Methodology:

1. There was an unexpected delay due to FQHC/RHC staffing and hiring issues. Assume three limited-term positions will be recruited and hired by November 1, 2011.
2. Assume the new staff will be trained and ready to complete 12 reconciliation audits each month beginning January 1, 2012, until the positions expire on June 30, 2012.

FQHC/RHC AUDIT STAFFING

REGULAR POLICY CHANGE NUMBER: 160

3. Based on 2008 reconciliation audit data, each reconciliation audit saves \$42,477.

12 audits X \$42,477 = \$509,724 savings per month

\$509,724 X 6 months = **\$3,058,000 TF (\$1,529,000 GF) FY 2011-12 savings**

Funding:

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

ANTI-FRAUD INITIATIVE

REGULAR POLICY CHANGE NUMBER: 161
 IMPLEMENTATION DATE: 1/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1392

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	-\$5,823,000	-\$6,500,000
- STATE FUNDS	-\$2,911,500	-\$3,250,000
PAYMENT LAG	0.9630	1.0000
% REFLECTED IN BASE	85.20 %	82.80 %
APPLIED TO BASE		
TOTAL FUNDS	-\$829,900	-\$1,118,000
STATE FUNDS	-\$414,960	-\$559,000
FEDERAL FUNDS	-\$414,960	-\$559,000

DESCRIPTION

Purpose:

This policy change estimates the savings achieved from anti-fraud activities focusing on physician services.

Authority:

Welfare & Institutions Code, section 14123.25

Background:

Effective July 1, 2010, the Department expanded its anti-fraud activities for physician services using preventative, front-end claims analyses tools. Savings began in January 2011.

Physicians Services/Provider Claims Analysis

The Medi-Cal Provider Error Study (MPES) has shown that physicians and physician groups are associated with a significant percentage of billing errors ranging from miscoding to providing medically unnecessary services.

The Department implemented a "Provider Claims Analysis" as a preventive measure to display to providers their payment patterns and types of errors the Department has uncovered through research and data mining. In December 2010, the Department sent each provider who can prescribe medication to Medi-Cal beneficiaries a baseline "report" comparing the number and type of their prescriptions against other similar types and specialties of providers. A second round of reports will be sent by December 2011 and annually thereafter.

The Department estimates the preventative impact of Provider Claims Analysis will reduce excessive and non-medically necessary prescribing.

Reason for Change from Prior Estimate:

There is no change.

ANTI-FRAUD INITIATIVE
REGULAR POLICY CHANGE NUMBER: 161

Methodology:

1. Savings will be phased in over 12 months.
2. Savings for the provider claims analysis strategy is estimated to be \$6.5 million annually based upon medical necessity error data involving physicians.

Total Savings	FY 2011-12	FY 2012-13
Physician Services Activities	<u>\$5,823,000</u>	<u>\$6,500,000</u>

Funding:

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

MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER: 162
 IMPLEMENTATION DATE: 3/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1587

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	-\$6,667,000	-\$20,000,000
- STATE FUNDS	-\$6,333,500	-\$19,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$6,667,000	-\$20,000,000
STATE FUNDS	-\$6,333,500	-\$19,000,000
FEDERAL FUNDS	-\$333,500	-\$1,000,000

DESCRIPTION

Purpose:

This policy change estimates the savings resulting from recovery of overpayments to Centers for Medicare and Medicaid Services (CMS) or Medicare providers.

Authority:

Welfare and Institutions Code, sections 14124.90 et seq.
 Social Security Act, section 1634

Background:

On October 1, 2010, the Department entered into a three-year contract with the University of Massachusetts (UMASS) to identify potential overpayments to CMS or Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles. UMASS will assist the Department in auditing the invoices received from CMS to pay the Medicare premiums.

The contract costs are budgeted in the Medicare Buy-In Quality Review Project policy change.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Assume the contractor will begin auditing invoices and provide findings to the Department in November 2011.
2. Assume recovery of overpayments will begin March 2012.
3. Assume that 90% of recoveries will be from CMS Medicare Premiums and 10% will be from provider overpayments.
4. Based on current Medicare and Medi-Cal dual beneficiary data it is assumed there will be \$20,000,000 recovered annually.

MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER: 162

5. The FY 2011-12 savings are estimated to be \$6,667,000.

$20,000,000 \div 12 \text{ months} \times 4 \text{ months} = \$6,667,000 \text{ TF}$

(In Thousands)	FY 2011-12		FY 2012-13	
	TF	GF	TF	GF
Provider	\$ -667	\$ -333	\$ -2,000	\$ -1,000
Overpayments				
Medicare Premiums *	\$ -6,000	\$ -6,000	\$ -18,000	\$ -18,000
	\$ -6,667	\$ -6,333	\$ -20,000	\$ -19,000

Funding:

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

Title XIX 100% GF (4260-101-0001) *

MEDICARE PAYMENTS - PART D PHASED-DOWN ARRA

REGULAR POLICY CHANGE NUMBER: 163
 IMPLEMENTATION DATE: 3/2010
 ANALYST: Jade Li
 FISCAL REFERENCE NUMBER: 1490

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	-\$32,511,000	\$0
- STATE FUNDS	-\$32,511,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$32,511,000	\$0
STATE FUNDS	-\$32,511,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy changes estimates the savings incurred by applying the higher Federal Medical Assistance Percentage (FMAP) to Medi-Cal's Medicare Part D Phased-down Contribution expenditures.

Authority:

American Recovery and Reinvestment Act of 2009 (ARRA)

Background:

On January 1, 2006, Medicare's Part D benefit began. Part D provides a prescription drug benefit to all dual eligible beneficiaries and other Medicare eligible beneficiaries that enroll in Part D. Dual eligible beneficiaries had previously received drug benefits through Medi-Cal. To help pay for this benefit, the federal government requires the states to contribute part of their savings for no longer providing the drug benefit to dual eligible beneficiaries. This is called the Phased-down Contribution or "clawback". For more information on the Phased-down Contribution, see the Medicare Payments – Part D Phased-down policy change.

Under the ARRA, California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2011-12. The changes in the per member per month (PMPM) were:

	<u>Original PMPM</u>	<u>ARRA PMPM</u>	<u>Difference</u>
2009 PMPM	\$ 99.82	\$ 76.68	\$ (23.14)
2010 PMPM	\$ 102.54	\$ 78.77	\$ (23.77)
2011 PMPM Jan - Mar	\$ 100.77	\$ 83.09	\$ (17.68)
2011 PMPM Apr - Jun	\$ 100.77	\$ 86.90	\$ (13.87)

The retroactive adjustment from October 2008 through January 2010 was \$393,405,000 and was

MEDICARE PAYMENTS - PART D PHASED-DOWN ARRA

REGULAR POLICY CHANGE NUMBER: 163

applied as a credit to the Department's February – May 2010 Medicare Part D payments (paid in April – July 2010).

ARRA Credit	
<u>Fiscal Year applied</u>	<u>Credit</u>
Oct 2008 - January 2010	\$ (393,405,000)
FY 2009-10	\$ 369,117,000
FY 2010-11	\$ 24,288,000

Starting with the February 2010 invoice, the new phased-down PMPM incorporating ARRA reduced the Department's monthly Medicare Part D invoice.

Reason for Change from Prior Estimate:

Updated monthly dual eligible Part D enrollment data.

Methodology:

1. Additional savings due to reduction in the PMPM for ongoing monthly invoices are estimated to be:

ARRA PMPM Adjustment	
	<u>Estimated Savings</u>
FY 2009-10	\$ 77,845,000
FY 2010-11	\$ 285,668,000
FY 2011-12	\$ 32,511,000
Total	\$ 396,024,000

2. The total savings due to ARRA is estimated to be:

Total Estimated Savings	
FY 2009-10 Credit Savings	\$ 369,117,000
FY 2009-10 Original ARRA	\$ 77,845,000
FY 2009-10	\$ 446,972,000
FY 2010-11 Credit Savings	\$ 24,288,000
FY 2010-11 Original ARRA	\$ 211,111,000
FY 2010-11 Extend ARRA	\$ 74,557,000
FY 2010-11	\$ 309,956,000
FY 2010-11 Original ARRA	\$ 233,000
FY 2010-11 Extend ARRA	\$ 32,278,000
FY 2011-12	\$ 32,511,000
Total ARRA Savings	\$ 789,439,000

Funding:

State Only General Fund (4260-101-0001)

TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVINGS

REGULAR POLICY CHANGE NUMBER: 165
 IMPLEMENTATION DATE: 3/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1640

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$12,332,000
- STATE FUNDS	\$0	-\$12,332,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$12,332,000
STATE FUNDS	\$0	-\$12,332,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change is part of the Administration's proposed Transition of Dual Eligibles to Coordinated Care Delivery Systems initiative and estimates the funding that will be provided to California from the federal government under a Medicare shared savings program.

Authority:

Proposed Legislation

Background:

There are approximately 14.1% Medi-Cal beneficiaries who are considered Dual Eligibles because they are also enrolled in Medicare. For these individuals, Medicare covers their acute care services and Medi-Cal covers, in some cases, their Medicare premiums, cost sharing requirements, and long-term care services.

Today's system is riddled with perverse incentives that encourage Medicare and Medi-Cal to shift cost to one another. This proposal will rebalance these incentives around supporting the Dual Eligibles with appropriate medical and social services, thereby achieving savings in Medicare-covered high-cost, institutional health care services. The Administration will seek a sharing arrangement with the federal government so that California will receive half of the Medicare savings attributed to this proposal.

Reason for Change from Prior Estimate:

The change is due to delay in implementation.

Methodology:

1. Assume Dual Eligibles will be enrolled into Managed Care plans over a 24-month period beginning on March 1, 2013.
2. Assume shared savings will only result from savings generated in the Medicare program. No Medi-Cal savings are included in this Policy Change.

TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVINGS

REGULAR POLICY CHANGE NUMBER: 165

3. Assume inpatient Hospital Utilization will drop by 15% in the FY 2012-13 and 20% annually thereafter.
4. Assume Skilled Nursing Facility utilization will drop by 5% in the FY 2012-13 and 5% annually thereafter.
5. Assume Physician utilization will increase by 4% in the FY 2012-13 and 5% annually thereafter.
6. Assume Pharmaceutical utilization will increase by 2% in the FY 2012-13 and 2% annually thereafter.
7. Assume the State will share savings 50/50 with the federal government.
8. Per-Member-Per-Month costs used to derive these estimates were based on five samples of 1,000 beneficiaries from the following aid categories: Aged, Blind, Disabled, Long-Term care, and all other. Utilizing the samples, the Department developed an estimate of the total Medicare health care costs associated with Medi-Cal's fee-for-service Dual Eligible population.
9. The Department utilized regression analysis to develop an estimate for Medicare Part D pharmaceutical expenses.
10. The Patient Protection and Affordable Care Act (ACA) of 2010 included more than \$424 billion in net Medicare spending reductions over a ten-year period, reducing annual payment updates to hospitals and other providers. The impact of these changes was not considered in this analysis.

