# MEDI-CAL
# MAY 2012
# LOCAL ASSISTANCE ESTIMATE
**for**
# FISCAL YEARS
# 2011-12 and 2012-13

# POLICY CHANGES

Fiscal Forecasting and Data Management Branch
State Department of Health Care Services
1501 Capitol Avenue, Suite 6069
Sacramento, CA 95814
(916) 552-8550

EDMUND G. BROWN JR.
Governor
State of California

Diana Dooley
Secretary
California Health and Human Services Agency

Toby Douglas
Director
Department of Health Care Services

# MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX


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# MEDI-CAL PROGRAM REGULAR
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# FAMILY PACT PROGRAM

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 1 |
| IMPLEMENTATION DATE: | 1/1997 |
| ANALYST: | Cang Ly |
| FISCAL REFERENCE NUMBER: | 1 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $582,522,000 | $600,407,000 |
| - STATE FUNDS | $141,723,600 | $146,075,200 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $582,522,000 | $600,407,000 |
| STATE FUNDS | $141,723,600 | $146,075,200 |
| FEDERAL FUNDS | $440,798,400 | $454,331,800 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs of family planning services provided by the Family Planning, Access, Care and Treatment (PACT) program.

**Authority:**
Welfare and Institutions Code, section 14132(aa)

**Background:**
Effective January 1, 1997, family planning services were expanded under the Family PACT program to provide contraceptive services to more persons in need of such services who have incomes under 200% of Federal Poverty Level. A Section 1115 demonstration project waiver was approved by Centers for Medicare & Medicaid Services (CMS) effective December 1, 1999.

A State Plan Amendment (SPA) was approved on March 24, 2011, in accordance with the Affordable Care Act, to transition the current Family PACT Waiver into the State Plan. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund receive a 90% federal financial participation (FFP), and family planning-related services receive reimbursement at Title XIX 50/50 FFP.

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

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

**Methodology:**
1. Family planning services and testing for sexually transmitted infections (STIs) are eligible for 90% FFP.

2. The treatment of STIs and other family planning companion services are eligible for Title XIX 50/50 FFP.

# FAMILY PACT PROGRAM

## REGULAR POLICY CHANGE NUMBER: 1

3. The treatment of other medical conditions; including inpatient care for complications from family planning services are not eligible for FFP.

4. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% GF.

| | FY 2011-12 | | FY 2012-13 | |
|---|---|---|---|---|
| **Service Category** | **TF** | **GF** | **TF** | **GF** |
| Physicians | $80,587,000 | $19,606,000 | $86,468,000 | $21,037,000 |
| Other Medical | $345,723,000 | $84,112,000 | $348,207,000 | $84,716,000 |
| County Outpatient | $3,322,000 | $808,000 | $3,595,000 | $875,000 |
| Community Outpatient | $4,288,000 | $1,043,000 | $4,502,000 | $1,095,000 |
| Pharmacy | $148,602,000 | $36,154,000 | $157,635,000 | $38,351,000 |
| **Total** | **$582,522,000** | **$141,723,000** | **$600,407,000** | **$146,074,000** |

**Funding:**
Title XIX 50/50 FFP (4260-101-0001/0890)
GF (4260-101-0001)
Title XIX 90/10 FFP (4260-101-0001/0890)

# BREAST AND CERVICAL CANCER TREATMENT

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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $125,539,000 | $138,724,000 |
| - STATE FUNDS | $54,469,300 | $59,847,150 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $125,539,000 | $138,724,000 |
| STATE FUNDS | $54,469,300 | $59,847,150 |
| FEDERAL FUNDS | $71,069,700 | $78,876,850 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of the Breast and Cervical Cancer Treatment Program (BCCTP).

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

**Background:**
AB 430 authorized the BCCTP effective January 1, 2002, for women under 200% of the federal poverty level (FPL). Enhanced Title XIX Medicaid funds (35% GF/65% FFP) may be claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope Medi-Cal benefits for women under age 65 who are citizens or legal immigrants with no other health coverage.

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

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

**Reason for Change from Prior Estimate:**
Revised due to additional caseload projections and expenditures.

**Methodology:**
1. There were 10,191 fee-for-service (FFS) and 2,570 managed care eligibles as of January 2012 (total of 12,761). 2,452 of the FFS eligibles were eligible for State-Only services.

2. 682 of the FFS eligibles were in Accelerated Enrollment as of January 2012.

# BREAST AND CERVICAL CANCER TREATMENT

## REGULAR POLICY CHANGE NUMBER: 2

3. Assume the State will pay Medicare and other health coverage premiums for an average of 207 beneficiaries monthly in FY 2011-12 and FY 2012-13. Assume an average monthly premium cost per beneficiary of $250.10.

   FY 2011-12: 207 x $250.10 x 12 months = $620,000* TF ($620,000 GF) *Rounded
   FY 2012-13: 207 x $250.10 x 12 months = $620,000* TF ($620,000 GF) *Rounded

4. Costs are estimated as follows:

| (Rounded) | FY 2011-12 | | FY 2012-13 | |
|---|---|---|---|---|
| | TF | GF | TF | GF |
| Full Scope Costs | $109,338,000 | $38,268,000 | $121,349,000 | $42,472,000 |
| State-Only Costs | | | | |
| Services | $15,581,000 | $15,581,000 | $16,755,000 | $16,755,000 |
| Premiums | $620,000 | $620,000 | $620,000 | $620,000 |
| Total | **$125,539,000** | **$54,469,000** | **$138,724,000** | **$59,847,000** |

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

**Funding:**

| **FY 2011-12:** | | GF | FF | TF |
|---|---|---|---|---|
| General Fund | 4260-101-001 | $16,201,000 | $ 0 | **$16,201,000** |
| Title XIX 35/65 FFP | 4260-101-0001/0890 | $38,268,000 | $71,070,000 | **$109,338,000** |

| **FY 2012-13**: | | GF | FF | TF |
|---|---|---|---|---|
| General Fund | 4260-101-001 | $17,375,000 | $ 0 | **$17,375,000** |
| Title XIX 35/65 FFP | 4260-101-0001/0890 | $42,472,000 | $78,877,000 | **$121,349,000** |

# CHDP GATEWAY - PREENROLLMENT

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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $11,671,000 | $10,615,000 |
| - STATE FUNDS | $4,084,850 | $4,929,950 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $11,671,000 | $10,615,000 |
| STATE FUNDS | $4,084,850 | $4,929,950 |
| FEDERAL FUNDS | $7,586,150 | $5,685,050 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of providing pre-enrollment (PE) into the Healthy Families Program (HFP) for children who receive a Children's Health and Disability Program (CHDP) screening.

**Authority:**
Welfare & Institutions Code, section 14011.7
AB 442 (Chapter 1161, Statutes of 2002)

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

Effective October 1, 2012, the HFP will cease to enroll new applicants and will be phased-out over a nine-month period. Children enrolled in the HFP will be transitioned to the Medi-Cal program, and children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal.

**Reason for Change from Prior Estimate:**
Updated FY 2011-12 data on eligibles for aid code 8X, and the HFP transition to Medi-Cal proposal.

**Methodology:**
1. Based on June 2009 through February 2012 eligible data there will be 527,698 children (57,010 HFP, 432,052 Medi-Cal and 38,636 CHDP State-Only) in FY 2011-12 and 457,990 children (12,295 HFP, 38,007 Shift of HFP to Medi-Cal, 376,244 Medi-Cal and 31,444 CHDP State-Only) in FY 2012-13 who will be screened through the Gateway.

2. Based on November 2010 through August 2011 cost data and August 2010 through May 2011 eligible data, the per member per month (PMPM) cost for HFP PE is $204.72.

# CHDP GATEWAY - PREENROLLMENT

## REGULAR POLICY CHANGE NUMBER: 3

3. Based on January 2011 through December 2011 cost data and October 2010 through September 2011 eligible data, the PMPM cost for Medi-Cal PE is $213.06.

4. The funding for the Childhood Lead Poisoning Prevention (CLPP), previously included in this policy change, is now budgeted in the Childhood Lead Poisoning Prevention (CLPP) policy change.

5. The estimated FY 2011-12 and FY 2012-13 HFP and Medi-Cal PE costs are as follows:

| **FY 2011-12:** | **Avg. Mo. Eligibles** | **TF** | **GF** |
|---|---|---|---|
| Medi-Cal PE | 36,004 | $ 92,054,000 | $ 46,027,000 |
| **HFP PE** | **4,751** | **$ 11,671,000** | **$ 4,085,000** |
| Total | | $ 103,725,000 | $ 50,112,000 |

| **FY 2012-13:** | **Avg. Mo. Eligibles** | **TF** | **GF** |
|---|---|---|---|
| **HFP PE*** | **4,098** | **$ 2,517,000** | **$ 881,000** |
| **Shift HFP to Medi-Cal PE** | **4,223** | **$ 8,098,000** | **$ 4,049,000** |
| | | **$ 10,615,000** | **$ 4,930,000** |
| Medi-Cal PE | 31,961 | $ 80,163,000 | $ 40,081,500 |
| Total | | $ 90,778,000 | $ 45,011,500 |

**Due to the Shift of HFP into Medi-Cal, HFP PE is based on three months of impact in FY 2012-13. The other nine months is captured in the Shift HFP to Medi-Cal PE.*

**Funding:**
Title XXI 35/65 FFP (4260-113-0001/0890)
Title XIX 50/50 FFP (4260-101-0001/0890)

# BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 4
IMPLEMENTATION DATE: 11/1998
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 5

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $19,221,000 | $4,828,000 |
| - STATE FUNDS | $6,727,350 | $1,689,800 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $19,221,000 | $4,828,000 |
| STATE FUNDS | $6,727,350 | $1,689,800 |
| FEDERAL FUNDS | $12,493,650 | $3,138,200 |

## DESCRIPTION

**Purpose:**
This policy change estimates the expenditures for children placed in the Bridge to Healthy Families Program (HFP).

**Authority:**
AB 2780 (Chapter 310, Statutes of 1998)

**Background:**
In order to allow time for families to apply for the HFP for their children, AB 2780 provides one month additional Medi-Cal eligibility as a bridge for children who become ineligible for Medi-Cal without a share-of-cost or are eligible for Medi-Cal with a share-of-cost and have income less than 250% of poverty (aid code 7X). The costs for this program are not included in the Medi-Cal base estimate. They are added through this policy change.

Effective October 1, 2012, the HFP will cease to enroll new applicants and will be phased-out over a nine-month period, which will eliminate the need for the bridge from Medi-Cal to the HFP.

**Reason for Change from Prior Estimate:**
Change due to additional caseload and cost data. Also, the Shift of HFP to Medi-Cal proposal will eliminate this program.

**Methodology:**
1. Based on current Medi-Cal data, 132,431 children in FY 2011-12 and 34,288 children in FY 2012-13 are expected to receive one-month bridge (aid code 7 X). The average monthly number of beneficiaries will be 11,036 in FY 2011-12 and 11,429 in FY 2012-13.

2. The FFS eligible months for aid code 7X are estimated to be 29,696 in FY 2011-12 and 7,372 in FY 2012-13. The managed care eligible-months for aid code 7X are estimated to be 102,736 in FY 2011-12 and 26,916 in FY 2012-13.

# BRIDGE TO HFP

## REGULAR POLICY CHANGE NUMBER: 4

3. Based on cost data from November 2011 through August 2011 and eligible data from August 2010 through May 2011, the FFS PMPM cost for aid code 7X is $45.37. The total FFS expenditures for aid code 7X will be $1,347,000 in FY 2011-12 and $334,500 in FY 2012-13.

   FY 2011-12: $45.37 PMPM x 29,696 = $1,347,000
   FY 2012-13: $45.37 PMPM x 7,372 = $334,500

4. Based on cost data from November 2011 through August 2011 and eligible data from August 2010 through May 2011, the total average monthly managed care carve-out cost for aid code 7X is $20.14. The total managed care carve-out expenditures for aid code 7X will be $2,069,000 in FY 2011-12 and $542,000 in FY 2012-13.

   FY 2011-12: $20.14 Carve-Out x 102,736 = $2,069,000
   FY 2012-13: $20.14 Carve-Out x 26,916 = $542,000

5. The managed care capitation cost for aid code 7X will be $15,804,000 in FY 2011-12 and $3,951,000 in FY 2012-13.

6. The total managed care cost for aid code 7X will be $17,874,000 in FY 2011-12 and $4,493,000 in FY 2012-13.

   FY 2011-12: $2,069,000 Carve-Out + $15,804,000 Capitation = $17,874,000
   FY 2012-13: $542,000 Carve-Out + $3,951,000 Capitation = $4,493,000

7. Total expenditures for aid code 7X are expected to be $19,221,000 TF in FY 2011-12 and $4,828,000 TF in FY 2012-13.

   FY 2011-12: $1,347,000 + $17,874,000 = **$19,221,000 TF**
   FY 2012-13: $334,500 + $4,493,000 = **$4,827,500 TF**

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

# CRAIG V. BONTA DISALLOWANCE

REGULAR POLICY CHANGE NUMBER: 5
IMPLEMENTATION DATE: 3/2012
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1623

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $12,337,000 | $0 |
| - STATE FUNDS | $12,337,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $12,337,000 | $0 |
| STATE FUNDS | $12,337,000 | $0 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the disallowance against claims for federal financial participation (FFP) for persons, who were determined to be ineligible for Medicaid during the period of April 1, 2003 through September 30, 2004.

**Authority:**
Not Applicable

**Background:**
As a result of *Craig v. Bontá,* counties were instructed that Medi-Cal beneficiaries losing Supplemental Security Income and State Supplemental Payment (SSI/SSP) based Medi-Cal on or after June 30, 2002, cannot have their Medi-Cal eligibility automatically discontinued. These cases must first be reviewed and evaluated for eligibility in other Medi-Cal programs using the three-step SB 87 redetermination process.

The Centers for Medicare and Medicaid Services (CMS) has determined there is a disallowance of federal funding for failure to make prompt Medicaid eligibility determinations after beneficiaries were found to be ineligible for SSI based Medi-Cal. The Department will provide repayment of FFP to CMS.

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

**Methodology:**

| | FY 2011-12 |
|---|---|
| Total General Fund Cost | **$12,337,000** |

**Funding:**
100% State GF (4260-101-0001)

# LANTERMAN DEVELOPMENTAL CENTER CLOSURE

REGULAR POLICY CHANGE NUMBER: 6
IMPLEMENTATION DATE: 3/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1560

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $607,000 | $7,372,000 |
| - STATE FUNDS | $303,500 | $3,686,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $607,000 | $7,372,000 |
| STATE FUNDS | $303,500 | $3,686,000 |
| FEDERAL FUNDS | $303,500 | $3,686,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs for the closure of the Lanterman Development Center.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011)

**Background:**
On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families and the regional centers to transition residents to community living arrangements beginning in FY 2011-12. Residents moving into the community will be enrolled in a Medi-Cal managed care health plan or receive services through the Medi-Cal fee-for-service system.