Funding:

100% GF (4260-101-0001)

TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 166
 IMPLEMENTATION DATE: 3/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1641

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$1,198,255,000
- STATE FUNDS	\$0	-\$599,127,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,198,255,000
STATE FUNDS	\$0	-\$599,127,500
FEDERAL FUNDS	\$0	-\$599,127,500

DESCRIPTION

Purpose:

This policy change estimates the savings from transitioning dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long-Term Care (LTC) institutional benefits.

Authority:

Proposed Legislation

Background:

This proposal will mandatorily enroll dual eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and other Home and Community-Based Services (HCBS). Savings will be generated from a reduction in inpatient and LTC institutional services. The managed care payments assume immediate savings.

The transitions and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS.

Additional Medicare shared savings will be achieved through this proposed legislation. These savings will be budgeted in a separate policy change, Transition of Dual Eligibles-Medicare Savings.

Reason for Change from Prior Estimate:

The changes are due to delay in implementation.

TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 166

Methodology:

1. Assume dual eligible and Medi-Cal Eligible populations who are using LTC institutional services or HCBS will transition to managed care plans and phase in over 10 months beginning on March 1, 2013. Savings will be generated over time from a shift from Medi-Cal institutional services to HCBS.
2. There are an estimated 1,220,909 beneficiaries who will transition into a managed care plan, based on fee-for-service paid claims data for calendar year 2010.
3. Assume transitions will occur at a rate of 8% per month beginning March 1, 2013.
4. Assume Inpatient Care will be reduced by 22.5% and LTC institutional services will be reduced by 8.1%.
5. Assume IHSS, CBAS, and other HCBS will be increased by 6.0%.
6. Savings were calculated based on actual expenditures during calendar year 2010 for Medi-Cal beneficiaries utilizing nursing home, HCBS, and dual eligible without LTC institutional services.

FY 2012-13	TF	GF
FFS Savings (Non IHSS)	(\$760,511,842)	(\$380,255,921)
Payment Lag	0.649	0.649
FFS Lagged Savings	(\$493,572,186)	(\$246,786,093)
Managed Care Capitation Payments	\$1,241,873,747	\$620,936,874
FFS Cost	\$748,301,561	\$374,150,781
CDSS IHSS Savings	(\$519,051,123)	(\$259,525,562)
FFS Cost	\$229,250,438	\$114,625,219

7. Since Medi-Cal is on the cash basis, there will continue to be fee-for-service costs. In order to achieve savings, the budget defers one managed care payment and one check write in FY 2012-13. Annual savings thereafter, are \$878 million TF (\$439 million GF).

The chart below details the overall impact of the Dual and LTC Integration proposal.

FY 2012-13	TF	GF
Medicare Shared Savings	(\$12,332,000)	(\$12,332,000)
Long-Term Care	\$223,197,000	\$111,598,500
Defer Managed Care Payment	(\$1,271,055,000)	(\$635,527,500)
Delay Checkwrite	(\$150,397,000)	(\$75,198,500)
Total	(\$1,210,587,000)	(\$611,459,500)

Funding:

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

VALUE BASED PURCHASING

REGULAR POLICY CHANGE NUMBER: 167
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1642

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$150,000,000
- STATE FUNDS	\$0	-\$75,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$150,000,000
STATE FUNDS	\$0	-\$75,000,000
FEDERAL FUNDS	\$0	-\$75,000,000

DESCRIPTION

Purpose:

This policy change estimates the savings achieved due to the implementation of value based purchasing.

Authority:

Proposed legislation

Background:

The Medi-Cal health care delivery system must have the capacity to respond to the rapidly changing field of health care and be able to change benefits, services, rates methodologies and payments policies faster than the current regulatory process allows. Examples of potential program changes include reducing laboratory rates, no longer funding avoidable hospital admissions, and no longer paying for services of limited value.

The Administration proposes a process that will incorporate stakeholder input and determine cost-effectiveness before implementing changes in benefit design, and includes a post-implementation assessment to ensure that changes achieve the intended results. Similarly, any changes in rate methodologies and payment policies driven by this process will comply with federal requirements to rigorously monitor the impact of rate changes on beneficiary access to services and to mitigate any problems as they arise.

Under the proposed process, Medi-Cal will have the flexibility it needs to operate a health care delivery system that meets its obligations to use sound evidence, transparent processes, and monitoring mechanisms to ensure the program achieves its outcomes in the most efficient possible manner.

Reason for Change from Prior Estimate:

There is no change.

VALUE BASED PURCHASING
REGULAR POLICY CHANGE NUMBER: 167

Methodology:

1. Assume all savings will begin July 1, 2012.

FY 2012-13	TF	GF
Savings	(\$156,053,000)	(\$78,026,500)
Payment Deferral	\$6,053,000	\$3,026,500
Net Savings:	(\$150,000,000)	(\$75,000,000)

Funding:

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

SHIFT OF HEALTHY FAMILIES CHILDREN TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 168
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1511

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$524,475,000
- STATE FUNDS	\$0	\$183,566,250
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$524,475,000
STATE FUNDS	\$0	\$183,566,250
FEDERAL FUNDS	\$0	\$340,908,750

DESCRIPTION

Purpose:

This policy change estimates the benefits cost associated with shifting the Healthy Families Program (HFP) eligibles into the Medi-Cal program.

Authority:

Proposed Legislation

Background:

The Administration is proposing legislation to shift all HFP eligibles into the Medi-Cal program. Beginning October 2012, a nine-month transition of eligibles will take place. Children over 150% of the federal poverty level (FPL) will continue to be required to pay a premium for coverage. The administrative costs associated with this change are budgeted separately in the Shift of Healthy Families Children to Medi-Cal policy changes under County Administration and Other Administration section of the Medi-Cal Estimate. Any savings to the HFP will be reflected in the Managed Risk Medical Insurance Board (MRMIB) budget.

Reason for Change from Prior Estimate:

The HFP caseload, phase-in structure, and managed care capitated rates were all updated. There were changes as to which premium HFP eligibles (over 150% FPL) would pay in Medi-Cal, and an assumption was added to exclude the Access for Infants and Mothers program (AIM) infants with incomes between 250-300% FPL in the transition.

Methodology:

1. Beginning October 1, 2012, 879,140 eligibles will be transferred to Medi-Cal. This does not include AIM infants with incomes between 250-300% FPL who will transition to Medi-Cal on July 1, 2013.
2. These eligibles will be enrolled into managed care plans in those counties that have County Organized Health Systems, Geographic Managed Care, or the Two Plan Model. In all other counties they will participate in the Fee-For-Service (FFS) system.

SHIFT OF HEALTHY FAMILIES CHILDREN TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 168

3. The shift of HFP eligibles into the Medi-Cal program will occur in four separate phases. The first phase will transition on October 1, 2012, for all HFP eligibles currently enrolled in a managed care plan that also contracts directly with the Department. The second phase will transition on January 1, 2013, for all HFP eligibles currently enrolled in a managed care plan that subcontracts with a Medi-Cal managed care plan. The third phase will transition over 3-months (March 1, 2013 to May 30, 2013) for all HFP eligibles in a managed care county that were not transitioned in Phase 1 or Phase 2. The fourth phase will transition on June 1, 2013, for all remaining HFP eligibles.
4. The weighted average monthly cost of benefits for these eligibles under the Medi-Cal program is estimated to be \$81.92. This includes managed care capitation payments, FFS costs, managed care carve-outs, Federally Qualified Health Center (FQHC) wrap-around payments and dental payments (excluding California Children Services (CCS)).
5. Premiums only will be assessed for eligibles over 150% of Federal Poverty Level (FPL) at the HFP Community Provider Plan (CPP) premium level. In FY 2012-13, premiums are estimated to total \$37,208,000.
6. Of the 879,140 eligibles, there are an estimated 13,612 CCS-HFP eligibles that will be shifted to CCS-Medi-Cal. The cost for these eligibles is currently budgeted in the Family Health Estimate. CCS-HFP is funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under Medi-Cal. In FY 2012-13, the GF reimbursement from the counties for CCS-Medi-Cal is estimated to be \$6,408,000.
7. Enhanced federal funding under Title XXI is available for these eligibles enrolled in Medi-Cal.
8. This policy change includes \$14,542,000 TF (\$5,090,000 GF) in FY 2012-13 for benefit costs that was part of the Bridge to HFP policy change.
9. This policy change includes caseload growth for the period of October 1, 2012 through June 30, 2013.

(In Thousands) FY 2012-13	TF	GF	County Reimbursement
Other Services	\$499,585	\$174,854	
CCS	\$47,556	\$10,237	\$6,408
Bridge to HFP	\$14,542	\$5,090	
Benefits Total	\$561,683	\$190,181	
Premiums	-\$37,208	-\$13,023	
Net	\$524,475	\$177,158	\$6,408

Funding:

Title XXI 65/35 FFP (4260-113-0001/0890)

Reimbursement GF (4260-610-0995)

ANNUAL OPEN ENROLLMENT PERIOD

REGULAR POLICY CHANGE NUMBER: 169
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1606

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$7,135,000
- STATE FUNDS	\$0	-\$3,567,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$7,135,000
STATE FUNDS	\$0	-\$3,567,500
FEDERAL FUNDS	\$0	-\$3,567,500

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact of implementing an annual open enrollment period for Medi-Cal managed care beneficiaries.

Authority:

Proposed Legislation

Background:

The Department is proposing legislation to change the managed care enrollment policy to allow enrollees in Two-Plan and Geographic Managed Care counties to change plans on an annual basis. Currently, managed care enrollees may change plans on a monthly basis. New beneficiaries will have 90 days from their initial enrollment date to select or change their managed care plan. On an annual basis, based on their redetermination date, existing members will be provided a 60 day period to change plans.

Currently, managed care plans are required to perform a health assessment each time a new beneficiary enrolls into their plan. Plans will now be required to share health records when beneficiaries switch plans.

Reason for Change from Prior Estimate:

Technical error related to entering the savings as a cost has been fixed.

Methodology:

1. Assume the annual open enrollment period will be implemented October 1, 2012.
2. Upon implementation, an initial notification will be mailed to approximately 3,600,000 beneficiaries informing them of their open enrollment period. It is assumed there will be no additional mailing costs for these notifications.

ANNUAL OPEN ENROLLMENT PERIOD**REGULAR POLICY CHANGE NUMBER: 169**

3. Currently, the average annual cost of mailing information packets to beneficiaries who are changing plans is \$510,000. It is assumed that approximately 164,400 will change plans. Of these, 50%, or 82,200 beneficiaries, will request an information packet so they can change plans by mail, at a cost of \$5.10 per packet. The remaining 50% will change plans, at no cost, by phone. This would result in a net savings of \$91,000 for mailing costs for FY 2012-13.

82,195 information packets x \$5.10 = \$419,000 projected mailing cost
 \$510,000 current cost - \$419,000 projected cost = \$91,000 (\$45,500 GF) net annual savings for mailings

4. Assume there will be an additional one-time cost of \$600,000 (\$300,000 GF) in FY 2012-13 for system modifications.
5. It is assumed that most health assessments will no longer be required when an existing beneficiary changes plans. The new plan will rely on the initial health assessment of the previous plan. The average cost of an assessment is \$68.00.
6. Currently, an average of 200,240 beneficiaries change plans each year. This would result in a savings \$10,213,000 in FY 2012-13 by no longer providing assessments for these beneficiaries.
7. Of the estimated 164,400 beneficiaries changing plans it is assumed 85% will no longer require a health assessment and the remaining 15% will still require an additional assessment resulting in a cost of \$1,677,000 in FY 2012-13. The net benefit savings will be \$8,536,000 in FY 2012-13.