**Reason for Change from Prior Estimate:**
Updated implementation date.

**Methodology:**
1. Under CDDS' Plan for Closure of Lanterman Developmental Center, the individual planning process will be the basis for ensuring that each resident's needs and choices are identified and appropriately addressed in the community. Therefore, the costs of the services to be provided through the Medi-Cal program once the residents transition to the community are unknown at this time.

2. Placeholder costs of $607,000 ($303,500 GF) for FY 2011-12 and $7,372,000 ($3,686,000 GF) for FY 2012-13 are included in the May 2012 Medi-Cal Estimate.

3. Assume 70 residents will transition from Lanterman Developmental Center into the community in 2011-12 and 110 residents will transition in 2012-13.

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

# REFUGEES

REGULAR POLICY CHANGE NUMBER: 7
IMPLEMENTATION DATE: 7/1980
ANALYST: Luna Woo
FISCAL REFERENCE NUMBER: 14

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,573,000 | $5,674,000 |
| - STATE FUNDS | $3,573,000 | $5,674,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,573,000 | $5,674,000 |
| STATE FUNDS | $3,573,000 | $5,674,000 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the refugees' medical expenditures to be reimbursed by the California Department of Public Health (CDPH).

**Authority:**
Interagency Agreement

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

The RRP federal grant is administered by CDPH, which has program responsibility through the Refugee Health Assessment Program. The federal Office of Refugee Resettlement allows only one grant award for refugee health services in the state. The Department of Health Care Services invoices the CDPH for the reimbursement of refugee expenditures, which are originally funded with General Fund.

**Reason for Change from Prior Estimate:**
Lower refugee eligibles than previously estimated.

**Methodology:**
Total refugee expenditures to be reimbursed by CDPH are estimated to be $3,573,000 in FY 2011-12 and $5,674,000 in FY 2012-13.

**Funding:**
Reimbursements (4260-610-0995)

# MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

REGULAR POLICY CHANGE NUMBER: 8
IMPLEMENTATION DATE: 4/2012
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1569

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $7,663,000 | $6,628,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $7,663,000 | $6,628,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $7,663,000 | $6,628,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the federal match provided to the California Department of Corrections and Rehabilitation (CDCR) for the cost of inpatient services for inmates who are deemed eligible for Medi-Cal.

**Authority:**
AB 1628 (Chapter 729, Statutes of 2010)
SB 1399 (Chapter 405, Statutes of 2010)

**Background:**
AB 1628 authorizes the Department and the CDCR to claim federal reimbursement for inpatient hospital services for adult inmates in State correctional facilities when these services are provided off the grounds of the State correctional facility, and the inmates are determined eligible for either the Medi-Cal program or the Low Income Health Program (LIHP) run by counties.

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

**Reason for Change from Prior Estimate:**
The estimates for monthly Medi-Cal and LIHP applications were updated for additional actual caseload data and Medical Parolees.

**Methodology:**
1. Implementation began April 1, 2011 and reimbursements will begin April 2012.

# MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

## REGULAR POLICY CHANGE NUMBER: 8

2. Claims may be filed retroactively to January 1, 2011. It is assumed that the cost of retroactive claims from January 1, 2011 through March 31, 2011, will be insignificant and therefore will not be budgeted for in this policy change. Claims in the amount of $2,703,000 for the period of April 1, 2011 to September 30, 2011 will be included in the FY 2011-12 costs.

3. Applications for Medi-Cal will be processed by the Department if the applicant received off-site inpatient related services. Costs for inmates eligible for LIHP are budgeted in the LIHP Inpatient Hosp. Costs for CDCR Inmates policy change.

4. It is assumed the Department will process 500 applications per month for inmates with verified citizenship.

5. Of the estimated 500 monthly applications it is assumed 25% in FY 2011-12 and 20% in FY 2012-13 are for Medi-Cal. Of the Medi-Cal applications, it is assumed 75% are age 65 or older, 15% are disabled, 5% are for pregnancy events, and 5% are under 21 years of age.

| **Monthly Applications** | **FY 2011-12** | | | | | | | **FY 2012-13** | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aged | 500 | x | 25% | x | 75% | = | **94** | 500 | x | 20% | x | 75% | = | **75** |
| Disabled | 500 | x | 25% | x | 15% | = | **19** | 500 | x | 20% | x | 15% | = | **15** |
| Pregnancy Event | 500 | x | 25% | x | 5% | = | **6** | 500 | x | 20% | x | 5% | = | **5** |
| Under 21 | 500 | x | 25% | x | 5% | = | **6** | 500 | x | 20% | x | 5% | = | **5** |

6. Assume 96 percent of the Medi-Cal monthly applicants will become eligible.

7. Based on birth events data 30% of the annual birth events will be for cesarean deliveries and 70% will be for vaginal deliveries.

8. Based on fee-for-service (FFS) cost data the average per member per month (PMPM) cost for an inpatient admission is $9,506 for aged, $11,751 for disabled, and $9,401 for under 21.

9. Based on FFS delivery cost data the average PMPM cost per event is $5,931 for cesarean delivery and $3,759 for a vaginal delivery.

10. In FY 2011-12 and FY 2012-13, it is assumed the Department will process 25 applications monthly for Medical Parolees with verified citizenship. It is assumed these eligibles will receive long term care (LTC) services.

11. Based on FFS cost data the average PMPM cost for a LTC eligible is $7,576.

300 LTC eligible months x $7,576 = $2,273,000 ($1,136,500 FF)

# MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES

## REGULAR POLICY CHANGE NUMBER: 8

12. The total cost will be $15,326,000 ($7,663,000 FF) in FY 2011-12 and $13,256,000 ($6,628,000 FF) in FY 2012-13 and annually.

| | FY 2011-12 | | FY 2012-13 | |
|---|---|---|---|---|
| (Rounded) | TF | FF | TF | FF |
| Apr- Sep Retro | $2,703,000 | $1,351,500 | - | - |
| Medical Parole | $2,273,000 | $1,136,500 | $2,273,000 | $1,136,500 |
| Aged | $7,700,000 | $3,850,000 | $8,213,000 | $4,106,500 |
| Disabled | $1,904,000 | $952,000 | $1,974,000 | $987,000 |
| Under 21 | $508,000 | $254,000 | $542,000 | $271,000 |
| Delivery | $238,000 | $119,000 | $254,000 | $127,000 |
| **Total** | $15,326,000 | **$7,663,000** | $13,256,000 | **$6,628,000** |

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

# LOMELI V. SHEWRY

REGULAR POLICY CHANGE NUMBER: 9
IMPLEMENTATION DATE: 12/2011
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1583

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $294,000 | $504,000 |
| - STATE FUNDS | $147,000 | $252,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 29.43 % | 15.39 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $207,500 | $426,400 |
| STATE FUNDS | $103,740 | $213,220 |
| FEDERAL FUNDS | $103,740 | $213,220 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of reimbursements made to Supplemental Security Income (SSI) beneficiaries for out-of-pocket medical and dental costs related to the *Lomeli, et al., v. Shewry* lawsuit.

**Authority:**
Not Applicable

**Background:**
The Department finalized a settlement of the *Lomeli* lawsuit, which alleged that the Department did not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage. In August 2011, the Department began sending notices to SSI applicants who did not have Medi-Cal eligibility for all three months before applying for SSI and an updated notice to new SSI recipients, informing them of the availability of retroactive coverage. Benefit costs for eligible medical services during the retroactive coverage period may qualify individuals for reimbursement.

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

**Methodology:**
1. The Department has established the following assumptions based on previous lawsuit settlements.

2. The Department began receiving claims in October 2011, and costs began in December 2011.

3. Assume there are 1,000 Medi-Cal claims per month, of which 60% are eligible for retroactive coverage.

4. Of those, assume 33% of the claims are for dental services and 67% of the claims are for medical services.

5. It is estimated that 18% of dental claims will be approved.

# LOMELI V. SHEWRY

## REGULAR POLICY CHANGE NUMBER: 9

6. It is estimated that 28% of medical claims will be approved.

7. Assume the average cost is $533.74 for dental claims and $202.98 for medical claims.

| FY 2011-12 | TF | GF |
|---|---|---|
| Dental Costs | $ 133,000 | $ 66,500 |
| Medical Costs | $ 161,000 | $ 80,500 |
| **Total Cost** | **$ 294,000** | **$ 147,000** |

| FY 2012-13 | TF | GF |
|---|---|---|
| Dental Costs | $ 228,000 | $ 114,000 |
| Medical Costs | $ 276,000 | $ 138,000 |
| **Total Cost** | **$ 504,000** | **$ 252,000** |

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

# 250% WORKING DISABLED PROGRAM CHANGES

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 10 |
| IMPLEMENTATION DATE: | 8/2011 |
| ANALYST: | Ryan Witz |
| FISCAL REFERENCE NUMBER: | 1558 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $186,000 | $464,000 |
| - STATE FUNDS | $133,000 | $318,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $186,000 | $464,000 |
| STATE FUNDS | $133,000 | $318,000 |
| FEDERAL FUNDS | $53,000 | $146,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs of changes made to the 250% Working Disabled Program (WDP).

**Authority:**
AB 1269 (Chapter 282, Statutes of 2009)

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

AB 1269 requires the Department to implement changes to the WDP 30 days after the American Recovery and Reinvestment Act of 2009 (ARRA) ends on June 30, 2011.

The changes made by AB 1269 are:

1. Exemption of disability income that converts to retirement income.

2. Exemption of retained income from the resource calculation when held in a separately identifiable account and not comingled with other resources.

3. Allows beneficiaries to remain eligible for Medi-Cal up to 26 weeks while unemployed, provided premiums continue to be paid.

4. Allows the monthly premium calculation to be based on five percent of an individual's countable income.

However, under the Patient Protection and Affordable Care Act (PPACA) of 2010, Maintenance of Effort (MOE) requirements are imposed upon states until January 1, 2014. These requirements prevent states from implementing more restrictive Medicaid eligibility policies, procedures or methodologies

# 250% WORKING DISABLED PROGRAM CHANGES

## REGULAR POLICY CHANGE NUMBER: 10

without jeopardizing federal funding, therefore; change #4 concerning monthly premiums will not be implemented due to the MOE provisions of PPACA.

**Reason for Change from Prior Estimate:**
Changes due to updated data and projections for aid code 6G.

**Methodology:**

1. The changes to the WDP were implemented August 1, 2011.

2. The provisions of the bill concerning retained income exemption and 26 weeks of eligibility while unemployed have an indeterminate impact.

3. The exemption of disability income that converts to retirement income will create an increase in the number of WDP participants resulting in additional costs to Medi-Cal.

4. Those affected by the exemption of disability income that converts to retirement income are age 65 and older.

5. Based on FY 2010-11 eligible data there are 510 average monthly eligibles in Aid Code 6G who are over 65 years of age.

6. The current growth rate of over 65 year olds in Aid Code 6G is 1.1% monthly or 6 beneficiaries per month (rounded). It is assumed there will be an additional increase of 70 eligibles per year to the WDP.

7. The full increase in eligibles will be phased-in over 12 months.

8. The fee-for-service (FFS) per member per month (PMPM) cost per eligible for aid code 6G is $270.97 and the average monthly managed care cost is $586.62 ($510.02 cap rate and $70.57 for carve-out PMPM cost). The monthly dental capitation rate is $6.03.

9. The monthly premium for the 2011 Medicare Part B premium is $115.40 and is estimated to be $99.90 in 2012 and 2013. The monthly premium for the Medicare Part D premium is $100.77 in 2011, and is estimated to be $102.76 in 2012 and $105.29 in 2013.

| **FY 2011-12** | **TF** | **GF** |
|---|---|---|
| FFS (lagged) | $41,000 | $20,500 |
| Managed Care | $63,000 | $31,500 |
| Medicare Part B | $40,000 | $40,000 |
| Medicare Part D | $40,000 | $40,000 |
| Dental | $2,000 | $1,000 |
| **Total** | **$186,000** | **$133,000** |

| **FY 2012-13** | **TF** | **GF** |
|---|---|---|
| FFS (lagged) | $143,000 | $71,500 |
| Managed Care | $144,000 | $72,000 |
| Medicare Part B | $84,000 | $84,000 |
| Medicare Part D | $88,000 | $88,000 |
| Dental | $5,000 | $2,500 |
| **Total** | **$464,000** | **$318,000** |

# 250% WORKING DISABLED PROGRAM CHANGES

## REGULAR POLICY CHANGE NUMBER: 10

**Funding:**

| **FY 2011-12:** | | **GF** | **FF** | **TF** |
|---|---|---|---|---|
| Title XIX 50/50 FFP | 4260-101-0001/0890 | $ 53,000 | $ 53,000 | **$ 106,000** |
| GF | 4260-101-0001 | $ 80,000 | $ 0 | **$ 80,000** |

| **FY 2012-13**: | | **GF** | **FF** | **TF** |
|---|---|---|---|---|
| Title XIX 50/50 FFP | 4260-101-0001/0890 | $ 146,000 | $ 146,000 | **$ 292,000** |
| GF | 4260-101-0001 | $ 172,000 | $ 0 | **$ 172,000** |

# CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 11
IMPLEMENTATION DATE: 1/2011
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1371

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | -$8,858,100 | -$8,858,100 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$8,858,100 | -$8,858,100 |
| FEDERAL FUNDS | $8,858,100 | $8,858,100 |

## DESCRIPTION

**Purpose:**
This policy change estimates the technical adjustments in funding from 100% State GF to claim Title XIX or Title XXI federal match for the health care expenditures of qualified children and pregnant aliens who have not yet met the federal 5-year bar.

**Authority:**
Children's Health Insurance Program Reauthorization Act (CHIPRA)

**Background:**
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that immigrants who are designated as “Qualified Aliens” are eligible for full-scope Medi-Cal with 50% federal financial participation (FFP) if they have been in the United States for at least five years. California currently provides full scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the US for less than five years and pays for nonemergency services with 100% State funds if FFP is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services.) CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children or pregnant women even if they have been in the U.S. for less than five years, effective April 1, 2009. Enhanced Title XXI funding is available for children eighteen years of age and younger.

**Reason for Change from Prior Estimate:**
The changes are due to updated expenditures for qualified children and pregnant aliens under the 5-year bar.

**Methodology:**
1. Based on cost data for FY 2010-11 assume the total annual expenditures for New Qualified Aliens (NQA) children are $30,622,000 TF ($15,311,000 GF), of this amount $11,836,000 TF ($4,293,000 GF) are for non-emergency services. Of the non-emergency expenditures, $4,850,000 TF ($1,766,000 GF) is for FFS, including managed care carve-out costs, and $6,986,000 TF ($2,257,000 GF) is for managed care capitation rates.

# CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

## REGULAR POLICY CHANGE NUMBER: 11

2. Based on cost data for FY 2010-11 assume the FFS expenditures for NQA pregnant women are $36,631,000, including managed care carve-out costs. 93.36% of these costs are related to pregnancy, which are currently eligible for FFP. Assume the remainder of the costs for non-pregnancy related health care services account for 6.64% of expenditures, and will be eligible for FFP under CHIPRA.

| | | | | |
|---|---|---|---|---|
| FFS | $34,763,000 | x 6.64% = | $2,308,000 | |
| Carve-Out | $1,869,000 | x 6.64% = | $124,000 | |
| | | **Total** | $2,432,000 | ($1,216,000 GF) |

3. Assume the Managed Care costs for NQA pregnant women are now eligible for FFP under CHIPRA. Assume the annual cost for these beneficiaries is $198,000 TF ($99,000 GF).