164,400 assessments x 15% x \$68.00 = \$1,677,000 TF (\$838,500 GF)

\$10,213,000 assessment savings - \$1,677,000 = \$8,536,000 TF (\$4,268,000 GF) net benefit savings in FY 2012-13

8. The costs related to deferring the Managed Care payment are budgeted in this policy change.

FY 2012-13:	TF	GF
Benefit Savings	- \$8,536,000	- \$4,268,000
Mailing Costs	- \$91,000	- \$45,500
System Cost	\$600,000	\$300,000
Net Impact	- \$8,027,000	- \$4,013,500
Defer Managed Care Payment	\$892,000	\$446,000
Total	- \$7,135,000	- \$3,567,500

Funding:

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

FQHC PAYMENT REFORM

REGULAR POLICY CHANGE NUMBER: 170
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1643

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$55,660,000
- STATE FUNDS	\$0	-\$27,830,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$55,660,000
STATE FUNDS	\$0	-\$27,830,000
FEDERAL FUNDS	\$0	-\$27,830,000

DESCRIPTION

Purpose:

This policy change estimates the integration of all Federally Qualified Health Center (FQHC) and Rural Health Clinics (RHC) costs into managed care capitated rates.

Authority:

Proposed Legislation

Background:

The Department proposes to reform the payment methodology for FQHCs and RHCs funded under Medi-Cal to create a performance, risk-based payment model that will allow, and reward, these clinics to provide more efficient and better care. Under this proposal, payments made to FQHCs and RHCs participating in Medi-Cal managed care plan contracts will change from a cost and volume-based payment to a fixed payment to provide a broad range of services to its enrollees. A waiver of current operating restrictions will empower FQHCs and RHCs to follow efficient best practices, such as group visits, telehealth, and telephonic disease management. The waiver will ensure that medical care is provided by the most appropriate and affordable medical professional and allow clinics to perform multiple services on the same day. The efficiencies will allow these community health centers to provide better and more efficient care and to expand capacity.

The proposal generates immediate savings. However, since the Department is on a cash basis, the incorporation of wrap-around payments into the managed care capitation rates will result in an initial first year cost to the Department, with savings achieved in each subsequent year. To address this cost, the Administration is proposing to defer the last managed care payment of the fiscal year.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The proposed implementation date is July 2012.

FQHC PAYMENT REFORM

REGULAR POLICY CHANGE NUMBER: 170

2. Capitation rates will incorporate the FQHCs and RHCs wraparound payments beginning in FY 2012-13.
3. These clinics will now receive a per-member-per-month (PMPM) bundled payment for primary care within the clinic's scope of service for Medi-Cal managed care beneficiaries who have been selected or assigned to their clinic.
4. An efficiency savings of ten percent is assumed due to using the prospective payment reform and would be removed from the funding provided to the plans.

	TF	GF
FQHC - Current Managed Care Counties	\$26,429,000	\$13,214,500
FQHC - Managed Care Expansion	\$1,593,000	\$796,500
Managed Care Expansion	\$3,569,000	\$1,784,500
Defer Managed Care (FQHC Payment)	(\$83,206,000)	(\$41,603,000)
Defer Managed Care (MC Expansion FQHC Payment)	(\$4,045,000)	(\$2,022,500)
Total FY 2012-13	(\$55,660,000)	(\$27,830,000)

Funding:

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

HOSPITAL STABILIZATION

REGULAR POLICY CHANGE NUMBER: 171
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1644

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$85,754,000
- STATE FUNDS	\$0	-\$42,877,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$85,754,000
STATE FUNDS	\$0	-\$42,877,000
FEDERAL FUNDS	\$0	-\$42,877,000

DESCRIPTION

Purpose:

This policy change estimates the General Fund (GF) savings from redirecting private and non-designated public hospitals (NDPH) stabilization funding that has not yet been paid.

Authority:

Proposed Legislation

Background:

The Department is proposing legislation to redirect stabilization funding that has not been paid for fiscal year (FY) 2005-06 through FY 2009-10 for private hospitals and NDPHs. The stabilization funding was estimated to be paid in FY 2011-12 and FY 2012-13. A portion of the GF savings achieved will be used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 and FY 2006-07.

SB 1100 (Chapter 560, Statutes of 2005) established a methodology for distributing the federal funding made available under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD). Under SB 1100, additional funding termed "stabilization funding" may be available to designated public hospitals (DPHs), NDPH, private DSH, and distressed hospitals for each of the five years (FY 2005-06 through FY 2009-10) of the MH/UCD.

The methodology for determining the stabilization funding to each hospital group and the portion of the stabilization funding distributed by the Department are described in the MH/UCD-Stabilization Funding policy change.

Stabilization funding distributed through negotiations with the California Medical Assistance Commission (CMAC) are shown in the MH/UCD & BTR—Private Hospital Supplemental Payment and MH/UCD & BTR—NDPH Supplemental Payment policy changes.

Reason for Change from Prior Estimate:

There is no change.

HOSPITAL STABILIZATION

REGULAR POLICY CHANGE NUMBER: 171

Methodology:

1. A total of \$109.534 million TF (\$54.767 million GF) NDPH and private DSH hospitals stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 will be redirected for GF relief for FY 2012-13.
2. 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.
3. In addition, a total of \$23.78 million TF (\$11.89 million GF) of the savings from the redirection of stabilization funding will be used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 and FY 2006-07.

The estimated GF savings are:

FY 2012-13	TF	GF
FY 2005-06 Private	(\$10,578,000)	(\$5,289,000)
FY 2006-07 Private	(\$19,146,000)	(\$9,573,000)
FY 2007-08 NDPH	(\$2,152,000)	(\$1,076,000)
FY 2008-09 Private	(\$3,894,000)	(\$1,947,000)
FY 2010-11 Private	(\$73,764,000)	(\$36,882,000)
Total:	(\$109,534,000)	(\$54,767,000)
Less: Additional payments to hospitals receiving underpayments	\$23,780,000	\$11,890,000
Total FY 2012-13:	(\$85,754,000)	(\$42,877,000)

Funding:

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

MANAGED CARE DEFAULT ASSIGNMENT

REGULAR POLICY CHANGE NUMBER: 172
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1645

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$4,818,000
- STATE FUNDS	\$0	-\$2,409,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$4,818,000
STATE FUNDS	\$0	-\$2,409,000
FEDERAL FUNDS	\$0	-\$2,409,000

DESCRIPTION

Purpose:

This policy change estimates the savings associated with incorporating an additional factor into the default algorithm for the Two-Plan and Geographic Managed Care (GMC) plans.

Authority:

Proposed Legislation.

Background:

Currently, the default algorithm defaults beneficiaries based on the Health Plan quality and safety net population factors. Under this proposal, the Department will require beneficiaries in the Family or SPD mandatory aid categories who do not choose a plan to be defaulted into a plan based on default ratios which consider health plan cost in addition to quality of care and safety net population factors. The default algorithm will be adjusted to increase defaults to low cost plans by 5 percent. Savings would be recognized based on the shift of beneficiaries that would have been defaulted to the higher cost plans under the normal default ratios.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. Implementation will begin July 1, 2012.
2. All Two-Plan and GMC counties will participate with the exception of Kings and Madera. Kings and Madera plans are paid at the same capitation rates, therefore no savings would occur.
3. The default algorithm will be adjusted to incorporate the cost factor and the ratios for the Family and SPD aid categories will be adjusted.
4. Assume five percent of defaulted beneficiaries will shift into a lower cost plan.
5. Assume a 97% retention factor for the plans and the remaining 3% of defaults will leave the plan

MANAGED CARE DEFAULT ASSIGNMENT

REGULAR POLICY CHANGE NUMBER: 172

each month.

6. Assume there will be a 1.8% growth rate for Family aid codes and 2.3% for SPDs.
7. Estimated savings for FY 2012-13 are \$5,256,000.
8. This policy change estimates the savings due to implementing a default algorithm; therefore the savings will impact the payment deferral related to managed care capitation payments.

FY 2012-13	TF	GF
Health Plan Default Assignment Method	-\$5,256,000	-\$2,628,000
Defer Managed Care Payment	\$438,000	\$219,000
Total	-\$4,818,000	-\$2,409,000

Funding:

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

ALIGN MANAGED CARE BENEFIT POLICIES

REGULAR POLICY CHANGE NUMBER: 173
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1646

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$96,406,000
- STATE FUNDS	\$0	-\$48,203,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$96,406,000
STATE FUNDS	\$0	-\$48,203,000
FEDERAL FUNDS	\$0	-\$48,203,000

DESCRIPTION

Purpose:

This policy change aligns Managed Care policies by shifting the cost of retroactive services from the County Organized Health System (COHS) plans to the fee-for-service (FFS) system.

Authority:

Proposed Legislation

Background:

Medi-Cal covers the cost of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal. Currently, the COHS are responsible for covering the cost of the retroactive period and they receive an adjustment in their capitation rates for this cost. The Two-Plan and Geographic Managed Care health plans are not responsible to cover the costs of their enrollees during the retroactive period. Instead, these costs are paid in FFS. The Administration proposes to eliminate the COHS' responsibility for the retroactive period and shift this cost to FFS.

Reason for Change from Prior Estimate:

Corrected payment lags and inclusion of the impact of managed care payment deferral.

Methodology:

1. Assume 5% of COHS eligibles received medical services during the retroactive period.
2. The July 2011 capitation rates and the number of eligibles from the November 2011 estimate were used to calculate the savings.
3. A per-member-per-month (PMPM) of \$450 was assumed to cover the costs of the retroactive services.
4. Assume a three-month delay due to the time required to enroll potential beneficiaries into Medi-Cal.
5. The FFS payment pattern was used to calculate the potential savings.

ALIGN MANAGED CARE BENEFIT POLICIES

REGULAR POLICY CHANGE NUMBER: 173

FY 2012-13	TF	GF
Align Managed Care Benefit Policies	<u>-\$122,466,000</u>	<u>-\$61,233,000</u>
Defer Managed Care Payment	<u>\$24,060,000</u>	<u>\$12,030,000</u>
Total	<u>-\$98,406,000</u>	<u>-\$49,203,000</u>

Funding:

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

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 174
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1647

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the transfer of funds collected from the Gross Premium Tax Fund to the General Fund (GF) to be retained by the Department beginning October 1, 2012.

Authority:

Proposed Legislation

Background:

The Administration is proposing legislation to eliminate the gross premium tax sunset date that under current law, ends on June 30, 2012. Prior to October 1, 2012 transition of the Healthy Families Program to Medi-Cal, the portion of the gross premium tax shown in this policy change was used to fund the Healthy Families Program. Beginning October 1, 2012, this portion of the tax will be retained by the Department to offset GF cost for the Medi-Cal program. This policy change estimates GF savings resulting from the elimination of the gross premium tax sunset date through FY 2012-13.