4. Assume the total expenditures for non-pregnancy related services for NQA pregnant women are $2,630,000 TF ($1,315,000 GF) annually.

   $2,432,000 + $198,000= $2,630,000 ($1,315,000 GF) annually

5. Assume a savings to the General Fund since the non-emergency expenditures for NQA children and pregnant women were previously budgeted at 100% GF, but are now eligible for FFP.

6. Total non-emergency costs for NQA children under the age of 19 years and non-pregnancy related services for NQA pregnant women are as follows:

| **FY 2011-12 & Annually** | **TF** | **GF** | **FFP** |
|---|---|---|---|
| Children | $11,836,000 | $4,293,000 | $7,543,000 |
| Pregnant Women | $2,630,000 | $1,315,000 | $1,315,000 |
| **Total** (Rounded) | **$14,466,000** | **$5,608,000** | **$8,858,000** |

**Funding:**
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XXI Enhanced Healthy Families FFP (4260-113-0890)
100% State GF (4260-101-0001)

# NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 12
IMPLEMENTATION DATE: 12/1997
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 15

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $99,622,000 | $99,663,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $99,622,000 | $99,663,000 |
| FEDERAL FUNDS | -$99,622,000 | -$99,663,000 |

## DESCRIPTION

**Purpose:**
This policy change is a technical adjustment to shift funds from Title XIX 50% federal financial participation (FFP) to 100% GF because FFP cannot be claimed for nonemergency health care expenditures for New Qualified Aliens (NQA).

**Authority:**
H.R. 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA)
Welfare & Institutions Code, section 14007.5

**Background:**
PRWORA specified that FFP is not available for full-scope Medi-Cal services for most qualified nonexempt aliens who enter the country after August 1996, for the first 5 years they are in the country. They are eligible for FFP for emergency services only. As California law requires that legal immigrants receive the same services as citizens, the nonemergency services are 100% State funded.

**Reason for Change from Prior Estimate:**
The changes are due to updated expenditures for nonemergency services for NQAs.

**Methodology:**
1. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of NQAs from January 2006 through September 2011, current year and budget year costs were projected.

2. Based on the historical pattern of FFS versus managed care nonemergency service expenditures for the period of April 2009 through March 2010 (17.15%), the managed care totals for current year and budget year were projected.

3. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified aliens is included in the SCHIP Funding for Prenatal Care policy change.

# NEW QUALIFIED ALIENS

## REGULAR POLICY CHANGE NUMBER: 12

4. The impact of Children's Health Insurance Program Reauthorization Act (CHIPRA) funding for full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children or pregnant women, even if they have been in the U.S. for less than five years, is budgeted in the CHIPRA Medi-Cal for Children and Pregnant Women policy change.

| (rounded) | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FFS | $ 170,069,000 | $ 170,139,000 |
| Managed Care | $ 29,175,000 | $ 29,187,000 |
| Total | $ 199,244,000 | $ 199,326,000 |
| **FFP Repayment** | **$ 99,622,000** | **$ 99,663,000** |

**Funding:**
Title XIX General Fund (4260-101-0001)

# RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 13
IMPLEMENTATION DATE: 12/1998
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 13

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | -$52,651,500 | -$60,354,450 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$52,651,500 | -$60,354,450 |
| FEDERAL FUNDS | $52,651,500 | $60,354,450 |

## DESCRIPTION

**Purpose:**
This policy change estimates the technical adjustment in funding for the 100 and 133 Percentage Programs expenditures to be adjusted from Title XIX 50% FFP to enhanced Title XXI 65% FFP.

**Authority:**
SB 903 (Chapter 624, Statutes of 1997)

**Background:**
Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility for children ages one to 19 in the 100 and 133 Percent programs. This change was implemented to help streamline the application process and to align Medi-Cal eligibility more closely with the Healthy Families Program.

Effective October 1, 2012, the Healthy Families Program will cease to enroll new applicants and will be phased-out over a nine-month period. Children enrolled in the Healthy Families Program will be transitioned to the Medi-Cal Program as targeted low-income children and resources will not be counted for children with incomes up to 250% of the FPL.

**Reason for Change from Prior Estimate:**
The changes are due to additional caseload and expenditures.

**Methodology:**
1. Aid codes (8N, 8P, 8R, and 8T) that identify children eligible for Medi-Cal due to disregarding assets were implemented in December 1998.

2. Average monthly fee-for-service eligibles, which are included in the base, are estimated to be 51,299 in FY 2011-12 and 53,765 in FY 2012-13. It is assumed total FFS expenditures will be $30,335,000 in FY 2011-12 and $31,794,000 in FY 2012-13.

# RESOURCE DISREGARD - % PROGRAM CHILDREN

## REGULAR POLICY CHANGE NUMBER: 13

3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 169,667 in FY 2011-12 and 176,039 in FY 2012-13. It is assumed total Managed Care expenditures will be $320,675,000 in FY 2011-12 and $370,570,000 in FY 2012-13.

4. Enhanced federal funding under Title XXI Medicaid Children's Health Insurance Program (M-CHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2011-12 and FY 2012-13.

**Funding:**

| **FY 2011-12:** | | **GF** | **FF** | **TF** |
|---|---|---|---|---|
| Title XIX 50/50 FFP | 4260-101-0001/0890 | ($175,505,000) | ($175,505,000) | ($351,010,000) |
| Title XXI 65/35 FFP | 4260-113-0001/0890 | $122,853,500 | $228,156,500 | $351,010,000 |
| **Net Impact** | | **($52,651,500)** | **$52,651,500** | **$0** |

| **FY 2012-13:** | | **GF** | **FF** | **TF** |
|---|---|---|---|---|
| Title XIX 50/50 FFP | 4260-101-0001/0890 | ($201,181,500) | ($201,181,500) | ($402,363,000) |
| Title XXI 65/35 FFP | 4260-113-0001/0890 | $140,827,000 | $261,536,000 | $402,363,000 |
| **Net Impact** | | **($60,354,500)** | **$60,354,500** | **$0** |

# PARIS - VETERANS MATCH

REGULAR POLICY CHANGE NUMBER: 14
IMPLEMENTATION DATE: 8/2011
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1632

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$228,000 | -$742,000 |
| - STATE FUNDS | -$114,000 | -$371,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$228,000 | -$742,000 |
| STATE FUNDS | -$114,000 | -$371,000 |
| FEDERAL FUNDS | -$114,000 | -$371,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from the Public Assistance Reporting Information System (PARIS) Veterans Match.

**Authority:**
Welfare & Institutions Code, section 14124.11

**Background:**
PARIS is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS system includes three different data matches; PARIS-Interstate, PARIS-Federal, and PARIS-Veterans.

The PARIS-Veterans match allows the Department to improve the identification of veterans enrolled in the Medi-Cal program. Improved veteran identification enhances the Department's potential to shift health care costs from the Medi-Cal program to the United States Department of Veterans Affairs (USDVA).

**Reason for Change from Prior Estimate:**
Updated data showed discontinued managed care beneficiaries, which resulted in additional savings.

**Methodology:**
1. The Department currently is operating PARIS-Veterans in 10 counties.

2. Savings for PARIS-Veterans is for eligibles in managed care and fee-for-service (FFS).

3. It is estimated 40 veterans will discontinue their Medi-Cal benefits in FY 2011-12, of which 13 will be managed care and 27 will be FFS. It is estimated 80 veterans will discontinue their Medi-Cal benefits in FY 2012-13, of which 33 will be managed care and 47 will be FFS.

# PARIS - VETERANS MATCH

## REGULAR POLICY CHANGE NUMBER: 14

4. It is estimated the Department will achieve savings of $228,000 TF for FY 2011-12, and $742,000 TF for FY 2012-13.

| | TF | GF |
|---|---|---|
| **FY 2011-12** | **-$228,000** | -$114,000 |
| **FY 2012-13** | **-$742,000** | -$371,000 |

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

# PARIS-INTERSTATE AND PARIS-FEDERAL

REGULAR POLICY CHANGE NUMBER: 15
IMPLEMENTATION DATE: 10/2009
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1357

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$1,030,000 | -$3,596,000 |
| - STATE FUNDS | -$515,000 | -$1,798,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,030,000 | -$3,596,000 |
| STATE FUNDS | -$515,000 | -$1,798,000 |
| FEDERAL FUNDS | -$515,000 | -$1,798,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from the Public Assistance Reporting Information System (PARIS)-Interstate and PARIS-Federal.

**Authority:**
Not applicable

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

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

Since the launch of the pilot program Medi-Cal savings have been achieved through improved verification and identification capabilities. Currently, PARIS-Interstate and PARIS-Federal are implemented in 25 counties. The Department plans to expand to 40 counties in FY 2012-13.

**Reason for Change from Prior Estimate:**
The number of beneficiaries that will be discontinued as a result of PARIS-Interstate and PARIS-Federal matches has been reduced based on recent matches and the narrative for "Asset and Eligibility Verification" was removed because we are unable to estimate savings for it.

# PARIS-INTERSTATE AND PARIS-FEDERAL

## REGULAR POLICY CHANGE NUMBER: 15

**Methodology:**

1. Savings for PARIS-Interstate is only for eligibles in Managed Care, since it is assumed that no expenditures exist for those in fee-for-service (FFS). Savings for PARIS-Federal is assumed for both Managed Care and FFS.

2. Based on quarterly reports for August 2011 through May 2012, it is estimated 4,208 managed care and 48 FFS beneficiaries will be discontinued from Medi-Cal in FY 2011-12.

3. Based on quarterly reports for August 2011 through May 2012, it is estimated 6,502 managed care and 75 FFS beneficiaries will be discontinued from Medi-Cal in FY 2012-13.

4. Total managed care savings is estimated to be $7,552,000 TF in FY 2011-12, and $15,149,000 TF in FY 2012-13. Total FFS savings is estimated to be $934,000 TF in FY 2011-12 and $2,590,000 TF in FY 2012-13.

5. In FY 2011-12, it is estimated that 88.56% of the managed care savings and 82.26% of the FFS savings is captured in the base trends. In FY 2012-13, it is estimated that 80.52% of the managed care savings and 75.04% of the FFS savings is captured in the base trends.

| **FY 2011-12** | **Total Savings** | **% in Base** | **Savings in Base** |
|---|---|---|---|
| Managed Care Savings | $7,552,000 | 88.56% | $6,688,078 |
| FFS Savings | $934,000 | 82.26% | $768,306 |
| **Total** | $8,486,000 | | $7,456,384 |

| **FY 2012-13** | **Total Savings** | **% in Base** | **Savings in Base** |
|---|---|---|---|
| Managed Care Savings | $15,149,000 | 80.52% | $12,198,599 |
| FFS Savings | $2,590,000 | 75.04% | $1,943,524 |
| **Total** | $17,739,000 | | $14,142,123 |

6. Total estimated savings not in the base trends:

| **FY 2011-12** | **TF** | **GF** |
|---|---|---|
| Managed Care Savings | $864,000 | $432,000 |
| FFS Savings | $166,000 | $83,000 |
| **Total** | **$1,030,000** | **$515,000** |

| **FY 2012-13** | **TF** | **GF** |
|---|---|---|
| Managed Care Savings | $2,950,000 | $1,475,000 |
| FFS Savings | $646,000 | $323,000 |
| **Total** | **$3,596,000** | **$1,798,000** |

**Funding:**

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

# ADULT DAY HEALTH CARE - CDA

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 16 |
| IMPLEMENTATION DATE: | 7/1984 |
| ANALYST: | Cang Ly |
| FISCAL REFERENCE NUMBER: | 24 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $321,748,000 | $327,635,000 |
| - STATE FUNDS | $160,874,000 | $163,817,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $321,748,000 | $327,635,000 |
| STATE FUNDS | $160,874,000 | $163,817,500 |
| FEDERAL FUNDS | $160,874,000 | $163,817,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs for the Adult Day Health Care (ADHC) services provided to beneficiaries that are at risk of institutionalization.

**Authority:**
Welfare and Institutions Code, Division 9, Part 3, Chapter 8.7, commencing with Section 14520

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

A moratorium on the certification of new ADHC centers has been in place since August 16, 2004, with some exceptions. Under the authority given to the Director under Welfare and Institutions Code §14043.46, this moratorium has been extended through FY 2011-12.

AB 97 eliminates ADHC services as an optional benefit under the Medi-Cal program. See the Eliminate ADHC Services for the impact of AB 97 on the ongoing estimate for ADHC services.

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

**Methodology:**
1. ADHC rates are increased each year by the same percentage as the NF-A weighted average rate increase.

2. ABX4 5 (Chapter 5, Statutes of 2009), freezes rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. Therefore, no rate increase is assumed for rate year 2011-12 or 2012-13.

# ADULT DAY HEALTH CARE - CDA

## REGULAR POLICY CHANGE NUMBER: 16

3. The estimated average monthly cost per ADHC user is expected to be $908.00 for FY 2011-12 and $932.00 for FY 2012-13. This is based on paid claims data through February 2012.

4. The projected average monthly users for FY 2011-12 are 29,529.

5. The projected average monthly users for FY 2012-13 are 29,295.

6. The projected costs for FY 2011-12 and FY 2012-13 are:

   **FY 2011-12:** 29,529 x 12 months x $908.00 = **$321,748,000 TF ($160,874,000 GF)**

   **FY 2012-13:** 29,295 x 12 months x $932.00 = **$327,635,000 TF ($163,817,500 GF)**

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

# ADDITIONAL SERVICES FOR HCBS CLIENTS

REGULAR POLICY CHANGE NUMBER: 17
IMPLEMENTATION DATE: 8/2012
ANALYST: Randolph Alarcio
FISCAL REFERENCE NUMBER: 1476

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $651,423,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $651,423,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $0 | $651,423,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the federal match to the Department of Developmental Services for the additional services provided to Home and Community Based Services (HCBS) clients.

**Authority:**
Interagency Agreement (IA)

**Background:**
In December 2009, the Department submitted to the Centers for Medicare and Medicaid Services (CMS) a 1915(i) HCBS state plan amendment (SPA) to include certain services provided by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC clients who have previously received or currently receive certain services will continue to be eligible for these services even though they do not meet the institutional level of care requirements for the HCBS waiver for persons with developmental disabilities. Services scheduled for coverage under this SPA include: habilitation, respite care, personal care services, homemaker services, home health aide services, and adult day health care. It is anticipated that the SPA will be approved in FY 2012-13, with a retroactive effective date of October 1, 2009. Non-emergency medical transportation and services for adults, which were eliminated from the Medi-Cal scope of services, were included in an amendment to this SPA in FY 2010-11.

A 1915(i) SPA to add Infant Development Services was submitted to CMS in December 2011, retroactive to October 1, 2011.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional Federal Financial Participation (FFP) for FY 2011-12 and FY 2012-13.

# ADDITIONAL SERVICES FOR HCBS CLIENTS

## REGULAR POLICY CHANGE NUMBER: 17

The budgeted amount for FY 2012-13 includes expenditures for the retroactive period of October 1, 2009 through June 30, 2012.