Reason for Change from Prior Estimate:

The most recent estimates of managed care revenues have been used to estimate the gross premium tax amount.

Methodology:

1. The gross premium tax on the current managed care base revenues was estimated.
2. Additionally, the gross premium tax was estimated based upon other policy changes affecting managed care revenues. These policy changes include Healthy Families Program transition to Medi-Cal, Transition of Dual Eligibles, ACA – Payments to Primary Care Physicians, ADHC Transition, and Hospital QAF – Hospital Payments.
3. The FY 2012-13 impact of the increase in capitation payments related to the gross premium tax is included in the Extend Gross Premium Tax – Incr. Capitation Rates policy change.

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 174

4. The amount shown in this policy change does not include \$8,722,000 for the Healthy Families Program in FY 2012-13.

The gross premium tax fund transfers to the GF are expected to be:

	GF	Gross Premium Tax	TF
Base Program	\$ (138,335,000)	\$ 138,335,000	\$ 0
SB 335 Hospital Fee	\$ (31,259,000)	\$ 31,259,000	\$ 0
Coordinated Care Initiative	\$ (12,947,000)	\$ 12,947,000	\$ 0
Healthy Families Transition	\$ (4,322,000)	\$ 4,322,000	\$ 0
FQHC Payment Reform	\$ (1,537,000)	\$ 1,537,000	\$ 0
Total FY 2012-13	\$ (188,400,000)	\$ 188,400,000	\$ 0

Funding:

100% State GF (4260-101-0001)

3156 Gross Premium Tax (Non-GF) (4260-601-3156)

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 176
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1651

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$5,360,000
- STATE FUNDS	\$0	-\$2,680,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$5,360,000
STATE FUNDS	\$0	-\$2,680,000
FEDERAL FUNDS	\$0	-\$2,680,000

DESCRIPTION

Purpose:

This policy change estimates the savings related to expanding managed care into rural counties that are now fee-for-services only.

Authority:

Proposed Legislation

Background:

Managed care is currently in 30 counties. The Department is proposing to expand managed care into the remaining 28 counties across the State. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

- The expansion of managed care into rural counties will be a cost in FY 2012-13 on a cash basis due to the fact that capitation payments will begin immediately, while fee-for-service payments will continue to be paid for services provided before the expansion due to the time it takes providers to bill for services. The costs are expected to be:

	<u>FY 2012-13</u>
Managed Care Capitation Payments	\$45,512,000
FFS Savings	-\$50,569,000
FFS Payment Lag	0.106
FFS Lagged Savings	-\$5,360,000
FY Cost (Rounded)	\$40,152,000

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 176

2. This policy change estimates the savings related to expanding managed care into rural counties; therefore the savings will impact the payment deferral related to managed care capitation payments.
3. The overall impact due to the expansion of managed care to rural counties including the impact to the payment deferral is expected to be:

FY 2012-13	TF	GF
Expand Managed Care into all counties, June 2013	\$40,152,000	\$20,076,000
Defer Managed Care Payment	-\$45,512,000	-\$22,756,000
Total	-\$5,360,000	-\$2,680,000

Funding:

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

EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 177
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1652

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$435,505,000
- STATE FUNDS	\$0	\$217,752,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$435,505,000
STATE FUNDS	\$0	\$217,752,500
FEDERAL FUNDS	\$0	\$217,752,500

DESCRIPTION

Purpose:

This policy change estimates the cost of capitation rate increases that are offset by gross premium tax proceeds resulting from the elimination of the gross premium tax sunset date. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:

Proposed Legislation

Background:

The Administration is proposing legislation to eliminate the sunset date on the gross premium tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:

The most recent estimates of managed care revenues have been used to estimate the gross premium tax amount.

Methodology:

1. The gross premium tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the gross premium tax.
2. Capitation rate increases due to the gross premium tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax Fund (Fund 3156) on a quarterly basis. The reimbursement is budgeted in the Extend Gross Premium Tax – Funding Adjustment policy change.

**EXTEND GROSS PREMIUM TAX - INCR. CAPITATION
RATES**
REGULAR POLICY CHANGE NUMBER: 177

The costs of capitation rate increases related to the elimination of the gross premium tax sunset date are expected to be:

(In Thousands)	<u>Gross Premium Tax</u>	<u>FFP</u>	<u>TF</u>
Total FY 2012-13	\$217,753	\$217,753	\$435,505

Funding:

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

TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 178
 IMPLEMENTATION DATE: 3/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1653

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$495,430,000
- STATE FUNDS	\$0	\$495,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$495,430,000
STATE FUNDS	\$0	\$495,430,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the reimbursement from the Department to the California Department of Social Services (CDSS) for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:

Proposed Legislation

Background:

The IHSS program provides an alternative to out-of-home care, such as nursing homes or board and care facilities. The transitions and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of Home and Community-Based Services (HCBS).

The Department will transition care for dual eligibles who receive LTC institutional services, IHSS and other HCBS to managed care health plans beginning March 1, 2013 (see policy change Transition Of Dual Eligibles-Long Term Care). It is assumed that the transition to managed care will increase the use of IHSS and other HCBS by 6.0%.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the CDSS pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population.

This policy change addresses the transfer of IHSS costs from the managed care plans to the Department who will in turn transfer the funds to CDSS to pay the IHSS providers. The policy change, Transfer of IHSS Costs to DHCS, reflects the transfer of General Fund and county funds to the Department which is used to increase managed care capitation rates.

TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 178

Reason for Change from Prior Estimate:

A technical adjustment was made related to the reimbursement of HCBS to CDSS.

Methodology:

Not applicable

Funding:

100% Reimbursement (4260-610-0995)

TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 179
 IMPLEMENTATION DATE: 3/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1654

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the reimbursement from managed care health plans to the Department for In-Home Supportive Services (IHSS) costs related to dual eligible Medi-Cal Long-Term Care (LTC) beneficiaries.

Authority:

Proposed Legislation

Background:

The Department will transition care for dual eligibles who receive LTC institutional services, IHSS and other Home and Community-Based Services (HCBS) to managed care health plans beginning March 1, 2013.

The IHSS payment process will be impacted as a result of transitioning eligible beneficiaries to managed care plans. Currently, the California Department of Social Services (CDSS) pays for IHSS services through their Case Management and Information and Payroll System (CMIPS) process. CDSS provides the matching General Fund and county funds and the Department draws down the federal financial participation (FFP). Under this proposal, managed care capitation will be increased to include IHSS services to this population. This policy change reflects the transfer of \$233,729,000 General Fund and county funds to the Department used to increase managed care capitation rates.

An additional policy change, Transfer of IHSS Costs to CDSS, addresses the transfer of IHSS costs from the managed care plans to the Department who will in turn transfer the funds to CDSS to pay the IHSS providers. For additional information about the transfer of IHSS costs to DHCS, see policy change Transition of Dual Eligibles-Long Term Care.

Reason for Change from Prior Estimate:

A technical adjustment was made related to the reimbursement for the HCBS.

TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 179

Methodology:

Not applicable

Reimbursement: \$233,729,000

Funding:

100% Reimbursement (4260-610-0995)

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 180
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1655

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the transfer of funds from the Gross Premium Tax Fund to the General Fund for FY 2012-13 as a result of a proposal to eliminate the Gross Premium Tax sunset date.

Authority:

Proposed Legislation

Background:

The Department is proposing language to eliminate the sunset date on the collection of a gross premium tax on the total operating revenue of Medi-Cal Managed Care plans. The proceeds from the tax are used to offset capitation rates.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax Fund (Fund 3156) on a quarterly basis.

Reason for Change from Prior Estimate:

The most recent estimates of gross premium tax revenues have been used to estimate the funding adjustment.

Methodology

Based upon the gross premium tax estimates, the expected funding adjustment is:

	<u>FY 2012-13</u>
Total Gross Premium Tax	<u>\$169,847,000</u>
GF	<u>-\$169,847,000</u>
Total	\$0

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 180

Funding:

100% State GF (4260-101-0001)

3156 Gross Premium Tax (Non-GF) (4260-601-3156)

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 181
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1656

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$693,505,000	\$174,555,000
- STATE FUNDS	\$346,752,500	\$87,277,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$693,505,000	\$174,555,000
STATE FUNDS	\$346,752,500	\$87,277,500
FEDERAL FUNDS	\$346,752,500	\$87,277,500

DESCRIPTION

Purpose:

This policy change estimates the erosion of savings related to preliminary injunctions preventing the implementation of Assembly Bill (AB) 97 payment reductions.

Authority:

Not Applicable

Background:

AB 97 (Chapter 3, Statutes of 2011) 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.

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *California Hospital Association, et al. v. Douglas et al.* and *Managed Pharmacy Care, et al. v. Sebelius, et al.* against the implementation of AB 97 payment reductions for distinct part nursing facilities and pharmacy services. In compliance with these injunctions, the Department is prohibited from implementing these reductions.

On January 10, 2012, the same court issued a preliminary injunction in the case of *California Medical Transportation Association v. Douglas, et al.* prohibiting the Department from implementing AB 97 payment reductions for non-emergency medical transportation providers.

On January 31, 2012, a preliminary injunction was issued in the case of *California Medical Association, et al. v. Douglas, et al.* against the implementation of AB 97 payment reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment. In compliance with this injunction, the Department is prohibited from implementing these reductions.

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 181

Appeals in all four cases have been filed.

On February 22, 2012, the United States Supreme Court issued its decision in the *Douglas v. Independent Living Center* Medi-Cal payment reductions cases. The 5-4 majority opinion vacated all of the Ninth Circuit decisions that were before it and remanded the cases to the Ninth Circuit Court of Appeals to reassess the plaintiffs' preemption/Supremacy Clause claims in light of the Centers for Medicare & Medicaid Services (CMS) approval of the State Plan Amendments (SPA) at issue in a number of those cases. The Supreme Court also strongly indicated that, on remand, the Ninth Circuit should show deference to CMS decisions to approve the SPAs, noting that CMS approval "carries weight".

Reason for Change from Prior Estimate:

Changes are due to subsequent court rulings that prevent the Department from implementing payment reductions to several additional provider types.

Methodology:

1. Assume all savings from the enjoined providers will be lost in FY 2011-12.
2. Assuming the Department receives favorable rulings on the appeals by summer 2012, implementation of the AB 97 reductions to the enjoined providers will resume beginning October 2012. As a result, it is estimated that only 3 months of savings from the enjoined providers will be lost in FY 2012-13.
3. Based on the December 28, 2011 preliminary injunctions, assume the loss in savings in FY 2011-12 is \$396,608,000 TF (\$198,304,000 GF) and FY 2012-13 is \$97,982,000 TF (\$48,991,000 GF).
4. Based on the January 10, 2012 preliminary injunction, assume the loss in savings in FY 2011-12 is \$14,116,000 TF (\$7,058,000 GF) and FY 2012-13 is \$3,726,000 TF (\$1,863,000 GF).
5. Based on the January 31, 2012 preliminary injunction, assume the loss in savings in FY 2011-12 is \$282,781,000 TF (\$141,390,500 GF) and FY 2012-13 is \$72,847,000 TF (\$36,423,500 GF).
6. Assume the Department will recover retroactive savings for the enjoined providers in FY 2013-14.
7. The Budget Bill of 2012 includes provision 13 that authorizes the Director of the Department of Finance (DOF), subject to a 30 day legislative notification, to increase the 4260-101-0001 appropriation if an adverse court ruling occurs. DOF will set aside \$523,664,000 TF (\$261,832,000 GF) in a non-budget act item in FY 2012-13.

(In Thousands)

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 181

Lawsuits	FY 2011-12	FY 2012-13
<i>California Hospital Association, et al. v. Douglas et al.</i>	\$37,100	\$9,671
<i>Managed Pharmacy Care, et al. v. Sebelius, et al.</i>	\$359,508	\$88,311
<i>California Medical Transportation Association v. Douglas, et al.</i>	\$14,116	\$3,726
<i>California Medical Association, et al. v. Douglas, et al.</i>	\$282,781	\$72,847
Total	\$693,505	\$174,555

Funding:

Title XIX (4260-101-0001/0890)

ACA - PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 183
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1659

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$372,992,000
- STATE FUNDS	\$0	\$38,744,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$372,992,000
STATE FUNDS	\$0	\$38,744,500
FEDERAL FUNDS	\$0	\$334,247,500

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation (FFP) provided for the incremental increase in rates from the 2009 Medi-Cal levels to 100% of Medicare for primary care physician services provided from January 1, 2013 to December 31, 2014.

Authority:

Section 1202 of the Affordable Care Act (ACA) (H.R. 4872, Health Care and Education Reconciliation Act of 2010)

Background:

Section 1202 of the ACA requires Medi-Cal to increase primary care service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department will receive 100% FFP for the additional incremental increase in Medi-Cal rates determined using Medi-Cal rates that were in effect as of July 1, 2009 compared to the 2013 and 2014 Medicare rates.

Primary care services are defined by certain Evaluation and Management (E&M) Codes and immunization administration procedure codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, and 90474. This provision extends to any subsequent modifications to the coding of these services.

The rate increase applies only to primary care physician services with a specialty designation of family medicine, general internal medicine, or pediatric medicine.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Implementation will begin January 1, 2013.

ACA - PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 183

2. Calendar year 2011 Medi-Cal fee-for-service (FFS) paid claims data for certain E&M and immunization administration procedure codes was used to study the Medi-Cal payment rate and utilization for each procedure code. Medicare cross-over and state-only paid claims were excluded from the data.
3. The calendar year 2011 data includes the one percent payment reduction to physicians, that was implemented pursuant to AB 1183 (Chapter 758, Statutes of 2008), effective March 1, 2009.
4. Medicare rates for future years 2013 and 2014 are not available. As a result, for FY 2012-13, the 2012 Medicare Physician Fee Schedule was used to determine California's weighted average Medicare rate for each procedure code.
5. Based on the rate analysis, Medi-Cal payments to physicians for the selected procedure codes totaled \$317,547,000 in calendar year 2011. Medi-Cal payments were determined to be at 51% of Medicare. The incremental increase needed to reach Medicare levels totaled \$303,493,000.
6. The FFS amount in FY 2012-13 is estimated to be \$100,456,000.
$$\$303,493,000 \text{ annual} \times 0.5 \text{ year} \times 0.662 \text{ (lag)} = \$100,456,000 \text{ FFP}$$
7. The managed care incremental costs of increasing primary care physician capitation rates to 100% of Medicare is estimated to be \$390,093,000 annually. The managed care amount in FY 2012-13 is estimated to be \$195,047,000.
$$\$390,093,000 \text{ annual} \times 0.5 \text{ year} = \$195,047,000 \text{ FFP}$$
8. Pursuant to AB 97 (Chapter 3, Statutes of 2011) FFS physicians will be subjected to an additional 9% payment reduction, effective June 1, 2011. Managed care providers will be reduced by an actuarial equivalent, effective July 1, 2011. The Department is currently prohibited from implementing these payment reductions to physicians due to the January 31, 2012 preliminary injunction issued in the case of *California Medical Association, et al. v. Douglas, et al.* An appeal of this injunction has been filed. The Department anticipates a ruling in favor of the Department by summer 2012 allowing the Department to implement the AB 97 payment reductions beginning January 2013.

The AB 97 reductions will decrease the Medi-Cal base payment rate for physician primary care services by the additional 9% payment reduction. To receive the 100% federal funding for the primary care rate increase, the incremental costs are to be calculated from the July 1, 2009 base rate, before the 9% reduction.

Therefore, in FY 2012-13, the Department expects General Fund (GF) costs of \$77,489,000 to raise rates for primary care services to the July 1, 2009 Medi-Cal levels to qualify for the enhanced federal funding.

ACA - PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 183

(In Thousands)	<u>Annual FFP</u>
FFS	\$303,493
Managed care	\$390,093
	<u>\$693,586</u>
FY 2012-13	<u>TF</u>
FFS (lagged)	\$100,456
Managed care	\$195,047
Total FFP	\$295,503
GF Costs	\$77,489
Total	<u>\$372,992</u>

Funding:

Title XIX 100% Federal Funds (4260-101-0890)

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

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 184
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1660

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$1,868,000	\$6,227,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$1,868,000	\$6,227,000
FEDERAL FUNDS	-\$1,868,000	-\$6,227,000

DESCRIPTION

Purpose:

This policy change estimates the cost of federal financial participation (FFP) repayments made to the Centers for Medicare and Medicaid Services (CMS) for improper claims for Medi-Cal services made by Siskiyou County Mental Health Plan. In addition, Siskiyou County General Fund (GF) reimbursements are also included in this policy change.

Authority:

Title 42, United States Code (USC), section 1396b(d)(2)(C)

Background:

The California Department of Mental Health (CDMH) identified overpayments to Siskiyou County Mental Health Plan as result of improper Medi-Cal billing practices during the audit and cost settlement process. Pursuant to federal statute, Title 42, USC, section 1396b(d)(2)(C), the Department is required to remit the overpaid FFP to CMS within a year of the discovery date. The county acknowledged its Medi-Cal billing problems, but also its inability to repay the amounts owed in a significant or timely manner.

Siskiyou County and the State are currently negotiating a plan for the county to reimburse the State for the repayment.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Repayments to CMS began in January 2012.
2. Assume Siskiyou County will reimburse \$200,000 annually to the GF beginning August 2012. As a result, of the total FFP repayment of \$6,227,000 in FY 2012-13, \$6,027,000 will be paid from the GF.

**SISKIYOU COUNTY MENTAL HEALTH PLAN
OVERPAYMENT
REGULAR POLICY CHANGE NUMBER: 184**

3. Effective July 1, 2012, CDMH mental health services program and associated funding will be shifted to the Department.

<u>Date of Overpayment Discovery</u>	<u>FY 2011-12 Repayment</u>	<u>FY 2012-13 Repayment</u>	
1/11/2011	\$1,752,000		
3/2/2011	\$ 116,000		
8/4/2011		\$2,189,000	
11/15/2011		\$ 586,000	
12/21/2011		\$ 95,000	
3/12/2012		\$3,357,000	
Total:	\$1,868,000	\$6,227,000	(\$6,027,000 GF, \$200,000 Reimbursement)

Funding:

GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

Reimbursement GF (4260-610-0995)

GROUND EMT PAYMENT

REGULAR POLICY CHANGE NUMBER: 185
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1661

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$218,645,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$218,645,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$218,645,000

DESCRIPTION

Purpose:

This policy change estimates the supplemental payments to publicly owned ground emergency medical transportation (EMT) service providers.

Authority:

AB 678 (Chapter 397, Statutes of 2011)

Background:

A provider that delivers ground EMT services to Medi-Cal beneficiaries will be eligible for supplemental payment for services if the following requirements are met:

1. The provider must be enrolled as a Medi-Cal provider for the period being claimed, and
2. The provider must be owned or operated by the State, a city, county, city and county, federally recognized Indian tribe, or fire protection district.

Supplemental payments combined with other reimbursements cannot exceed 100% of actual costs.

Specified governmental entities will pay the non-federal share of the supplemental reimbursement through certified public expenditures (CPEs). The supplemental reimbursement program will be retroactive to January 30, 2010 once the Centers for Medicare and Medicaid Services (CMS) approves a State Plan Amendment (SPA). Annual payments are scheduled to be submitted on a lump-sum basis following the State fiscal year.

Reason for Change from Prior Estimate:

This is a new 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 was 58.77% for January 1, 2011 through

GROUND EMT PAYMENT

REGULAR POLICY CHANGE NUMBER: 185

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. Since the supplemental payments will be retroactive to January 30, 2010, the FMAP will be matched with the period of the CPE.
3. A payment of \$138,765,000 is expected to be made in December 2012 based on CPE claims.
4. A payment of \$80,000,000 is expected to be made in April 2013 based on CPE claims.

Budget estimate (including ARRA) for the program is as follows:

(In Thousands)

FY 2012-13	<u>CPE</u>	<u>Regular FFP</u>	<u>ARRA</u>	<u>Total FFP</u>
FY 2009-10	\$70,000	\$35,000	\$8,113	\$43,113
FY 2010-11	\$160,000	\$80,000	\$15,532	\$95,532
FY 2011-12	\$160,000	\$80,000	\$0	\$80,000
Total	\$390,000	\$195,000	\$23,645	\$218,645

Funding:

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

REFUNDS ON ACTS OF FRAUD

REGULAR POLICY CHANGE NUMBER: 186
 IMPLEMENTATION DATE: 3/2012
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1662

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$97,030,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$97,030,000	\$0
FEDERAL FUNDS	\$97,030,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the recoupment of Medicaid recoveries pursuant to legal action under the False Claims Act (FCA).

Authority:

FCA § 1903 (d)(2)(A)

Background:

The Centers for Medicare & Medicaid Services (CMS) established a policy to refund the federal share of Medicaid overpayments of a legal judgment or settlement when a State recovers funds pursuant to legal action under its FCA.

Due to this new policy, the Department was able to collect Qui Tam (whistleblower) settlement payments erroneously made to the federal government. The recoveries, which should have been identified as 100% State only funds, were improperly accounted for as a 50/50 split with the federal government. In addition, most of the settlements complied with the Deficit Reduction Act of 2005 (DRA) and qualified for a 60/40 split with the federal government.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Recoupment based on settlements from January 1, 2007 to current.

FY 2011-12:

FCA recoupment

\$97,030,000

Funding:

State Only General Fund (4260-101-0001)

EPC FOR AVERAGE WHOLESALE PRICE FROZEN RATES

REGULAR POLICY CHANGE NUMBER: 189
 IMPLEMENTATION DATE: 3/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1667

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$48,379,000	\$22,214,000
- STATE FUNDS	\$24,189,500	\$11,107,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$48,379,000	\$22,214,000
STATE FUNDS	\$24,189,500	\$11,107,000
FEDERAL FUNDS	\$24,189,500	\$11,107,000

DESCRIPTION

Purpose:

This policy change estimates the reimbursement to Medi-Cal fee-for-service (FFS) pharmacy providers for claims subject to erroneous payment corrections (EPC).