**Reason for Change from Prior Estimate:**
Pending federal approval has delayed implementation.

**Methodology:**

| (In Thousands) | Total Funds | CDDS GF | FFP Regular | FFP ARRA | Total FFP | IA # |
|---|---|---|---|---|---|---|
| **FY 2012-13** | $1,192,059 | $540,636 | $596,030 | $55,393 | **$651,423** | Pending |

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

# ADHC TRANSITION-BENEFITS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 18 |
| IMPLEMENTATION DATE: | 7/2011 |
| ANALYST: | Cang Ly |
| FISCAL REFERENCE NUMBER: | 1594 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $278,422,000 | $309,744,000 |
| - STATE FUNDS | $139,211,000 | $154,872,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $278,422,000 | $309,744,000 |
| STATE FUNDS | $139,211,000 | $154,872,000 |
| FEDERAL FUNDS | $139,211,000 | $154,872,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the benefits costs associated with transitioning current Adult Day Health Care (ADHC) program participants into Community-Based Adult Services (CBAS) or other services appropriate to their needs in order to minimize the risks of institutionalization.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011)
Settlement agreement

**Background:**
AB 97 eliminated ADHC services from the Medi-Cal program effective July 1, 2011. A class action lawsuit, *Esther Darling, et. al. v. Toby Douglas, et. al.*, sought to challenge the elimination of ADHC services. A settlement of the lawsuit was reached that establishes the new CBAS program. The Legislature appropriated $170 million TF ($85 million GF) to the Department to help transition existing ADHC enrollees to other appropriate Medi-Cal services. The funds may be used for assessment, placement, and the provision of services. The ADHC ongoing estimate and the effect of the July 1, 2011 termination are found in the Adult Day Health Care – CDA and Eliminate ADHC services policy changes.

The fiscal intermediary cost of the transition is included in the fiscal intermediary section of the Estimate. The other administration costs of the transition are included in the ADHC Transition – Administration policy change.

**Reason for Change from Prior Estimate:**
Benefits costs changed because of the extension of the ADHC benefit for one additional month (March 2012). Also, there was an increase in CBAS caseload due to patient assessments. The shift of eligibles into managed care is no longer included in this PC because the impact is included in the managed care base policy changes. The reasons for changes in administrative costs are included in the ADHC Transition – Administration policy change.

# ADHC TRANSITION-BENEFITS

## REGULAR POLICY CHANGE NUMBER: 18

**Methodology:**
Transition activities include:

Nine-month Extension of Services—The termination of coverage of ADHC services was delayed for nine months, from July 1, 2011, to April 1, 2012. This allowed the time to implement a multi-faceted approach to provide comprehensive health risk assessments, care coordination, case management and appropriate ongoing services to former ADHC clients.

CBAS—Effective April 1, 2012, this new, smaller, and more targeted program will be created for those former ADHC clients who are most in need of medical and social services. Based upon preliminary data, the average monthly caseload is expected to be 28,000. As additional information becomes available, this caseload estimate may be revised. For those eligible for enrollment in Medi-Cal managed care plans, these services will be covered only through the plans, no sooner than July 1, 2012.

Discharge Planning—The transition began with individualized discharge planning and the completion of the ADHC individual plan of care by ADHCs before the benefit was scheduled to end. The Department reimbursed ADHCs for these additional costs (one-time reimbursement per assessment submitted).

Health Care Options (HCO) Cost—The HCO contractor, Maximus, assists ADHC clients enrolling into managed care plans by preparing and mailing informational notices and making proactive phone calls. These costs are shown in the Fiscal Intermediary (FI) Estimate.

FFS Assessment and Care Coordination—For those ADHC clients in counties without managed care or when the client chooses FFS rather than managed care, the Department has contracted with APS, Inc., to provide health risk assessment, care coordination, and case management. Additionally, APS assisted with the ADHC clients who enrolled in managed care in Los Angeles County as well as Health Net plans in October 2011 and November 2011. APS will assist the Department with ADHC/CBAS assessments through February 2012.

In-Home Supportive Services (IHSS) Administration—These are the administrative costs provided to the California Department of Social Services for reassessing ADHC clients for IHSS eligibility.

# ADHC TRANSITION-BENEFITS

## REGULAR POLICY CHANGE NUMBER: 18

| (In Thousands) | FY 2011-12 | | FY 2012-13 | |
|---|---|---|---|---|
| Benefits Cost | TF | GF | TF | GF |
| Nine Month Extension | $244,326 | $122,163 | $ 21,318 | $ 10,659 |
| CBAS | $ 33,806 | $ 16,903 | $288,426 | $144,213 |
| Discharge Planning | $ 290 | $ 145 | $ - | $ - |
| **Total Benefits** | **$278,422** | **$139,211** | **$309,744** | **$154,872** |
| HCO (included in FI Estimate) | $ 2,342 | $ 1,171 | $ - | $ - |
| Other Administration Cost | | | | |
| FFS Assessment & Care Coordination | $ 7,888 | $ 3,944 | $ 1,800 | $ 900 |
| IHSS Administration | $ 3,500 | $ 1,750 | $ - | $ - |
| Total Other Administration | $ 11,388 | $ 5,694 | $ 1,800 | $ 900 |
| Total All Costs | $ 292,152 | $146,076 | $311,544 | $155,772 |

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

# LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 19
IMPLEMENTATION DATE: 7/2000
ANALYST: Andrew Yoo
FISCAL REFERENCE NUMBER: 25

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $117,810,000 | $115,122,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $117,810,000 | $115,122,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $117,810,000 | $115,122,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the federal match provided to Local Educational Agencies (LEAs) for Medi-Cal eligible services.

**Authority:**
Welfare & Institutions Code, section 14132.06

**Background:**
LEAs, which consist of school districts, county offices of education, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA Medi-Cal Billing Option Program. Through the program, LEAs submit claims for reimbursement for specific eligible health services provided to Medi-Cal eligible students. The LEAs submit a Cost and Reimbursement Comparison Schedule (CRCS) to the Department annually to compare each LEA's total actual costs for reimbursed Medi-Cal eligible services for the preceding fiscal year. These benefits are provided to the extent federal financial participation (FFP) is available. The Department is currently performing audits to reconcile the cost reports with payments for fiscal years 2006-07, 2007-08 and 2008-09.

**Reason for Change from Prior Estimate:**
No material change.

**Methodology:**
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the

# LOCAL EDUCATION AGENCY (LEA) PROVIDERS

## REGULAR POLICY CHANGE NUMBER: 19

applicable FMAP based on date of service, such as LEAs payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

3. Analysis of actual payments based on paid claims reports for FY 2011-12 and historical claims submitted by school districts and county offices of education enrolled as Medi-Cal providers for medical assistance they deliver to Medi-Cal eligible students provides the basis for the projected expenditures plus an adjustment for ARRA step down.

| (In Thousands) | FFP Regular | FFP ARRA | FFP Total |
|---|---|---|---|
| **FY 2011-12** | $101,155 | $16,655 | **$117,810** |
| **FY 2012-13** | $109,124 | $5,998 | **$115,122** |

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

# MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 20
IMPLEMENTATION DATE: 7/1984
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 28

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $40,464,000 | $39,614,000 |
| - STATE FUNDS | $20,232,000 | $20,232,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $40,464,000 | $39,614,000 |
| STATE FUNDS | $20,232,000 | $20,232,000 |
| FEDERAL FUNDS | $20,232,000 | $19,382,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of the Multipurpose Senior Services Program (MSSP) and for the General Fund (GF) reimbursement to the Department.

**Authority:**
Welfare and Institutions Code, section 9560-9568

**Background:**
The MSSP provides a comprehensive array of social and health services to persons 65 or older who are "at risk" of long-term care but who wish to remain in the community. The program provides services under a federal home and community-based services (HCBS) waiver for up to 16,335 clients in 11,789 client slots, at $4,285 per year per client slot.

SB 87 (Chapter 33, Statutes of 2011) reduced the operational costs of the MSSP program. The budgeted amount for FY 2011-12 and 2012-13 includes savings from a permanent reduction made to the MSSP. The GF is budgeted in the California Department of Aging (CDA) budget and at the beginning of each fiscal year the reimbursement is transferred to the Department to pay MSSP claims.

Beginning March 1, 2013, the Department will transition care for dual eligibles who receive Long-Term Care (LTC) institutional services, In-Home Supportive Services (IHSS) and other HCBS to managed care health plans. Under this proposal, managed care capitation will include IHSS services to the MSSP population, therefore, a reduction of federal financial participation (FFP) is reflected in FY 2012-13 for MSSP costs, that will included in the managed care capitated rates beginning March 1, 2013. See policy change Transition of Dual Eligibles-Long Term Care.

**Reason for Change from Prior Estimate:**
There is a decrease in FY 2012-13 as MSSP costs paid to IHSS providers will be funded through managed care capitated rates beginning March 1, 2013.

# MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

## REGULAR POLICY CHANGE NUMBER: 20

**Methodology:**

| **CASH BASIS** (In Thousands) **FY 2011-12** | **TF** | **Reimbursement from CDA** | **Regular FFP** |
|---|---|---|---|
| **MSSP** | **$40,464** | **$20,232** | **$20,232** |

| **FY 2012-13** | **TF** | **Reimbursement from CDA** | **Regular FFP** |
|---|---|---|---|
| **MSSP** | **$39,614** | **$20,232** | **$19,382** |

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

# MFP FUNDING TO CDDS AND CDSS FOR CCT

REGULAR POLICY CHANGE NUMBER: 21
IMPLEMENTATION DATE: 10/2011
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1562

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $3,587,000 | $2,100,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $3,587,000 | $2,100,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $3,587,000 | $2,100,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the supplemental federal funding associated with providing the California Department of Developmental Services (CDDS) and California Department of Social Services (CDSS) additional Title XIX for waiver services provided to Medi-Cal beneficiaries who participate in the California Community Transitions (CCT) project.

**Authority:**
Federal Deficit Reduction Act of 2005, section 6071
Affordable Care Act (ACA)

**Background:**
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. It was extended by the ACA, and is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition to federally-allowed home and community-based settings.

**Reason for Change from Prior Estimate:**
The estimated expenditures were reduced due to delayed implementation of an interagency agreement with CDSS and caseload adjustment for CDDS.

**Methodology:**
1. The Department provides Home and Community Based Services (HCBS) to developmentally disabled CCT participants and CCT participants who are receiving In-Home Supportive Services (IHSS). The Department provides federal funding to CDDS and CDSS as the base federal match through HCBS policy changes.

2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDDS is budgeted in a separate base policy change Home & Community Based Svcs.-CDDS. The GF for CDSS is provided by CDSS and is budgeted in base policy change Personal Care Services (Misc. Svcs.).

# MFP FUNDING TO CDDS AND CDSS FOR CCT

## REGULAR POLICY CHANGE NUMBER: 21

3. This policy change budgets the difference between the regular Federal Medical Assistance Percentage (FMAP) and the enhanced FMAP for eligible Medi-Cal beneficiaries participating in CCT. In FY 2010-11, the Department established Interagency Agreement (IA) 09-86345 with CDDS and in FY 2011-12 IA 10-87274 was established with CDSS. These IAs transfer additional 25% FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services during their 365 days of participation in the CCT demonstration.

   Estimated Costs:

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| CDSS | $780,000 | $600,000 |
| CDDS | $2,798,000 | $1,500,000 |
| **Total** | **$3,578,000** | **$2,100,000** |

**Funding:**
100% MFP Federal Grant (4260-106-0890)

# CALIFORNIA COMMUNITY TRANSITIONS COSTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 22 |
| IMPLEMENTATION DATE: | 12/2008 |
| ANALYST: | Julie Chan |
| FISCAL REFERENCE NUMBER: | 1228 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $6,958,000 | $12,704,000 |
| - STATE FUNDS | $1,739,000 | $3,176,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 59.86 % | 25.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $2,792,900 | $9,528,000 |
| STATE FUNDS | $698,030 | $2,382,000 |
| FEDERAL FUNDS | $2,094,910 | $7,146,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs of transitioning beneficiaries who have resided in health care facilities to federally-allowed home and community based settings (HCBS). It also estimates the costs for providing demonstration services to Medi-Cal eligible beneficiaries enrolled in the California Community Transitions (CCT) Demonstration Project.

**Authority:**
Federal Deficit Reduction Act of 2005, section 6071
Affordable Care Act (ACA)

**Background:**
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for $130 million in federal funds. The CCT demonstration is authorized under the Federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. It is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into federally-allowed HCBS. The revised award is $104 million in federal funds.

Participants are enrolled in the demonstration for a maximum of 12 months. Enrollment began December 1, 2008. Target enrollment for the period of July 1, 2011 through June 30, 2012 is 314 individuals and 360 individuals for July 1, 2012 through June 30, 2013.

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

# CALIFORNIA COMMUNITY TRANSITIONS COSTS

## REGULAR POLICY CHANGE NUMBER: 22

**Reason for Change from Prior Estimate:**
There is an increase in the number of estimated enrollees into the CCT demonstration for current year and budget year based on Department projections. Changes were also made to the methodology: 1) Assumption 1, NF B costs update; 2) Assumption 2, waiver costs increase; 3) 100% CCT participants will receive demonstration services.

**Methodology:**

1. Assume estimated costs for persons residing year-round in Nursing Facility (NF)-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be $61,081.

2. Assume waiver costs will be capped at $57,120 for those beneficiaries transitioning from NF-B level of care.

3. Assume all CCT services are reimbursed at 75% FFP and 25% GF. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

4. Assume 100% of CCT participants will receive demonstration services.

5. Assume demonstration services cost $7,500 per participant.

6. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change, see MFP Funding to CDDS and CDSS for CCT for more information. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.

7. Costs in the budget year include phased-in and lagged payments from the current year.

| | 2011-12 | | 2012-13 | |
|---|---|---|---|---|
| | **TF** | **GF** | **TF** | **GF** |
| Lagged savings | ($8,288,000) | ($4,144,000) | ($13,251,000) | ($6,625,500) |
| Lagged costs | **$6,958,000** | **$1,739,500** | **$12,704,000** | **$3,176,000** |
| Net (rounded) | ($1,330,000) | ($2,404,500) | ($547,000) | ($3,449,500) |

**Funding:**
GF (4260-101-0001)
MFP Federal Grant (4260-106-0890)

# QUALITY OF LIFE SURVEYS FOR MFP

REGULAR POLICY CHANGE NUMBER: 23
IMPLEMENTATION DATE: 7/2010
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1550

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $79,000 | $123,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $79,000 | $123,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $79,000 | $123,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the expenditures for the cost of completed Quality of Life (QoL) surveys administered to all California Community Transitions (CCT) enrollees.

**Authority:**
The CCT demonstration is administered under the federal authority of Section 6071 of the Deficit Reduction Act (DRA) of 2005, Money Follows the Person (MFP) Rebalancing Demonstration (P.L. 109-171).