Authority:

Not applicable

Background:

First Databank, the Department's primary drug price reference source, ceased publishing average wholesale prices (AWP) in September 2011. Drug claims for Medi-Cal FFS pharmacy providers submitted for reimbursement for dates of service after September 22, 2011 may be subject to erroneous payment correction (EPC) when the AWP price update reporting is re-established.

The EPC claim cycles, for all pharmacy drug claims with dates of service between September 2011 and March 2012, are scheduled to begin after March 14, 2012.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The Department ceased updating Medi-Cal drug prices on September 21, 2011.
2. All drugs on file as of September 21, 2011, were paid at the frozen rate.
3. New drugs, added to the Medi-Cal drug formulary, were not paid from September 2011 through January 2012. Effective January 2012, new drugs were paid at .01¢.
4. Based on historical trends prior to September 2011, a growth of 2.61% is assumed over the base estimated dollars.

EPC FOR AVERAGE WHOLESALE PRICE FROZEN RATES**REGULAR POLICY CHANGE NUMBER: 189**

5. FY 2011-12 rebates resulting from this EPC will be collected in FY 2012-13. Half of FY 2012-13 rebates will be collected in FY 2012-13 with the remaining half being collected in FY 2013-14.

FY 2011-12 Impact	\$48,379,000
FY 2012-13 Impact	\$64,505,000
Rebates on FY 2011-12 Impact	(\$25,375,000)
Rebates on FY 2012-13 Impact	<u>(\$16,916,000)</u>
FY 2012-13 Total	\$22,214,000

Funding:

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

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 190
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1595

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$411,121,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$411,121,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$411,121,000

DESCRIPTION

Purpose:

This policy change budgets Title XIX federal funding for the Department of Social Services (CDSS) associated with the Community First Choice Option (CFCO).

Authority:

Welfare and Institutions Code, section 14132.956
 Affordable Care Act (ACA), section 2401

Background:

The ACA establishes a new State option to provide home and community-based attendant services and supports through CFCO. The state submitted to the Centers for Medicare & Medicaid Services (CMS) an application to obtain enhanced federal funding for federally eligible Personal Care Services Program (PCSP) and In-Home Support Services (IHSS) Plus Option (IPO) program participants. CFCO is available October 1, 2010 and allows States to receive a 6% increase in federal match for expenditures related to this option. The Department budgets Title XIX FFP for the provision of IHSS and PCSP services to Medi-Cal beneficiaries.

The Department assumes the CFCO will generate an estimated \$240.7 million in new federal funds annually and GF savings to the State and counties who provide matching funds. The anticipated savings would be offset by cost increases to administer CFCO. Draft federal regulations for CFCO were released in February 2011. CMS expects to release final regulations before the end of FY 2011-12.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. It is assumed all eligible participants will enroll on June 1, 2012. Assume billing for additional FFP will begin January 2013.
2. Assume costs will be retroactive to December 1, 2011.

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 190

3. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced FMAP rate of 6%.

Estimated Costs provided by CDSS.

	FFP
FY 2012-13	<u>\$411,121,000</u>

Funding:

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

KALYDECO FOR TREATMENT OF CYSTIC FIBROSIS

REGULAR POLICY CHANGE NUMBER: 191
 IMPLEMENTATION DATE: 2/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1669

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$4,800,000
- STATE FUNDS	\$1,000,000	\$2,400,000
PAYMENT LAG	0.8610	0.9980
% REFLECTED IN BASE	13.82 %	7.23 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,484,000	\$4,444,100
STATE FUNDS	\$742,010	\$2,222,030
FEDERAL FUNDS	\$742,010	\$2,222,030

DESCRIPTION

Purpose:

This policy change estimates the costs of Kalydeco for the treatment of patients, ages six years and older, with cystic fibrosis (CF).

Authority:

Social Security Act, section 1927 [42 U.S.C. 1396r-8]

Background:

Effective January 31, 2012, the U.S. Food and Drug Administration approved Kalydeco for the treatment of CF in patients ages six years and older who have the specific mutation in the Cystic Fibrosis Transmembrane Regulator (CFTR) gene.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. It is estimated that only 4% of the population nationwide, with CF, have the specific mutation.
2. Assume the annual cost of Kalydeco will be \$300,000 per beneficiary.
3. There are 385 beneficiaries with CF who are six years of age and older.

$$385 \times 4\% = 16 \text{ beneficiaries with specific mutation}$$

$$16 \times \$300,000 = \$4,800,000 \text{ TF annually}$$

$$\$4,800,000 \div 12 \times 5 = \$2,000,000 \text{ TF } (\$1,000,000 \text{ GF})$$

KALYDECO FOR TREATMENT OF CYSTIC FIBROSIS

REGULAR POLICY CHANGE NUMBER: 191

Fiscal Year	TF	GF
2011-12	\$2,000,000	\$1,000,000
2012-13	\$4,800,000	\$2,400,000

Funding:

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

RATE INCREASES DUE TO SB 90 IGTS

REGULAR POLICY CHANGE NUMBER: 192
 IMPLEMENTATION DATE: 3/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1670

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$82,905,000	\$0
- STATE FUNDS	\$34,948,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$82,905,000	\$0
STATE FUNDS	\$34,948,000	\$0
FEDERAL FUNDS	\$47,957,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the intergovernmental transfers (IGTs) from designated and non-designated public hospitals to the Department for the purpose of increasing hospital reimbursement through providing health plans with capitation rate increases.

Authority:

SB 90 (Chapter 19, Statutes of 2011)

Background:

SB 90 requires the Department to design and implement an intergovernmental transfer program, which will increase hospital reimbursement through providing health plans with capitation rate increases. Federal regulations require participating hospitals to voluntarily elect to make the IGTs. These transfers provide the nonfederal share of the capitation rate increases.

The program is applicable for the period of January 1, 2011, through June 30, 2011. The Department received CMS approval on December 30, 2011.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume hospitals will make all the IGTs and receive the reimbursements in FY 2011-12.
2. IGT amounts are expected to be \$34,948,000. When matched with federal financial participation (FFP), the IGTs will provide \$82,905,000 in capitation rate increases to designated and non-designated public hospitals.
3. IGT funds will be used for the non-federal share of capitation rate increases.

RATE INCREASES DUE TO SB 90 IGTS

REGULAR POLICY CHANGE NUMBER: 192

Funding:

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

Reimbursement GF (4260-610-0995)

BTR - LIHP - HIV TRANSITION INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 193
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1672

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$225,000,000
- STATE FUNDS	\$0	\$112,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$225,000,000
STATE FUNDS	\$0	\$112,500,000
FEDERAL FUNDS	\$0	\$112,500,000

DESCRIPTION**Purpose:**

This policy change budgets the federal funds for the Human Immunodeficiency Virus (HIV) Transition Incentive Program.

Authority:

SB 208 (Chapter 714, Statutes of 2010)
 California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR)
 The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990

Background:

As part of BTR, California counties are implementing the Low Income Health Program (LIHP). The LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). The MCE will cover eligibles with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those with family incomes above 133% through 200% of Federal Poverty Level.

The Department received program direction from the federal Health Resources and Services Administration (HRSA) and the Centers for Medicare & Medicaid Services (CMS) that according to the Ryan White Care Act "payer of last resort" requirements, Ryan White funded services can no longer be available to individuals living with HIV once they are determined eligible for and enrolled in a local LIHP. Therefore, these individuals who were previously covered under the Ryan White program will, upon enrollment in a local LIHP, be required to receive their medical care, pharmaceuticals, and mental health services under the LIHP.

The Department has proposed an amendment to the Demonstration to CMS which would authorize the LIHP HIV Transition Incentive Program to assure that persons living with HIV make the transitions of coverage from Ryan White to LIHP. Upon approval by CMS, the amendment will authorize implementation of quality improvement projects within the local LIHPs that support their efforts to address continuity of quality care, care coordination and other coverage transition issues concerning LIHP enrollees living with HIV, particularly those enrollees who previously received services under the Ryan White program. Each local LIHP that elects to participate in the HIV Transition Incentive Program

BTR - LIHP - HIV TRANSITION INCENTIVE PROGRAM

REGULAR POLICY CHANGE NUMBER: 193

will receive incentive payments under the Safety Net Care Pool upon achievement of project milestones. The local LIHP provides the non-federal share of the payments through intergovernmental transfers (IGTs). The LIHP HIV Transition Incentive Program will be effective for 30 months from July 1, 2011 through December 31, 2013. The Department anticipates CMS approval of the Program by April 2012.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

During the term of the LIHP component of the Demonstration commencing with FY 2011-12, a total of \$150 million in HIV Transition Incentive Program payments (total computable) will be available annually; \$75 million (total computable) will be available for July 1 - December 31, 2013. The total available payments will be consistent with the Demonstration budget neutrality limit. Total payment amounts will be allocated to each participating LIHP on the basis of its approved proposal. Payment amounts will be disbursed in equal, semi-annual payments.

FY 2012-13	TF	FFP	IGT	
2011-12	\$150,000,000	\$75,000,000	\$ 75,000,000	-
2012-13	\$75,000,000	\$37,500,000	\$ 37,500,000	-
Total	\$225,000,000	\$112,500,000	\$112,500,000	-

Funding:

LIHP IGT Fund (4260-607-8502)

Title XIX FFP (4260-101-0890)

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 195
 IMPLEMENTATION DATE: 6/2012
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 110

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$137,000	\$0
- STATE FUNDS	\$137,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$137,000	\$0
STATE FUNDS	\$137,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the payments for audit settlements due to the Centers for Medicare and Medicaid Services (CMS).

Authority:

Public Law 95-452

Background:

Federal audit A-09-09-0000110 titled Review of Medicaid Payments for Services Claimed for Deceased Beneficiaries in California determined that FFP was improperly claimed for deceased beneficiaries. The Department will return the federal portion of the improperly claimed payments for services to CMS for claims paid from January 1, 2007 through June 30, 2008.

Reason for Change from Prior Estimate:

There are new audit settlements.

Methodology:

1. The audit identified California Medicaid beneficiaries from whom the Department had paid fee-for-service claims after the beneficiary's death.
2. The Department paid \$273,457 TF for deceased beneficiaries. The FFP of \$137,000 will be returned to the CMS.

Funding:

State Only General Fund (4260-101-0001)

FIRST 5 CALIFORNIA FUNDING

REGULAR POLICY CHANGE NUMBER: 196
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1581

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the reimbursement from the California First 5 Commission.

Authority:

Proposed Legislation

Background:

In FY 2012-13, \$40,000,000 of First 5 California funding, will be reimbursed to Medi-Cal through an interagency agreement.

Reason for Change from Prior Estimate:

Not applicable

Methodology:

FY 2012-13

Reimbursement	\$40,000,000
General Fund	(\$40,000,000)
Net	<u>\$0</u>

Funding:

100% State GF (4260-101-0001)
 Reimbursement (4260-610-0995)

ELIMINATE 2012-13 RATE INCREASE & SUPP. PAYMENT

REGULAR POLICY CHANGE NUMBER: 198
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1683

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$112,696,000
- STATE FUNDS	\$0	-\$56,348,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$112,696,000
STATE FUNDS	\$0	-\$56,348,000
FEDERAL FUNDS	\$0	-\$56,348,000

DESCRIPTION

Purpose:

This policy change estimates the savings from redirecting AB 1629 freestanding skilled nursing facilities (NF-Bs) rate increase and supplemental payment funds to the General Fund (GF).

Authority:

Proposed Legislation

Background:

The Department is proposing legislation to redirect funding for a rate year 2012-13 rate increase of 1.973% and supplemental payments for AB 1629 facilities to the GF.

ABX1 19 (Chapter 4, Statutes of 2011) provided AB 1629 facilities an overall rate increase of up to 2.4% in the 2011-12 and 2012-13 rate years. These rate increases are estimated in the NF-B Rate Changes policy change.

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability payments program for AB 1629 facilities that provides for supplemental payments to NF-Bs in the 2012-13 rate year. The supplemental payments are estimated in the Quality and Accountability Payments Program policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Savings from additional revenue from Quality Assurance (QA) fee collections are estimated to be \$13,171,000 GF in FY 2012-13.
2. The savings from redirecting funding for rate increases is estimated to \$66,053,000 TF (\$33,026,500 GF) in FY 2012-13.

ELIMINATE 2012-13 RATE INCREASE & SUPP. PAYMENT

REGULAR POLICY CHANGE NUMBER: 198

3. The savings from redirecting the 2012-13 supplemental payments for AB 1629 facilities is estimated to be \$46,643,000 TF (\$23,321,500 GF).

FY 2012-13	TF	GF
Eliminate rate increases	(\$66,053,000)	(\$33,026,500)
Eliminate supplemental payments	(\$46,643,000)	(\$23,321,500)
Subtotal	(\$112,696,000)	(\$56,348,000)
Additional QAF revenue savings	(\$13,171,000)	(\$13,171,000)
Total	(\$125,867,000)	(\$69,519,000)

Funding:

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

100% General Fund (4260-605-0001)

SNF Quality & Accountability (less funded by GF) (4260-698-3167)

SNF Quality & Accountability (4260-605-3167)

NDPH IP FFS PAYMENT METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 201
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1686

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$52,844,000
- STATE FUNDS	\$0	-\$76,422,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$52,844,000
STATE FUNDS	\$0	-\$76,422,000
FEDERAL FUNDS	\$0	\$23,578,000

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact from changing the Medi-Cal inpatient (IP) fee-for-service (FFS) payment methodology for Non-Designated Public Hospitals (NDPHs) from a negotiated per diem rate or non-contract cost based methodology to a certified public expenditures (CPEs) methodology.

Authority:

Proposed Legislation

Background:

For Medi-Cal hospital inpatient services NDPHs receive either:

- The California Medical Assistance Commission (CMAC) negotiated per diem rates if they are a contract facility or
- Cost-based reimbursement if they are a non-contract facility.

The CMAC negotiated per diem rate or non-contract cost reimbursement is paid with 50% federal financial participation (FFP) and 50% General Fund (GF). Pending approval of the proposed legislation, the Department will seek approval of a State Plan Amendment (SPA) from the Centers for Medicare & Medicaid Services (CMS) to authorize NDPHs to receive reimbursement based on CPEs. The proposed interim payments are 100% federal funds matching the hospitals CPEs, resulting in 50% FFP and 50% local spending. Because they would no longer be funded with GF, NDPHs would be exempt from the Diagnosis-Related Group (DRG) payment methodology for inpatient services that will replace the current inpatient reimbursement methodology effective July 1, 2013.

With the change in methodology, NDPHs would be funded for their inpatient Medi-Cal FFS in the same manner as Designated Public Hospitals. Pending approval of the proposed legislation, the Department will also seek approval of a waiver from CMS to increase Safety Net Care Pool Uncompensated Care and Delivery System Reform Incentive Pool funding available to California. The additional funds would be made available to NDPHs to offset their uncompensated care costs and to support their efforts to enhance the quality of care and the health of the patients and families they serve. Please see the

NDPH IP FFS PAYMENT METHODOLOGY CHANGE**REGULAR POLICY CHANGE NUMBER: 201**

policy changes NDPH Deliver System Reform Incentive Pool and NDPH Safety Net Care Pool for more information.

With this change in methodology, NDPHs would no longer receive \$3.8 million in annual supplemental payments starting in FY 2012-13 (see policy change MH/UCD & BTR-NDPH Supplemental Payment). The supplemental payments are 50% GF and 50% FFP and were originally authorized by SB 1100 (Chapter 560, Statutes of 2005). They will also no longer be eligible for the supplemental payments authorized by AB 113 (Chapter 20, Statutes of 2011), which are funded by inter-governmental transfers and FFP (see policy change NDPH IGT Supplemental Payments). See the policy changes Eliminate NDPH IGT Supplemental Payments and Eliminate NDPH Supplemental Payments.

The table below shows the overall fiscal impact:

(In Thousands)

FY 2012-13

	<u>TF</u>	<u>GF</u>	<u>FF</u>	<u>IGT</u>
Eliminate Current IP FFS Payments	(\$152,844)	(\$76,422)	(\$76,422)	\$0
CPE Methodology Reimbursement	\$100,000		\$100,000	\$0
Total IP FFS Payments	(\$52,844)	(\$76,422)	\$23,578	\$0
NDPH SNCP	\$30,000	\$0	\$30,000	\$0
NDPH DSRIP	\$60,000	\$0	\$30,000	\$30,000
Eliminate SB 1100 Supplemental Payments	(\$3,800)	(\$1,900)	(\$1,900)	\$0
Eliminate AB 113 IGT Supplemental Payments	(\$70,000)	\$3,322	(\$35,000)	(\$38,322)
Total	(\$36,644)	(\$75,000)	\$46,678	(\$8,322)

The table below shows the net impact to NDPHs, which is a loss of \$28,322,000.

(In Thousands)

FY 2012-13

	<u>Net Payment</u>
Eliminate Current IP FFS Payments	(\$152,844)
CPE Methodology Reimbursement	\$100,000
NDPH SNCP	\$30,000
NDPH DSRIP	\$30,000
Eliminate SB 1100 Supplemental Payments	(\$3,800)
Eliminate AB 113 IGT Supplemental Payments	(\$31,678)
Total	(\$28,322)

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume annual NDPH inpatient FFS payments of \$152.844 million under the CMAC negotiated rate.

NDPH IP FFS PAYMENT METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 201

2. Assume the new annual NDPH inpatient FFS payment is \$100 million under CPE methodology reimbursement.

The estimated fiscal impact is:

(In Thousands)

FY 2012-13

	<u>TF</u>	<u>GF</u>	<u>FF</u>	<u>IGT</u>
Eliminate Current IP FFS Payments	(\$152,844)	(\$76,422)	(\$76,422)	\$0
CPE Methodology Reimbursement	\$100,000		\$100,000	\$0
Total IP FFS Payments	(\$52,844)	(\$76,422)	\$23,578	\$0

Funding:

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

NDPH SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 202
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1688

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$30,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$30,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$30,000,000

DESCRIPTION

Purpose:

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

Authority:

Proposed Legislation

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 Designated Public Hospitals (DPHs) for uncompensated care to the uninsured and the federalizing of Designated State Health Programs. Pending approval of the proposed legislation, the Department will also seek approval of a waiver from CMS to increase SNCP funding and make the increased funding available to NDPHs.

This policy change is one component of the overall change in reimbursement for NDPHs that is outlined in the NDPH IP FFS Payment Methodology Change policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

NDPH SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 202

Methodology:

The estimated SNCP FFP on an accrual basis is:

(In Thousands)	
<u>Demonstration Year (DY)</u>	<u>Due to NDPHs</u>
2012-13	\$30,000

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

(In Thousands)		
<u>FY 2012-13</u>	<u>TF</u>	<u>FF</u>
DY 2012-13	\$30,000	\$30,000

Funding:

Health Care Support Fund (4260-601-7503)

NDPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 203
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1689

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$60,000,000
- STATE FUNDS	\$0	\$30,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$60,000,000
STATE FUNDS	\$0	\$30,000,000
FEDERAL FUNDS	\$0	\$30,000,000

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 Non-Designated Public Hospitals' (NDPHs) efforts in enhancing the quality of care and the health of the patients and families they serve.

Authority:

Proposed Legislation

Background:

The Centers for Medicare & Medicaid Services (CMS) approved the Bridge to Reform (BTR) effective November 1, 2010. The BTR establishes the DSRIP for Designated Public Hospitals (DPHs). Pending approval of the proposed legislation, the Department will also seek approval of a waiver amendment from CMS to increase federal funding through a new DSRIP fund for NDPHs.

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

NDPHs will submit their DSRIP proposals for approval and be paid based on milestones. NDPHs will provide the non-federal share of their DSRIP through IGTs.

NDPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 203

Annual federal funds available will be the applicable FMAP of annual total computable expenditure limits as follows:

(In Thousands)		
Demonstration Year	Total Computable	DSRIP
2012-13	\$60,000	\$30,000

This policy change is one component of the overall change in reimbursement for NDPHs that is outlined in the NDPH IP FFS Payment Methodology Change policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

DDSRIP payments are estimated to be:

(In Thousands)				
FY 2012-13	DY 2012-13	TF	FF	IGT
		\$60,000	\$30,000	\$30,000

Funding:

DSRIP IGT (4260-601-3172)

Title XIX FFP (4260-101-0890)

ELIMINATE NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 204
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1690

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$70,000,000
- STATE FUNDS	\$0	-\$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$70,000,000
STATE FUNDS	\$0	-\$35,000,000
FEDERAL FUNDS	\$0	-\$35,000,000

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact from eliminating payments for a supplemental reimbursement program for Non-Designated Public Hospitals (NDPHs).

Authority:

Proposed Legislation

Background:

AB 113 (Chapter 20, Statutes of 2011) established an 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. See the NDPH IGT Supplemental Payments policy change for more information.

Pending approval of the proposed legislation, the Department is proposing to eliminate this supplemental payment starting in FY 2012-13.

This policy change is one component of the overall change in reimbursement for NDPHs that is outlined in the NDPH IP FFS Payment Methodology Change policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

ELIMINATE NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 204

Methodology:

The estimated fiscal impact is:

(In Thousands)

FY 2012-13	TF	GF	IGT	FF
Payments to NDPHs	(\$70,000)	\$0	(\$35,000)	(\$35,000)
Children's Services	\$0	\$3,322	(\$3,322)	\$0
Total 2012-13	(\$70,000)	\$3,322	(\$38,322)	(\$35,000)

Funding:

Medi-Cal Inpatient Payment Adjustment (MIPA) Fund (4260-606-0834)

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

ELIMINATE NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 205
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1691

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$3,800,000
- STATE FUNDS	\$0	-\$1,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$3,800,000
STATE FUNDS	\$0	-\$1,900,000
FEDERAL FUNDS	\$0	-\$1,900,000

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact from eliminating the supplemental payments made to Non-Designated Public Hospitals (NDPHs).