**Background:**
The Centers for Medicare and Medicaid Services (CMS) requires the Department to conduct QoL surveys with participants in the MFP Rebalancing Demonstration project called the CCT project. QoL surveys are given within specified timeframes and methodology. MFP provider agencies, which are Medi-Cal HCBS waiver providers, conduct QoL surveys designed for the following situations:

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

The QoL surveys were designed to measure seven domains: living situation, choice and control, access to personal care services, respect/dignity, community integration/inclusion, overall life satisfaction, and health status.

**Reason for Change from Prior Estimate:**
Increased costs in FY 2012-13 are due an increase in CCT caseload and delay in receiving invoices.

**Methodology:**
1. In FY 2010-11, 285 beneficiaries were enrolled in the CCT demonstration project and 289 additional beneficiaries will enroll into CCT in FY 2011-12 and 300 in FY 2012-13.

# QUALITY OF LIFE SURVEYS FOR MFP

## REGULAR POLICY CHANGE NUMBER: 23

2. Assume the QoL surveys are administered to all CCT enrollees twice and once again approximately one year after they have been living in community settings. Assume first follow-up QoLs are conducted 11 months after the initial transition.

3. Assume the Department reimburses $100 per completed survey for survey administration. The QoL surveys began in July 2010.

4. Assume 360 eligible participants completed only one survey in FY 2011-12 and 400 in FY 2012-13.

360 x $100 = $36,000 Baseline
285 x $100 = $28,500 First follow up
145 x $100 = $14,500 Second follow up

FY 2011-12 Estimated Costs: **$79,000 TF**

400 x $100 = $40,000 Baseline
290 x $100 = $29,000 First follow up
285 x $100 = $28,500 Second follow up
240 x $100 = $25,400 Baseline, first and second follow ups administered by CDSS during April 2009 through June 2011.

FY 2012-13 Estimated Costs: **$123,000 TF**

**Funding:**
100% Federal Fund MFP Grant (4260-106-0890)

# SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 24
IMPLEMENTATION DATE: 7/2012
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1436

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $752,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $752,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $0 | $752,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the Federal Financial Participation (FFP) provided for the City and County of San Francisco Community-Living Support Benefit Waiver (SF CLSB).

**Authority:**
AB 2968 (Chapter 830, Statutes of 2006)

**Background:**
In the proposed new waiver, the Department is working with the SF Department of Public Health to propose service delivery under a 1915(c) Home and Community Based (HCBS) Waiver. The waiver application is pending with CMS. This benefits Medi-Cal beneficiaries who are 21 years of age and older, residing in the City and County of San Francisco and who would otherwise reside in nursing facilities or be rendered homeless.

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

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

**Reason for Change from Prior Estimate:**
There is a delay in implementation due to developing processes and financing methodology.

# SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

## REGULAR POLICY CHANGE NUMBER: 24

Methodology:

1. The waiver has a maximum capacity of 486 over five years. These slots will be continuously enrolled by backfilling available slots. Enrollment will begin in July 2012. Target enrollment for the period of July 1, 2012 through June 30, 2013 is 221 individuals.

2. The annual total cost is estimated to be $28,644 per participant in FY 2012-13.

3. The Department will utilize Certified Public Expenditures (CPE) from the City and County of San Francisco to match the federal funds for this waiver. Assume a four-month payment lag due to the utilization of CPEs. This policy change budgets the FFP only.

4. Assume State Plan services will remain constant, but to the extent beneficiaries enroll into the waiver from skilled nursing facilities, there may be GF savings to the Medi-Cal program.

**Funding:**

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

# INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER: 25
IMPLEMENTATION DATE: 7/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1557

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $0 | -$9,535,200 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $0 | -$9,535,200 |
| FEDERAL FUNDS | $0 | $9,535,200 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings to the General Fund due to the increased federal matching rate of eligible family planning services and supplies.

**Authority:**
Welfare and Institutions Code, Section 14132(aa)

**Background:**
In September 2010, the Department requested that CMS approve a State Plan Amendment (SPA) to replace the Family Planning, Access, Care and Treatment (FPACT) Waiver in accordance with the Federal Patient Protection and Affordable Care Act. The SPA was approved on March 24, 2011. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund will receive a 90% federal matching rate, and family planning-related services will receive reimbursement at the State's regular Federal Medical Assistance Percentage (FMAP) rate effective retroactively to July 1, 2010.

**Reason for Change from Prior Estimate:**
The Fiscal Intermediary (FI) backlog has delayed the implementation of the new FPACT reimbursement rates. As a result, savings for FY 2011-12 were shifted to FY 2012-13.

**Methodology:**
1. Assume a retroactive SPA implementation date of July 1, 2010.

2. Costs for eligible family planning services and supplies which were previously paid with 100% GF will now be claimed at 90%, and costs for family planning-related services at 50% FFP.

3. Based on FY 2009-10 data, costs for eligible family planning services and supplies were $3,969,000 GF, and costs for family planning-related services were $2,391,000 GF, for a total cost of $6,360,000 GF.

# INCREASED FEDERAL MATCHING FUNDS FOR FPACT

## REGULAR POLICY CHANGE NUMBER: 25

| Total Cost | | **New FFP** |
|---|---|---|
| $3,969,000 x 90% | = | $3,572,000 |
| $2,391,000 x 50% | = | $1,195,000 |
| $6,360,000 | | **$4,767,000** |

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

5. FY 2011-12 savings of $4,767,000 have been shifted to FY 2012-13. As a result, total GF savings for FY 2012-13 are $9,534,000.

**Funding:**
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)
GF (4260-101-0001)

# SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 26
IMPLEMENTATION DATE: 7/2005
ANALYST: Ryan Witz
FISCAL REFERENCE NUMBER: 1007

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | -$88,970,050 | -$92,041,950 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | -$88,970,050 | -$92,041,950 |
| FEDERAL FUNDS | $88,970,050 | $92,041,950 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from the State Children's Health Insurance Program's (SCHIP) federal funding for prenatal care for women previously ineligible for federal funding.

**Authority:**
AB 131 (Chapter 80, Statutes of 2005)

**Background:**
In order to maximize revenues, AB 131 required Managed Risk Medical Insurance Board (MRMIB) to file a State Plan Amendment (SPA) to claim 65% SCHIP federal funding for prenatal care for undocumented women, and legal immigrants who have been in the country for less than five years. Previously, these costs for prenatal care were funded with 100% General Fund.

**Reason for Change from Prior Estimate:**
The changes are due to updated data and projections for undocumented women and legal immigrants.

**Methodology:**
1. The cost of prenatal care for undocumented women is estimated to be $130,414,000 in FY 2011-12 and $135,128,000 in FY 2012-13.

2. Based on the estimated costs and 65% SCHIP FFP, the following amounts are budgeted for FY 2011-12 and FY 2012-13:

| | | |
|---|---|---|
| FY 2011-12: | $130,414,000 x .65 = | $84,769,000 FFP |
| FY 2012-13: | $135,128,000 x .65 = | $87,833,000 FFP |

3. The estimated prenatal care cost for legal immigrants, who have been in the country for less than five years, is $6,463,000 for FY 2011-12 and $6,475,000 for FY 2012-13.

| | | |
|---|---|---|
| FY 2011-12: | $6,463,000 x .65 SCHIP FFP = | $4,201,000 FFP |
| FY 2012-13: | $6,475,000 x .65 SCHIP FFP = | $4,209,000 FFP |

# SCHIP FUNDING FOR PRENATAL CARE

## REGULAR POLICY CHANGE NUMBER: 26

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

| | | |
|---|---|---|
| **FY 2011-12 Savings**: | $84,769,000 + $4,201,000 = | **$88,970,000** |
| **FY 2012-13 Savings**: | $87,833,000 + $4,209,000 = | **$92,042,000** |

**Funding:**
Title XXI 35/65 FFP (4260-113-0001/0890)
GF (4260-101-0001)

# HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 27
IMPLEMENTATION DATE: 5/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1515

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$92,000 | -$764,000 |
| - STATE FUNDS | -$46,000 | -$382,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$92,000 | -$764,000 |
| STATE FUNDS | -$46,000 | -$382,000 |
| FEDERAL FUNDS | -$46,000 | -$382,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings associated with applying a benefit cap for hearing aids provided under the Medi-Cal program.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, section 14131.05

**Background:**
AB 97 enacted a $1,510 cap on hearing aids expenditures per beneficiary. Hearing aid reimbursements are composed of three primary categories: 1) repairs, 2) ear molds, and 3) hearing aids. The majority of the reimbursements are for the actual costs of hearing aids. Hearing aids may be dispensed individually (monaural) or as a pair (binaural). The hearing aid cap is for adults 21 years of age or older who are not residing in a long-term care facility, pregnant, or a Family Planning, Access, Care and Treatment (FPACT) program beneficiary.

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

**Methodology:**
1. Assume savings will begin May 1, 2012.

2. Actual annual hearing aid expenditures for FY 2009-10 were $20,186,000 for 24,762 unduplicated users.

3. Of the annual hearing aid expenditures amount, $1,547,000 were associated with beneficiaries residing in long-term care and pregnant women, and $2,015,000 were associated with beneficiaries under 21 years of age.
   $1,547,000 + $2,015,000 = $3,562,000

4. Expenditures subject to cap are: $20,186,000 - $3,562,000 = $16,624,000

# HEARING AID CAP

## REGULAR POLICY CHANGE NUMBER: 27

5. Based on paid claims for hearing aids for dates of service between July 1, 2009 and June 30, 2010, total FFS hearing aids expenditures below the $1,510 cap were $8,643,000 for 14,201 beneficiaries. Based on this data an average $1,580 is spent annually per beneficiary at and above the $1,510 expenditure cap.

| | Users | Expenditures |
|---|---|---|
| Total unduplicated users | 24,762 | $20,186,000 |
| LTC, children, & pregnant women | 5,510 | $3,562,000 |
| Expenditures subject to cap | 19,252 | $16,624,000 |
| Below the $1,510 cap for adults | 14,201 | $8,642,000 |
| Above the $1,510 cap for adults | 5,051 | $7,982,000 |

| (In Thousands) | TF | GF | FFP |
|---|---|---|---|
| Annual FFS Expenditures | $20,186 | $10,093 | $10,093 |
| LTC, children, & pregnant women | -$3,562 | -$1,781 | -$1,781 |
| Expenditures Subject to Cap | $16,624 | $8,312 | $8,312 |
| FFS Expenditures < $1,510 cap | -$8,642 | -$4,321 | -$4,321 |
| FFS Expenditures > $1,510 cap | $7,982 | $3,991 | $3,991 |
| | | | |
| Allowable costs for > the $1,510 cap | -$7,627 | -$3,814 | -$3,814 |
| Annual FFS savings due to cap | $355 | $177 | $178 |
| Annual Managed Care savings due to cap | $440 | $220 | $220 |
| **Total Annual Savings** | $795 | $397 | $398 |
| | | | |
| **FY 2011-12** | | | |
| FFS (lagged) | $19 | $9 | $10 |
| Managed Care | $73 | $37 | $36 |
| **Total FY 2011-12** | **$92** | **$46** | **$46** |
| | | | |
| **FY 2012-13** | | | |
| FFS (lagged) | $324 | $162 | $162 |
| Managed Care | $440 | $220 | $220 |
| **Total FY 2012-13** | **$764** | **$382** | **$382** |

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

# DISCONTINUE PART B PREMIUM FOR UNMET SOC BENES

REGULAR POLICY CHANGE NUMBER: 28
IMPLEMENTATION DATE: 9/2011
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1506

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$218,000 | -$246,000 |
| - STATE FUNDS | -$218,000 | -$246,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 72.03 % | 57.24 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$61,000 | -$105,200 |
| STATE FUNDS | -$60,970 | -$105,190 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings due to eliminating payments of Medicare Part B premiums for those beneficiaries with an unmet share of cost (SOC) of $500 or less.

**Authority:**
The SB 853 (Chapter 717, Statutes of 2010) eliminates the payment of Medicare Part B premiums for those beneficiaries with an unmet SOC of $500 or less.

**Background:**
This change was implemented September 1, 2011. Premium payments for beneficiaries with unmet SOCs greater than $500 were eliminated effective December 1, 2008.

**Reason for Change from Prior Estimate:**
Medicare reduced the Part B premiums effective January 1, 2012.

**Methodology:**
1. Implementation and savings began September 2011.

2. Part B premiums are $115.40 per month per beneficiary from July through December 2012. Premiums are estimated to be $99.90 per month per beneficiary from January through June 2013.

3. Based on the most recent 12 months of SOC data, an average of 205 beneficiaries each month had a SOC less than $500 and did not meet their SOC.

4. The FY 2011-12 savings are estimated to be $218,000.

   205 x 4 months x $115.40 =$ 95,000 GF
   205 x 6 months x $99.90 =$123,000 GF

# DISCONTINUE PART B PREMIUM FOR UNMET SOC BENES

## REGULAR POLICY CHANGE NUMBER: 28

5. FY 2012-13 savings is estimated to be $246,000 GF.

   205 x 12 months x $99.90 =$246,000 GF

| FY 2011-12 | | FY 2012-13 | |
|---|---|---|---|
| **TF** | **GF** | **TF** | **GF** |
| $218,000 | **$218,000** | $246,000 | **$246,000** |

**Funding:**
General Fund (4260-101-0001)

# ELIMINATION OF OTC COUGH AND COLD PRODUCTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 29 |
| IMPLEMENTATION DATE: | 3/2012 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1575 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$1,264,000 | -$4,421,000 |
| - STATE FUNDS | -$632,000 | -$2,210,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,264,000 | -$4,421,000 |
| STATE FUNDS | -$632,000 | -$2,210,500 |
| FEDERAL FUNDS | -$632,000 | -$2,210,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from the elimination of over-the-counter (OTC) cough and cold products as Medi-Cal benefits.

**Authority:**
AB 97 (Chapter 33, Statutes of 2011)

**Background:**
AB 97 eliminated selected nonprescription cough and cold products as Medi-Cal benefits for adults and children. Children eligible for Early Periodic Screening, Diagnosis and Treatment (EPSDT) are exempt from this provision.

**Reason for Change from Prior Estimate:**
The estimated savings decreased as a result of a delay in implementation. The Department had to await the Centers for Medicare and Medicaid Services approval of the OTC cough and cold reduction State Plan Amendment.

**Methodology:**
1. The legislation was enacted on March 24, 2011, and savings are expected to begin on March 1, 2012.

2. Fee-for-service expenditures for nonprescription cough and cold products for adults and children are estimated to be $3,762,000 annually.

3. Managed care savings are estimated to be $670,000 annually.

# ELIMINATION OF OTC COUGH AND COLD PRODUCTS

## REGULAR POLICY CHANGE NUMBER: 29

4. Annual savings are estimated to be: $3,762,000 + $670,000 = $4,432,000 TF

| **FY 2011-12 Savings:** | **TF** | **GF** |
|---|---|---|
| FFS (Lagged) | $1,041,000 | $ 520,500 |
| Managed Care | $ 223,000 | $ 111,500 |
| **Total FY 2011-12** | **$1,264,000** | **$ 632,000** |

| **FY 2012-13 Savings:** | **TF** | **GF** |
|---|---|---|
| FFS (Lagged) | $3,751,000 | $1,875,500 |
| Managed Care | $ 670,000 | $ 335,000 |
| **Total FY 2012-13** | **$4,421,000** | **$2,210,500** |

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

# PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 30
IMPLEMENTATION DATE: 7/2012
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1519

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$44,955,000 |
| - STATE FUNDS | $0 | -$22,477,500 |
| PAYMENT LAG | 1.0000 | 0.8346 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$37,519,400 |
| STATE FUNDS | $0 | -$18,759,720 |
| FEDERAL FUNDS | $0 | -$18,759,720 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from implementing an annual seven physician visit cap for Medi-Cal beneficiaries.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, Section 14131.07

**Background:**
AB 97 caps the number of physician visits and clinic visits, including Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs), allowed per Medi-Cal beneficiary at seven per year. The cap on the number of physician and clinic visits is for adults 21 years of age or older, except those who are Family Planning, Access, Care and Treatment (FPACT) program beneficiaries. The Department concluded that any changes in the managed care utilization would be minimal and any savings from a utilization decrease would be offset by increased administrative costs for the plans and providers. Consequently, the cap applies only to fee-for-service (FFS) settings.

**Reason for Change from Prior Estimate:**
A delay in implementation to July 1, 2012 due to State Plan Amendment (SPA) revisions and extension of anticipated time needed for implementation after federal approvals are received.

**Methodology:**
1. AB 97 was enacted March 24, 2011, and savings will begin on July 1, 2012.

2. The annual physician visit cap is set at seven visits per beneficiary. All visits above the seven allowed will require a physician's certification to be paid by Medi-Cal.

3. In FY 2009-2010, the number of FFS beneficiaries with 8 or more physician visits was 342,361 and their total number of physician visits was 5,010,363. The average number of visits per beneficiary was 15.

# PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

## REGULAR POLICY CHANGE NUMBER: 30

4. Medi-Cal will pay for up to seven visits per beneficiary:
   342,361 beneficiaries x 7 allowable visits = 2,396,527 allowable visits

5. The number of visits above the cap is estimated to be:
   5,010,363 total visits – 2,396,527 allowable visits = 2,613,836 visits above the cap

6. The average cost per visit is $114.66. The total annual cost above the cap is estimated to be $299,702,000.
   2,613,836 visits above the cap x $114.66 = $299,702,000

7. Assume that 85% of the visits above the cap will meet the physicians' certification requirement, and the remaining 15% will be eliminated.

8. FFS annual savings are estimated to be:
   $299,702,000 cost above the cap x 15% = $44,955,000 TF ($22,477,500 GF)

| **Annual Savings:** | **TF** | **GF** |
|---|---|---|
| FFS | $44,995,000 | $22,477,500 |

| **FY 2012-13 Savings:** | **TF** | **GF** |
|---|---|---|
| FFS (Lagged) | **$37,520,000** | **$18,760,000** |

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

# CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 31
IMPLEMENTATION DATE: 12/2008
ANALYST: Julie Chan
FISCAL REFERENCE NUMBER: 1222

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$8,288,000 | -$13,251,000 |
| - STATE FUNDS | -$4,144,000 | -$6,625,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 54.80 % | 25.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$3,746,200 | -$9,938,200 |
| STATE FUNDS | -$1,873,090 | -$4,969,120 |
| FEDERAL FUNDS | -$1,873,090 | -$4,969,120 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from Medi-Cal eligible beneficiaries who have resided in health care facilities and transitioned to federally-allowed home and community based settings (HCBS). These beneficiaries are also enrolled in the California Community Transitions (CCT) Demonstration Project.

**Authority:**
Federal Deficit Reduction Act of 2005, section 6071
Affordable Care Act (ACA)

**Background:**
In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for $130 million in federal funds. The CCT demonstration is authorized under the Federal Deficit Reduction Act of 2005 and was extended by the Patient Protection and Affordable Care Act. It is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into federally-allowed HCBS. The revised award is $104 million in federal funds.

Participants will be enrolled in the demonstration for a maximum of 12 months. Target enrollment for the period of July 1, 2011 through June 30, 2012 is 314 individuals, and 360 individuals for July 1, 2012 through June 30, 2013.

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

# CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

## REGULAR POLICY CHANGE NUMBER: 31

**Reason for Change from Prior Estimate:**
There is an increase in estimated enrollees into the CCT demonstration for current year and budget year based on Department projections. The increased number of transitions from nursing facilities to CCT impacts the savings reflected in this policy change.

**Methodology**

1. Assume estimated costs for persons residing year-round in Nursing Facilities – Level B (NF-B), pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be $61,081.

2. Assume waiver costs will be capped at $57,120 for those beneficiaries transitioning from NF-Bs.

3. Assume CCT services are reimbursed at 75% FFP and 25% GF. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.

4. Assume 100% of CCT participants will receive demonstration services.

5. Assume demonstration services cost $7,500 per participant.

6. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.

| | 2011-12 | | 2012-13 | |
|---|---|---|---|---|
| | TF | GF | TF | GF |
| Lagged savings | **($8,288,000)** | **($4,144,000)** | **($13,251,000)** | **($6,625,500)** |
| Lagged costs | $6,958,000 | $1,739,500 | $12,704,000 | $3,176,000 |
| Net (rounded) | ($1,330,000) | ($2,404,500) | ($547,000) | ($3,449,500) |

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

# ELIMINATION OF OTC ACETAMINOPHEN DRUGS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 32 |
| IMPLEMENTATION DATE: | 4/2011 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1512 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$8,959,000 | -$8,997,000 |
| - STATE FUNDS | -$4,479,500 | -$4,498,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 83.33 % | 85.26 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,493,500 | -$1,326,200 |
| STATE FUNDS | -$746,730 | -$663,080 |
| FEDERAL FUNDS | -$746,730 | -$663,080 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from the elimination of over-the-counter (OTC) acetaminophen drugs.

**Authority:**
SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code, section 14132 (d)(4)(A)(ii)

**Background:**
SB 853 eliminated specific nonprescription acetaminophen-containing products as Medi-Cal benefits for adults.

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

**Methodology:**
1. Savings began in April 2011.

2. Fee-for-service expenditures for nonprescription acetaminophen-containing products for adults are estimated to be $7,638,000 annually.

3. Managed care savings are estimated to be $1,359,000 annually.

4. Annual savings are estimated to be:
   $7,638,000 + $1,359,000 = $8,997,000 TF

| FY 2011-12 Savings: | TF | GF |
|---|---|---|
| FFS (Lagged) | $7,600,000 | $3,800,000 |
| Managed Care | $1,359,000 | $ 680,000 |
| **Total FY 2011-12** | **$8,959,000** | **$4,480,000** |

# ELIMINATION OF OTC ACETAMINOPHEN DRUGS

## REGULAR POLICY CHANGE NUMBER: 32

| FY 2012-13 Savings: | TF | GF |
|---|---|---|
| FFS | $7,638,000 | $3,819,000 |
| Managed Care | $1,359,000 | $ 680,000 |
| **Total FY 2012-13** | **$8,997,000** | **$4,499,000** |

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

# LIMIT ENTERAL NUTRITION TO TUBE FEEDING

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 33 |
| IMPLEMENTATION DATE: | 10/2011 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1513 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$20,224,000 | -$29,277,000 |
| - STATE FUNDS | -$10,112,000 | -$14,638,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 72.03 % | 57.24 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$5,656,700 | -$12,518,800 |
| STATE FUNDS | -$2,828,330 | -$6,259,420 |
| FEDERAL FUNDS | -$2,828,330 | -$6,259,420 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings from limiting enteral nutrition to tube feeding.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011)

**Background:**
AB 97 limited enteral nutrition products to those products to be administered through a feeding tube. Beneficiaries under Early Periodic Screening, Diagnosis and Treatment (EPSDT) are exempt. The Department deems enteral nutrition products, not administered through a feeding tube, a benefit for patients. Patient diagnoses that include, but are not limited to, malabsorption syndromes and inborn errors of metabolism are eligible for this benefit.

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

**Methodology:**
1. The legislation was enacted March 24, 2011, and the limitation on enteral nutrition products was implemented on October 1, 2011.

2. Fee-for-service expenditures for enteral nutrition products for adults are approximately $32,777,000 annually.

3. Of this amount, expenditures for tube-fed adults are approximately $3,885,000 annually.

4. The FFS savings is estimated to be:

$32,777,000
-$ 3,885,000
$28,892,000 TF ($14,446,000 GF) annual FFS savings

# LIMIT ENTERAL NUTRITION TO TUBE FEEDING

## REGULAR POLICY CHANGE NUMBER: 33

5. The managed care savings is estimated to be $385,000 TF ($192,500 GF) annually.

| FY 2011-12 Savings: | TF | GF |
|---|---|---|
| FFS (Lagged) | $19,935,000 | $ 9,967,500 |
| Managed Care | $ 289,000 | $ 144,500 |
| **Total FY 2011-12** | **$20,224,000** | **$10,112,000** |

| FY 2012-13 Savings: | TF | GF |
|---|---|---|
| FFS (Lagged) | $28,892,000 | $14,446,000 |
| Managed Care | $ 385,000 | $ 192,500 |
| **Total FY 2012-13** | **$29,277,000** | **$14,638,500** |

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

# COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 36
IMPLEMENTATION DATE: 1/2013
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1524

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$14,291,000 |
| - STATE FUNDS | $0 | -$7,145,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$14,291,000 |
| STATE FUNDS | $0 | -$7,145,500 |
| FEDERAL FUNDS | $0 | -$7,145,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings resulting from the imposition of a copayment for non-emergency use of the emergency room.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, section 14134(c)(1)

**Background:**
AB 97 implemented a mandatory copayment of up to $50 for non-emergency use of the emergency room. After discussion with the Centers for Medicare & Medicaid Services (CMS), the Department plans to implement a $15 copayment.

Pending approval from the CMS, this copayment will be implemented in the managed care setting and will not apply to those who are Family Planning, Access, Care and Treatment (FPACT) program beneficiaries. The hospital will collect the $15 copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the $15 copayment.

**Reason for Change from Prior Estimate:**
Due to a delay in receiving CMS approval, the implementation date is changed from October 1, 2012 to January 1, 2013.

**Methodology:**
1. It is assumed that the copayment will be implemented January 1, 2013.

2. The managed care savings are estimated to be $14,291,000 TF ($7,145,500 GF) in FY 2012-13.

| **FY 2012-13 Savings:** | **TF** | **GF** |
|---|---|---|
| Managed Care | ($14,291,000) | ($7,145,500) |

# COPAYMENT FOR NON-EMERGENCY ER VISITS

## REGULAR POLICY CHANGE NUMBER: 36

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

# PHARMACY COPAYMENTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 37 |
| IMPLEMENTATION DATE: | 1/2013 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1520 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$26,116,000 |
| - STATE FUNDS | $0 | -$13,058,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$26,116,000 |
| STATE FUNDS | $0 | -$13,058,000 |
| FEDERAL FUNDS | $0 | -$13,058,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings related to mandatory copayments for prescription drugs.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, section 14134(c)(4)

**Background:**
AB 97 requires mandatory copayments of up to $3 per prescription for preferred drugs and $5 per prescription for non-preferred drugs. After discussion with the Centers of Medicare & Medicaid Services (CMS), the Department plans to implement a $3.10 copayment for non-preferred drugs only.

Pending approval from the CMS, these copayments will be implemented in the managed care setting and will not apply to those who are Family Planning, Access, Care and Treatment (FPACT) beneficiaries. The pharmacy will collect the $3.10 copayment from the beneficiaries at the time of service, and the pharmacy will be reimbursed the appropriate Medi-Cal reimbursement rate minus the $3.10 copayment.

**Reason for Change from Prior Estimate:**
Due to a delay in receiving CMS approval, the implementation date is changed from October 1, 2012 to January 1, 2013.

**Methodology:**
1. It is assumed that the copayment will be implemented January 1, 2013.

2. The managed care savings are estimated to be $26,116,000 TF ($13,058,000 GF) in FY 2012-13.

| **FY 2012-13 Savings:** | **TF** | **GF** |
|---|---|---|
| Managed Care | **($26,116,000)** | **($13,058,000)** |

**Funding:**

# PHARMACY COPAYMENTS

## REGULAR POLICY CHANGE NUMBER: 37

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

# ELIMINATE ADHC SERVICES

REGULAR POLICY CHANGE NUMBER: 40
IMPLEMENTATION DATE: 7/2011
ANALYST: Cang Ly
FISCAL REFERENCE NUMBER: 1472

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$355,915,000 | -$361,802,000 |
| - STATE FUNDS | -$177,957,500 | -$180,901,000 |
| PAYMENT LAG | 0.8010 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$285,087,900 | -$361,802,000 |
| STATE FUNDS | -$142,543,960 | -$180,901,000 |
| FEDERAL FUNDS | -$142,543,960 | -$180,901,000 |

## DESCRIPTION

**Purpose**:
This policy change estimates the savings due to the elimination of Adult Day Health Care (ADHC) services from the Medi-Cal program.

**Authority:**
AB 97 (Chapter 3, Statutes of 2011), Welfare and Institutions Code, sections 14589-14590

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

AB 97 eliminates ADHC services as an optional benefit under the Medi-Cal program, effective July 1, 2011. A class action lawsuit, *Esther Darling, et. al. v. Toby Douglas, et. al.* sought to challenge the elimination of ADHC services. A settlement was reached that establishes a new program, Community-Based Adult Services (CBAS). See the ADHC Transition policy changes for the impact on ADHC/CBAS services under the settlement.

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

**Methodology:**
1. Assume that savings will begin on July 1, 2011.

2. Expenditures for ADHC services are estimated to be $321,748,000 in FY 2011-12 and $327,635,000 in FY 2012-13 (see Adult Day Health Care – CDA policy change).

3. In addition, expenditures for ADHC services provided in an FQHC are estimated to be $34,167,000 annually for both FY 2011-12 and FY 2012-13.

# ELIMINATE ADHC SERVICES

## REGULAR POLICY CHANGE NUMBER: 40

4. Total ADHC expenditures are estimated to be:

   FY 2011-12: $321,748,000+ $34,167,000 = $355,915,000
   FY 2012-13: $327,635,000+ $34,167,000 = $361,802,000

5. ADHC savings are estimated to be:

   **FY 2011-12 Savings: $355,915,000 TF ($177,957,500 GF)**
   **FY 2012-13 Savings: $361,802,000 TF ($180,901,000 GF)**

6. The costs of delaying the elimination of ADHC services until April 1, 2012, are reflected in the ADHC Transition policy change.

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

# FEDERAL DRUG REBATE CHANGE

REGULAR POLICY CHANGE NUMBER: 41
IMPLEMENTATION DATE: 10/2010
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1559

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $92,909,000 | $108,000,000 |
| - STATE FUNDS | $92,909,000 | $108,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $92,909,000 | $108,000,000 |
| STATE FUNDS | $92,909,000 | $108,000,000 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost related to the retroactive rebates and ongoing rebates that were not adjusted for the increase in the share of rebates the Centers for Medicare & Medicaid Services (CMS) collects.