Authority:

Proposed Legislation

Background:

Effective July 1, 2005, based on the requirements of SB 1100 (Chapter 560, Statutes of 2005), supplemental reimbursements are available to NDPHs. Currently, 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. See the policy change MH/UCD & BTR-NDPH Supplemental Payment for more information.

Pending approval of the proposed legislation, the Department is proposing to eliminate NDPHs' \$3.8 million in annual supplemental payments starting in FY 2012-13.

This policy change is one component of the overall change in reimbursement for NDPHs that is outline in the NDPH IP FFS Payment Methodology Change policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

ELIMINATE NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 205

Methodology:

The estimated fiscal impact is:

FY 2012-13

	<u>TF</u>	<u>SF</u>	<u>FFP</u>
GF Appropriation	(\$3,800,000)	(\$1,900,000)	(\$1,900,000)

Funding:

NDPH Supplemental Fund (4260-601-3096)

Title XIX FFP (4260-101-0890)

BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER: 207
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1694

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$200,000,000
- STATE FUNDS	\$0	-\$27,654,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$200,000,000
STATE FUNDS	\$0	-\$27,654,500
FEDERAL FUNDS	\$0	-\$172,345,500

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact from allocating excess Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP). These funding streams are available pursuant to the California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration.

Authority:

Proposed Legislation

Background:

The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013, at which point they will be eligible for coverage under the California Health Benefit Exchange. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) and intergovernmental transfer (IGTs) are used to obtain the federal financial participation (FFP). Federal funding for the program is capped at \$360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and \$180 million for DY 2013-14. However, local spending under the HCCI has not reached \$360 million. The Department has requested approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent HCCI money to the SNCP uncompensated care component.

The funding reallocated to the SNCP will be shared 50/50 between the state and Designated Public Hospitals (DPHs) to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy changes BTR-Increase Safety Net Care Pool and BTR-Increase Designated State Health Programs (DSHPs) for more information.

**BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER
FUNDS
REGULAR POLICY CHANGE NUMBER: 207**

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume \$100 million FFP is available to rollover from DY 2010-11, \$73 million FFP is available to rollover from DY 2011-12, and \$45 million FFP will be available to rollover from DY 2012-13.
2. Assume funds will be split 50/50 between the state and DPHs.

(In Millions)	FFP	GF
FY 2012-13		
HCCI	(\$200.00)	\$0.00
SNCP-DPHs	\$100.00	\$0.00
SNCP-DSHPs	\$100.00	(\$100.00)
 FY 2013-14		
HCCI	(\$18.00)	\$0.00
SNCP-DPHs	\$9.00	\$0.00
SNCP-DSHPs	\$9.00	(\$9.00)

Funding:

Title XIX FFP (4260-101-0890)

Health Care Support Fund (4260-601-7503)

HOSPITAL QAF PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 208
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1695

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$300,000,000
- STATE FUNDS	\$0	-\$150,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$300,000,000
STATE FUNDS	\$0	-\$150,000,000
FEDERAL FUNDS	\$0	-\$150,000,000

DESCRIPTION

Purpose:

This policy change estimates the savings from changes to the distribution of hospital fee revenue.

Authority:

Proposed Legislation

Background:

SB 335 (Chapter 286, Statutes of 2011) extended the hospital quality assurance fee (QAF) program from July 1, 2011 through December 31, 2013. The fee generates approximately \$2.8 billion in annual revenue primarily to match federal funds to provide supplemental payments to private hospitals and increase payments to managed care plans so they can increase hospital payments. Some fee revenue is also used to provide grants to public hospitals, fund payments for out-of-network hospitals in county Low-Income Health Programs, and fund children's health coverage.

Pending approval of state legislation, the Department will reduce increased payments to managed care plans that fund supplemental payments to private hospitals and use the fee revenue to offset General Fund costs for children's health coverage in the Medi-Cal program. The managed care supplemental payments are budgeted in the Hospital QAF – Hospital Payments policy change. In FY 2013-14, the Department will also reduce payments to Designated Public Hospitals (DPHs) that fund their direct grants and increased payments to managed care plans and use the fee revenue to offset General Fund costs for children's health coverage.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume supplemental payments for managed care plans in FY 2012-13 are reduced by \$300 million total funds – 50% fee revenue and 50% federal funds.
2. Assume that the \$150 million in fee revenue is redirected to offset General Fund costs for children's health coverage in Medi-Cal.

HOSPITAL QAF PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 208

(In Thousands)

FY 2012-13

	<u>TF</u>	<u>FF</u>	<u>GF</u>	<u>SF(HQARF)</u>
Managed Care Payments to Private Hospitals	(\$300,000)	(\$150,000)	\$0	(\$150,000)
Children's Insurance Coverage	\$0	\$0	(\$150,000)	\$150,000
Total	(\$300,000)	(\$150,000)	(\$150,000)	\$0

FY 2013-14

Managed Care Payments to Private Hospitals	(\$150,000)	(\$75,000)		(\$75,000)
DPHs Grants	(\$21,500)			(\$21,500)
Managed Care Payments to DPHs	(\$40,000)	(\$20,000)		(\$20,000)
Children's Insurance Coverage	\$0		(\$116,500)	\$116,500
Total	(\$211,500)	(\$95,000)	(\$116,500)	\$0

Funding:

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

TRIGGER CUTS TO CDSS FOR IHSS

REGULAR POLICY CHANGE NUMBER: 209
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1696

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$325,420,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$325,420,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	-\$325,420,000

DESCRIPTION

Purpose:

This policy change budgets the implementation of a 7% across the board trigger reduction in In-Home Supportive Services (IHSS) hours and the elimination of Domestic and Related Services for the IHSS program recipients living in shared living arrangements (SLA) provided through the Department of Social Services (CDSS).

Authority:

Welfare and Institutions Code, section 12301.07
 SB 73 (Chapter 34, Statutes of 2011)

Background:

The 7% across the board reduction to IHSS service hours is effective beginning August 1, 2012.

Eliminate Domestic and Related Services for Recipients Living in Shared Living Arrangements is effective October 1, 2012. Those IHSS recipients who reside only with other IHSS recipients are excluded.

The Department provides the federal fund participation (FFP) to CDSS for these costs.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

The estimates, based on a cash basis, were provided by CDSS.

TRIGGER CUTS TO CDSS FOR IHSS

REGULAR POLICY CHANGE NUMBER: 209

7% Across-the-Board Reduction to IHSS Hours

(In Thousands)	<u>DHCS FFP</u>	<u>CDSS GF</u>	<u>County</u>
FY 2012-13	\$142,417	\$92,571	\$49,846

Eliminate Domestic and Related Services for Recipients Living in Shared Living Arrangements (SLR)

(In Thousands)	<u>DHCS FFP</u>	<u>CDSS GF</u>	<u>County</u>
FY 2012-13	\$183,003	\$118,952	\$64,051

Total FY 2012-13 Savings

7% Across-the-Board Reduction to IHSS Hours

Eliminate Domestic and Related Services for Recipients Living in SLR

Total DHCS FFP for FY 2012-13**DHCS
FFP**\$142,417\$183,003**\$325,420****Funding:**

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

BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 210
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1697

	FY 2011-12	FY 2012-13
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	-\$100,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	-\$100,000,000
FEDERAL FUNDS	\$0	\$100,000,000

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact from allocating excess Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP) for the Designated State Health Programs (DSHPs).

Authority:

Proposed Legislation

Background:

The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013, at which point they will be eligible for coverage under the California Health Benefit Exchange. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) and intergovernmental transfer (IGTs) are used to obtain the federal financial participation (FFP). Federal funding for the program is capped at \$360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and \$180 million for DY 2013-14. However, local spending under the HCCI has not reached \$360 million. The Department has requested approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent HCCI money to the SNCP uncompensated care component. See policy change BTR—Health Care Coverage Initiative Rollover Funds

The funding reallocated to the SNCP will be shared 50/50 between the state and Designated Public Hospitals (DPHs) to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy changes BTR—Increase Safety Net Care Pool for more information.

Reason for Change from Prior Estimate:

This is a new policy change.

**BTR—INCREASE DESIGNATED STATE HEALTH
PROGRAMS**
REGULAR POLICY CHANGE NUMBER: 210

Methodology:

1. Assume \$100 million FFP is available to rollover from DY 2010-11, \$73 million FFP is available to rollover from DY 2011-12, and \$45 million FFP will be available to rollover from DY 2012-13.
2. Assume funds will be split 50/50 between the state and DPHs.

(In Millions)

FY 2012-13	FFP	GF
HCCI	(\$200.00)	\$0.00
SNCP-DPHs	\$100.00	\$0.00
SNCP-DSHPs	\$100.00	(\$100.00)
FY 2013-14		
HCCI	(\$18.00)	\$0.00
SNCP-DPHs	\$9.00	\$0.00
SNCP-DSHPs	\$9.00	(\$9.00)

Funding:

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

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 211
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1698

	<u>FY 2011-12</u>	<u>FY 2012-13</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$100,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$100,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$100,000,000

DESCRIPTION**Purpose:**

This policy change estimates the fiscal impact FROM allocating excess Health Care Coverage Initiative (HCCI) funds to the Safety Net Care Pool (SNCP) for Designated Public Hospitals (DPHs)

Authority:

Proposed Legislation

Background:

The HCCI is the component of the Low Income Health Program (LIHP) that provides health coverage to individuals between 133% and 200% of the federal poverty level through December 31, 2013, at which point they will be eligible for coverage under the California Health Benefit Exchange. This is a discretionary local government program. The federal funding for this program is budgeted in the BTR—Low Income Health Program-HCCI policy change.

Local government certified public expenditures (CPEs) and intergovernmental transfer (IGTs) are used to obtain the federal financial participation (FFP). Federal funding for the program is capped at \$360 million total computable annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and \$180 million for DY 2013-14. However, local spending under the HCCI has not reached \$360 million. The Department has requested approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to reallocate unspent HCCI money to the SNCP uncompensated care component. See policy change BTR—Health Care Coverage Initiative Rollover Funds

The funding reallocated to the SNCP will be shared 50/50 between the state and DPHs to offset General Fund expenditures and provide additional funding for local uncompensated care costs. All waiver funds will be drawn down with DPHs' CPEs. See policy change BTR—Increase Designated State Health Programs (DSHPs) for more information.

Reason for Change from Prior Estimate:

This is a new policy change.

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 211

Methodology:

1. Assume \$100 million FFP is available to rollover from DY 2010-11, \$73 million FFP is available to rollover from DY 2011-12, and \$45 million FFP will be available to rollover from DY 2012-13.
2. Assume funds will be split 50/50 between the state and DPHs.

(In Millions)		
FY 2012-13	FFP	GF
HCCI	(\$200.00)	\$0.00
SNCP-DPHs	\$100.00	\$0.00
SNCP-DSHPs	\$100.00	(\$100.00)
FY 2013-14		
HCCI	(\$18.00)	\$0.00
SNCP-DPHs	\$9.00	\$0.00
SNCP-DSHPs	\$9.00	(\$9.00)

Funding:

Health Care Support Fund (4260-601-7503)