**Authority:**
Affordable Care Act (ACA), H.R. 3590

**Background:**
The ACA, H.R. 3590, increased the mandated federal rebate to 23.1% of the Average Manufacturer's Price (AMP) from the previous 15.1% for single source drugs and increased the multi-source drug rebate from 11% of AMP to 13%. CMS is claiming 100% of the 8% single source and 2% multi-source differential in the rebate increases. This will result in a cost to the Medi-Cal program, because California currently collects rebates at the higher percentage for most drugs and retains the General Fund (GF) share at the current Federal Medical Assistance Percentage (FMAP) rate, for all rebates collected.

The Department is required to pay back the GF share of the differential to CMS. CMS agreed to collect 25% of the amount owed for the first quarter, 50% of the amount owed for the next three quarters, and 100% thereafter until reconciliation for these time periods is completed. Once the reconciliation is completed, the Department will be required to pay any outstanding amount owed. The Department is required to complete the reconciliation process by September 30, 2012.

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

**Methodology:**
1. CMS will send the Department an estimated quarterly rebate offset amount (EQROA) to be remitted to the federal government. The EQROA will be reconciled with the total quarterly rebate offset amount (QROA) when the Department receives the unit offset amount from CMS.

# FEDERAL DRUG REBATE CHANGE

## REGULAR POLICY CHANGE NUMBER: 41

2. In October 2010, CMS began collecting the additional federal financial participation (FFP) for the rebates collected by the Department retroactive to January 1, 2010.

3. The Department estimates that the rebate increase differential owed to CMS will be $76 million per quarter. Currently, the Department pays CMS back at the current FMAP of that total.

4. Assume that, beginning with the October 2011 payment, CMS will collect 100% of the estimated additional amount due.

5. In FY 2012-13, the Department will pay $38 million for the April 2012 payment and $70 million to CMS for the final reconciliation of prior payments that included a discount factor.

6. Once the final reconciliation process is completed by September 2012, the additional FFP that CMS collects for federal drug rebates will be fully reflected in the Federal Drug Rebate Program policy change.

| **FY 2011-12** | | |
|---|---|---|
| July 2011 payment | $33,818,000 x 50% = | $ 16,909,000 |
| October 2011 payment | $38,000,000 x 100% = | $ 38,000,000 |
| January 2012 payment | $38,000,000 x 100% = | $ 38,000,000 |
| | | **$ 92,909,000** |

| **FY 2012-13** | | |
|---|---|---|
| April 2012 payment | $38,000,000 x 100% = | $ 38,000,000 |
| Reconciliation payment | | $ 70,000,000 |
| | | **$108,000,000** |

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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

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

# NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 42
IMPLEMENTATION DATE: 3/2007
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 108

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $0 |
| - STATE FUNDS | $2,118,000 | $1,488,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $0 |
| STATE FUNDS | $2,118,000 | $1,488,000 |
| FEDERAL FUNDS | -$2,118,000 | -$1,488,000 |

## DESCRIPTION

**Purpose:**
This policy change budgets 100% GF costs to reimburse the federal share to the Centers for Medicare and Medicaid Services (CMS) for drugs ineligible for federal financial participation (Non-FFP drugs).

**Authority:**
Social Security Act, section 1927 [42 U.S.C. 1396r–8]

**Background:**
Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid programs if the manufacturer of the drug has not signed a rebate contract with the CMS.

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

**Reason for Change from Prior Estimate:**
The collection projections were revised based on additional actual data.

**Methodology:**
1. The Department reimburses CMS quarterly for ongoing non-FFP drugs purchased.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

# NON FFP DRUGS

## REGULAR POLICY CHANGE NUMBER: 42

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

(In Thousands)

| Fiscal Year | Non-FFP Drug Exp. | Est. FFP Repayment | 50%FFP | ARRA |
|---|---|---|---|---|
| **FY 2011-12** | $3,904 | **$2,118** | $1,952 | $166 |
| **FY 2012-13** | $2,976 | **$1,488** | $0 | $0 |

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

# BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 43
IMPLEMENTATION DATE: 1/2010
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1433

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$14,000,000 | -$14,000,000 |
| - STATE FUNDS | -$4,900,000 | -$4,900,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$14,000,000 | -$14,000,000 |
| STATE FUNDS | -$4,900,000 | -$4,900,000 |
| FEDERAL FUNDS | -$9,100,000 | -$9,100,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the revenues collected from the Breast and Cervical Cancer Treatment Program (BCCTP) drug rebates.

**Authority:**
Welfare and Institutions Code, section 14105.33(b)(4)

**Background:**
Enhanced Title XIX Medicaid funds are claimed for drugs under the federal Medicaid BCCTP program. The Department is required by federal law to collect drug rebates whenever there is federal participation. The Department began collecting rebates for beneficiary drug claims for the full-scope federal BCCTP program in January 2010. This policy change reflects ongoing rebates invoiced. Revenues resulting from the resolution of disputed rebates are budgeted in the Aged and Disputed Drug Rebate policy change.

**Reason for Change from Prior Estimate:**
Projections were revised based on an upward trend in actual data.

**Methodology:**
1. Payments began in January 2010.

2. Rebates are invoiced quarterly.

3. The ongoing rebates collected are estimated to be $14,000,000 annually.

   **FY 2011-12: $14,000,000 TF ($4,900,000 GF)**

   **FY 2012-13: $14,000,000 TF ($4,900,000 GF)**

**Funding:**
Title XIX 65/35 FFP (4260-101-0001/0890)

# PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 44 |
| IMPLEMENTATION DATE: | 4/2012 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1434 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$33,250,000 | -$57,000,000 |
| - STATE FUNDS | -$16,625,000 | -$28,500,000 |
| PAYMENT LAG | 0.7790 | 0.9950 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$25,901,800 | -$56,715,000 |
| STATE FUNDS | -$12,950,880 | -$28,357,500 |
| FEDERAL FUNDS | -$12,950,880 | -$28,357,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the savings related to the change in the reimbursement rate methodology for physician-administered drugs.

**Authority:**
SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code, section 14105.456

**Background:**
The current rate of reimbursement for physician-administered drugs is the Average Wholesale Price (AWP) minus 5%. SB 853 established a new reimbursement rate methodology for physician-administered drugs to be reimbursed consistent with Medi-Cal rates of payment for non-physician-administered pharmaceuticals beginning in January 2011. The new methodology is expected to generate savings beginning April 2012 for claims from September 2011 and ongoing pending Centers for Medicare and Medicaid Services (CMS) approval of the State Plan Amendment (SPA).

The Department is conducting a study of the acquisition costs for drugs purchased by non-pharmacy providers prior to implementation of this reimbursement change, as well as the staffing needed to implement the rate adjustment, which is budgeted in the Rate Study for Physician-Administered Drugs policy change.

**Reason for Change from Prior Estimate:**
The estimated savings have changed due to the findings from a rate study conducted by Myers and Stauffers of the reimbursement methodology.

**Methodology:**
1. Assume CMS will approve the SPA and the savings will begin in April 2012.

2. Assume implementation will be retroactive to September 2011.

3. Annual savings are estimated to be $57,000,000 TF ($28,500,000 GF).

# PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

## REGULAR POLICY CHANGE NUMBER: 44

4. Assume the claims from September 2011 through March 2012 will be collected in FY 2011-12 and claims from April 2012 through June 2012 will be collected in FY 2012-13.

5. Savings are estimated to be:

   **FY 2011-12:** $57,000,000 ÷ 12 mos. x 7 mos. = **$33,250,000 TF ($16,625,000 GF)**

   **FY 2012-13: $57,000,000 TF ($28,500,000 GF)**

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

# MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 45
IMPLEMENTATION DATE: 10/2006
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1181

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$30,236,000 | -$24,900,000 |
| - STATE FUNDS | -$15,118,000 | -$12,450,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$30,236,000 | -$24,900,000 |
| STATE FUNDS | -$15,118,000 | -$12,450,000 |
| FEDERAL FUNDS | -$15,118,000 | -$12,450,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the revenues from the medical supply rebates collected by the Department through contracts with medical supply manufacturers.

**Authority:**
Welfare and Institutions Code, sections 14100.95(a) and 14105.47(c)(1)

**Background:**
A contracted Maximum Acquisition Cost (MAC) for medical supply diabetic products has resulted in savings to the Department. The product reimbursement rates for diabetic testing products are based on the contracted MAC.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers.

**Reason for Change from Prior Estimate:**
The estimated FY 2011-12 savings has decreased based on the shift in Seniors and Persons with Disabilities (SPD) population from fee-for-service (FFS) to managed care.

The estimated FY 2012-13 savings reflects a decrease from an anticipated drop in rebate percentages based on the renegotiated contract.

**Methodology:**
1. Based on rebates received for July 2011 to March 2012, the Department assumes a collection of $30,236,000 in FY 2011-12.

2. Assume the current medical supply diabetic testing products contract will be renegotiated and the new contract will be effective January 1, 2013.

# MEDICAL SUPPLY REBATES

## REGULAR POLICY CHANGE NUMBER: 45

3. Based on the renegotiation of the new contract, assume expenditures will decrease, resulting in lower rebates received in the third and fourth quarters of FY 2012-13.

   $7,114,000 x 2 qtrs. = $14,228,000 + $5,336,000 x 2 qtrs. = $10,672,000

| CASH BASIS | Medical Supply Rebates |
|---|---|
| FY 2009-10 | $ 11,256,000 |
| FY 2010-11 | $ 33,314,000 |
| **Est. FY 2011-12** | **$ 30,236,000** |
| **Est. FY 2012-13** | **$ 24,900,000** |

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

# AGED AND DISPUTED DRUG REBATES

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 46 |
| IMPLEMENTATION DATE: | 4/2004 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 1182 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$134,740,000 | -$55,000,000 |
| - STATE FUNDS | -$67,198,000 | -$27,430,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$134,740,000 | -$55,000,000 |
| STATE FUNDS | -$67,198,000 | -$27,430,000 |
| FEDERAL FUNDS | -$67,542,000 | -$27,570,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the recovery of monies due to the resolution of aged and disputed drug rebate payments for the State Supplemental Rebate Program, the Federal Rebate Program, the Breast and Cervical Cancer Treatment Program (BCCTP) and the Family Planning, Access, Care and Treatment (FPACT) program.

**Authority:**
Welfare and Institutions Code, Section 14105.33

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

The Department has completed its work on the oldest aged rebate disputes (1991-96) and is awaiting final agreements from a few pharmaceutical companies, which account for a majority of the disputes, before closing out the time period. The Department has begun work on disputes for the 1997-2002 time period.

**Disputed Rebates**
Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. Disputed rebates are being defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and receive payments.

| | Federal & State Rebates |
|---|---|
| FY 2011-12 | ($134,740,000) |
| FY 2012-13 | ($ 55,000,000) |

# AGED AND DISPUTED DRUG REBATES

## REGULAR POLICY CHANGE NUMBER: 46

**Reason for Change from Prior Estimate:**
The estimated savings increased based on the Department's resolution of older and substantial rebate disputes.

**Methodology:**
Not applicable.

**Funding:**
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)

# FAMILY PACT DRUG REBATES

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 47 |
| IMPLEMENTATION DATE: | 12/1999 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 51 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$70,826,000 | -$70,417,000 |
| - STATE FUNDS | -$9,267,000 | -$9,213,300 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$70,826,000 | -$70,417,000 |
| STATE FUNDS | -$9,267,000 | -$9,213,300 |
| FEDERAL FUNDS | -$61,559,000 | -$61,203,700 |

## DESCRIPTION

**Purpose:**
This policy change estimates the revenues collected from the Family Planning Access, Care and Treatment (FPACT) drug rebates.

**Authority:**
Welfare and Institutions Code, section 14105.33 (b)(4)

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

In October 2008, the Department discontinued the collection of rebates for drugs that are not eligible for federal financial participation (FFP), which the Centers for Medicare & Medicaid Services (CMS) determined to be 24% of the FPACT drug costs. Effective July 2009, it is assumed 13.95% of the FPACT drug costs are not eligible for rebates.

**Reason for Change from Prior Estimate:**
The collection projections were revised based on additional actual data.

**Methodology:**
1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 7.71% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 92.29% of the FPACT rebates.

# FAMILY PACT DRUG REBATES

## REGULAR POLICY CHANGE NUMBER: 47

**CASH BASIS**
(In Thousands)

| Fiscal Year | FPACT Drug Expenditures | FPACT Rebate |
|---|---|---|
| FY 2010-11 | $161,819 | ($68,566) |
| **Est. FY 2011-12** | | **($70,826)** |
| **Est. FY 2012-13** | | **($70,417)** |

| | TF | 50% FFP | 90% FFP |
|---|---|---|---|
| **FY 2011-12** | **($70,826)** | ($5,461) | ($65,365) |
| **FY 2012-13** | **($70,417)** | ($5,429) | ($64,988) |

**Funding:**
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)

# LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 48
IMPLEMENTATION DATE: 8/2009
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1449

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$115,368,000 | $0 |
| - STATE FUNDS | -$115,368,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$115,368,000 | $0 |
| STATE FUNDS | -$115,368,000 | $0 |
| FEDERAL FUNDS | $0 | $0 |

## DESCRIPTION

**Purpose:**
This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to the overcharges related to provider fraud against the Medi-Cal program.

**Authority:**
Not applicable

**Background:**
The Department works collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks and overcharging Medicaid.

**Reason for Change from Prior Estimate:**
Additional settlement agreements.

**Methodology:**
The following settlements are expected to be received in FY 2011-12:

# LITIGATION SETTLEMENTS

## REGULAR POLICY CHANGE NUMBER: 48

| | FY 2011-12 Settlement Payments |
|---|---|
| CVS | $ 879,000 |
| Eisai/Elan | $ 2,319,000 |
| LabCorp | $ 10,281,000 |
| Mariner/SavaSeniorCare | $ 1,229,000 |
| Maxim | $ 7,325,000 |
| Merck | $ 19,124,000 |
| Novartis | $ 810,000 |
| Novo Nordisk | $ 440,000 |
| Pfizer | $ 309,000 |
| Quest Diagnostics | $ 50,055,000 |
| Seacliff Diagnostics | $ 124,000 |
| Serono | $ 635,000 |
| UCB, Inc. | $ 450,000 |
| Ven-A-Care of the Florida Keys (Sandoz) | $ 21,308,000 |
| Whitefield Medical Lab | $ 80,000 |
| **Total GF Savings** | **$ 115,368,000** |

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

# MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49
IMPLEMENTATION DATE: 9/2012
ANALYST: Davonna McClendon
FISCAL REFERENCE NUMBER: 1585

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$316,347,000 |
| - STATE FUNDS | $0 | -$158,173,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$316,347,000 |
| STATE FUNDS | $0 | -$158,173,500 |
| FEDERAL FUNDS | $0 | -$158,173,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the amount of monies received from the collection of additional Managed Care drug rebates.

**Authority:**
Social Security Act Section 1927(b) as amended by Section 2501(c) of Patient Protection and Affordable Care Act (PPACA).

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

**Reason for Change from Prior Estimate:**
California Medicaid Management Information System (CA-MISS) system updates were not implemented in 2011-12; as a result, invoicing for managed care drugs did not commence.

The new collection projections are based on updated historical data provided by the Capitated Rates Development Division, as well as the shift in Seniors and Persons with Disabilities (SPD) population from fee-for-service (FFS) to managed care.

**Methodology:**
1. Rebates are invoiced quarterly.

2. Assume invoicing will begin in August 2012, retroactive to March 23, 2010.

3. Assume rebates will be received beginning in September 2012.

# MANAGED CARE DRUG REBATES

## REGULAR POLICY CHANGE NUMBER: 49

4. Assume the Department will collect $509 million TF in retroactive rebates and $70 million TF ongoing for each quarter.

5. Assume the collection of all managed care rebates (retroactive and current) will not be collected immediately due to disputes from drug manufacturers.

6. Assume the Department will collect 40% of the retroactive and current amounts invoiced in FY 2012-13.

7. The Department estimates $316,347,000 TF ($158,173,500 GF) will be collected in FY 2012-13.

| FY 2012-13 | |
|---|---|
| Retroactive Rebates | $ 203,961,000 |
| FY 2012-13 | $ 112,386,000 |
| **Total** | **$ 316,347,000** |

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

# STATE SUPPLEMENTAL DRUG REBATES

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 50 |
| IMPLEMENTATION DATE: | 1/1991 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 54 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$113,796,000 | -$95,942,000 |
| - STATE FUNDS | -$52,005,800 | -$47,848,600 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$113,796,000 | -$95,942,000 |
| STATE FUNDS | -$52,005,800 | -$47,848,600 |
| FEDERAL FUNDS | -$61,790,200 | -$48,093,400 |

## DESCRIPTION

**Purpose:**
This policy change estimates the revenues collected from the State Supplemental Drug rebates.

**Authority:**
Welfare and Institutions Code, section 14105.33

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

**Reason for Change from Prior Estimate:**
The collection projections were revised based on additional actual data.

**Methodology:**
1. Family planning drugs are 0.319% of rebates and are funded with 90% federal funds and 10% General Fund.

2. In October 2009, the Centers for Medicare & Medicaid Services (CMS) released Federal Upper Limits (FULs) for some products, which have created lower net cost for some generically available products. As a result of lower utilization of the equivalent brand name products, drug rebates are expected to decrease in FY 2011-12 and FY 2012-13.

3. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

# STATE SUPPLEMENTAL DRUG REBATES

## REGULAR POLICY CHANGE NUMBER: 50

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

**CASH BASIS**
(In Thousands)

| Fiscal Year | FFS Trends | Supplemental Rebate Savings |
|---|---|---|
| FY 2010-11 | $3,338,653 | ($ 172,705) |
| **Est. FY 2011-12** | | **($ 104,302)** |
| **Est. FY 2012-13** | | **($ 95,942)** |

| | TF | 50% FFP | 90% FFP | ARRA |
|---|---|---|---|---|
| **FY 2011-12** | **($104,302)** | ($51,969) | ($363) | ($9,494) |
| **FY 2012-13** | **($95,942)** | ($47,818) | ($306) | |

**Funding:**
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)
Title XIX 100% FFP (4260-101-0890)

# FEDERAL DRUG REBATE PROGRAM

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 51 |
| IMPLEMENTATION DATE: | 7/1990 |
| ANALYST: | Davonna McClendon |
| FISCAL REFERENCE NUMBER: | 55 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$1,331,040,000 | -$1,100,415,000 |
| - STATE FUNDS | -$628,032,600 | -$548,803,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$1,331,040,000 | -$1,100,415,000 |
| STATE FUNDS | -$628,032,600 | -$548,803,500 |
| FEDERAL FUNDS | -$703,007,400 | -$551,611,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the revenues collected from the Federal Drug rebates.

**Authority:**
Social Security Act, section 1927 [42 U.S.C. 1396r–8]
Omnibus Budget Reconciliation Act (OBRA) of 1990, Title IV, sec. 4401(a)(3), 104 Stat.

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

**Reason for Change from Prior Estimate:**
The collection projections were revised based on additional actual data.

**Methodology:**
1. Family planning drugs are 0.319% of rebates and are funded with 90% federal funds and 10% General Fund.

2. Beginning September 2012, the Federal Drug Rebate Change policy change which reflects the higher federal funding participation (FFP) claimed by the Centers for Medicare and Medicaid Services (CMS) will be fully reflected in this policy change.

3. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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

# FEDERAL DRUG REBATE PROGRAM

## REGULAR POLICY CHANGE NUMBER: 51

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

**CASH BASIS**
(In Thousands)

| Fiscal Year | FFS Trends | Federal Rebate Savings |
|---|---|---|
| FY 2010-11 | $3,338,653 | ($1,302,009) |
| **Est. FY 2011-12** | | **($1,259,461)** |
| **Est. FY 2012-13** | | **($1,100,415)** |

| | TF | 50% FFP | 90% FFP | ARRA |
|---|---|---|---|---|
| **FY 2011-12** | **($1,259,461)** | ($627,608) | ($4,821) | ($71,578) |
| **FY 2012-13** | **($1,100,415)** | ($548,453) | ($3,159) | |

**Funding:**
Title XIX 50/50 FFP (4260-101-0001/0890)
Title XIX 10/90 FFP (4260-101-0001/0890)
Title XIX 100% FFP (4260-101-0890)

# MANAGED CARE RATE RANGE IGTS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 55 |
| IMPLEMENTATION DATE: | 7/2005 |
| ANALYST: | Candace Epstein |
| FISCAL REFERENCE NUMBER: | 1054 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $229,051,000 | $525,946,000 |
| - STATE FUNDS | $87,626,000 | $234,345,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $229,051,000 | $525,946,000 |
| STATE FUNDS | $87,626,000 | $234,345,000 |
| FEDERAL FUNDS | $141,425,000 | $291,601,000 |

## DESCRIPTION

**Purpose**
This policy change estimates the rate range intergovernmental transfers (IGTs) from the counties to the Department for the purpose of providing capitation rate increases to the managed care plans.

**Authority:**
Welfare & Institutions Code, sections 14163 and 14164

**Background:**
An IGT is a transfer of funds from a public entity to the State. The non-federal share from the fund is matched with federal funds and used to make payments for capitation rate increases.

The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

**Reason for Change from Prior Estimate:**
The policy change was revised to incorporate updated IGTs.

**Methodology:**
COHS:
The initial transfer of funds began in June 2006, effective retroactively to July 2005. The County of San Mateo increased its IGT funds effective February 1, 2007, July 1, 2008, February 1, 2010, and July 1, 2010. The IGT will continue on an ongoing basis.

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

The IGTs for Orange, Napa, and Yolo Counties are expected to be effective retroactive to July 1, 2010; and Marin County is expected to be effective July 1, 2011. Once approved by Centers for Medicare and Medicaid Services (CMS), it is anticipated the IGTs will continue on an ongoing basis.

# MANAGED CARE RATE RANGE IGTS

## REGULAR POLICY CHANGE NUMBER: 55

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

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

AB 1422 (Chapter 157, Statutes of 2009) imposed a gross premium tax (MCO Tax) on the total operating revenue of the Medi-Cal Managed Care plans. The proceeds from the tax were used to offset the capitation rates. ABX1 21 (Chapter 11, Statutes of 2011) has extended the gross premium tax through June 30, 2012. The Administration is proposing legislation to eliminate the sunset date of the Gross Premium Tax on Medi-Cal managed care plans. For additional information see policy change Extend Gross Premium Tax –Incr. Capitation Rates and Extend Gross Premium Tax-Funding Adjustment. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for MCO Tax policy change.

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 on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of MCO Tax to General Fund policy change.

**(In Thousands)**

**FY 2011-12**

| | IGT* | Regular FFP | ARRA FFP | T21 FFP | Total FFP | TF |
|---|---|---|---|---|---|---|
| **Total** | **$87,626** | **$109,356** | **$25,348** | **$6,721** | **$141,425** | **$229,051** |

**FY 2012-13**

| | IGT* | Regular FFP | ARRA FFP | T21 FFP | Total FFP | TF |
|---|---|---|---|---|---|---|
| **Total** | **$234,345** | **$250,230** | **$23,397** | **$17,974** | **$291,601** | **$525,946** |

**Funding:**
Title XIX FFP (4260-101-0890)
Title XXI FFP (4260-113-0890)
Reimbursement (4260-610-0995)*

# INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 56
IMPLEMENTATION DATE: 11/2009
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1455

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $265,213,000 | $20,704,000 |
| - STATE FUNDS | $133,527,000 | $10,424,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $265,213,000 | $20,704,000 |
| STATE FUNDS | $133,527,000 | $10,424,000 |
| FEDERAL FUNDS | $131,686,000 | $10,280,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of capitation rate increases that are offset by the gross premium tax proceeds. These funds will be used for the non-federal share of capitation rate increases.

**Authority:**
AB 1422 (Chapter 157, Statutes of 2009)
ABX1 21 (Chapter 11, Statutes of 2009)

**Background:**
AB 1422 imposed a 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 Previous 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. The provision pertaining to the gross premium tax was effective retroactively to January 1, 2009 through June 30, 2011.

3. ABX1 21 extended the gross premium tax through June 30, 2012. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period will be matched with federal funds at the level in effect at that time.

# INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

## REGULAR POLICY CHANGE NUMBER: 56

4. 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 on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to GF policy change.

5. While most of Medi-Cal's expenditures receive the applicable Federal Medicaid Assistance Percentage (FMAP) in place on the date that payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased American Recovery and Reinvestment Act of 2009 (ARRA) FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as Gross Premium Tax, and Medi-Cal draws the federal funds in a subsequent fiscal year.

6. FY 2012-13 amounts are one-time retroactive rate adjustments using FY 2011-12 Gross Premium Taxes.

| (In Thousands) | Gross Premium Tax | FFP | TF |
|---|---|---|---|
| **Total FY 2011-12** | $133,527 | $131,686 | **$265,213** |
| **Total FY 2012-13** | $10,352 | $10,352 | **$20,704** |

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

# MANAGED CARE COST BASED REIMBURSEMENT CLINICS

REGULAR POLICY CHANGE NUMBER: 60
IMPLEMENTATION DATE: 10/2011
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1618

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$29,743,000 | $90,073,000 |
| - STATE FUNDS | -$14,871,500 | $45,036,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$29,743,000 | $90,073,000 |
| STATE FUNDS | -$14,871,500 | $45,036,500 |
| FEDERAL FUNDS | -$14,871,500 | $45,036,500 |

## DESCRIPTION

**Purpose:**
The policy change estimates the funding adjustment for cost based reimbursement clinics (CBRC) transitioning from fee-for-service (FFS) into the managed care program exclusively for the seniors and persons with disabilities (SPD) population residing in the Los Angeles County.

**Authority:**
Welfare & Institutions Code, section 14105.24 (a)

**Background:**
The Department will reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. For periods prior to the SPD transition, a tentative settlement is prepared by the Department after review of the reconciliation request. Within three years after the date of submission of the original reconciliation report, as required, a final audit is performed and either a final settlement or recovery invoice is prepared. The Department will transition these costs to managed care, thereby, eliminating the reconciliation process. As a result, the transition of these costs to the managed care program is a funding shift only and will result in an equivalent savings to the FFS program.

Previously, an interim rate was paid to the clinics and is adjusted once the audit reports were finalized. That rate was used for subsequent fiscal year claims. The Department is scheduled to complete the audits for 2007-08 in 2011-12 and for 2008-09 in 2012-13. Interim rates will be adjusted to the FY 2006-07 audited levels beginning in FY 2011-12, and to the FY 2007-08 audited levels in FY 2012-13. These reconciliations are budgeted in the FQHC/RHC/CBRC Reconciliation Process policy change. Managed care costs for FY 2011-12 are expected to be paid in FY 2012-13.

**Reason for Change from Prior Estimate:**
Adjustments were made to accommodate for the CBRCs rates that will not be received and approved until FY 12-13. Payments will not be made until CMS approval is received. FY 11-12 costs have been moved to FY 12-13.

# MANAGED CARE COST BASED REIMBURSEMENT CLINICS

## REGULAR POLICY CHANGE NUMBER: 60

**Methodology:**

1. Assume costs will be retroactive to October 1, 2011.

2. Assume the managed care costs are the actuarial equivalent of the FFS costs.

3. Based on FY 2010-11 annual costs of $91,063,000, assume there will be an annual growth of 5.71% based on historical data.

4. Annualized managed care costs are $96,263,000 for FY 2011-12.

5. Because of the 12-month June 2011 to May 2012 phase-in of SPDs into managed care, the managed care costs will be $53,479,000 in FY 2011-12 and are expected to be paid in FY 2012-13.

6. Total managed care costs will be $155,239,000 for FY 2012-13 which include the FY 2011-12 managed care costs in the amount of $53,479,000 and $101,760,000 for FY 2012-13.

7. While the transition of these costs from FFS to managed care is effective October 1, 2011, the adjustment to the managed care plan payments will not begin until FY 2012-13 when CMS approval is anticipated.

8. Cost settlements that would have occurred in future years for these SPDs will no longer have to be made because they will be included in the managed care capitation rates. For FY 2011-12, these settlements are estimated to be $19,232,000 and would have been made in FY 2014-15. For FY 2012-13, these settlements are estimated to be $36,593,000 would have been made in FY 2015-16.

9. FFS savings will be $29,743,000 for FY 2011-12 and $65,166,000 for FY 2012-13.

10. The FFS costs are in the base estimate. There will be a savings to the base estimate as a result of shifting the costs from the FFS base into managed care for the SPDs.

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| Managed Care Costs | $0 | $155,239,000 |
| FFS Savings | -$29,743,000 | -$65,166,000 |
| **Total Costs** | **-$29,743,000** | **$90,073,000** |

**Funding:**

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

# COURT-ORDERED MANAGED CARE RATE ADJUSTMENTS

REGULAR POLICY CHANGE NUMBER: 61
IMPLEMENTATION DATE: 7/2009
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1361

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $32,400,000 | $0 |
| - STATE FUNDS | $16,200,000 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $32,400,000 | $0 |
| STATE FUNDS | $16,200,000 | $0 |
| FEDERAL FUNDS | $16,200,000 | $0 |

## DESCRIPTION

**Purpose:**
The policy change estimates the costs for the prejudgment interest in the case *Health Net of California v. Department of Health Services*.

**Authority:**
The Third District Court of Appeals ruled the Department must pay prejudgment interest in February 2012.

**Background:**
The Third District Court of Appeal ruled that the Department must pay $27.4 million as well as prejudgment interest, post-judgment interest, and costs to Health Net for a dispute over Two Plan Model capitation rates for years ranging from 1997 to 2002. In FY 2009-10, $14.6 million was paid to Health Net. An additional payment of $2.99 million was paid in FY 2010-11. The Department anticipates paying the remaining balance of $32.4 million in April 2012.

| | FY 2011-12 |
|---|---|
| **Total Cost** | **$32,400,000** |

**Reason for Change from Prior Estimate:**
Updated payment calculation.

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

# NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER: 64
IMPLEMENTATION DATE: 7/1998
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 95

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

## DESCRIPTION

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

**Authority:**
Not applicable

**Background:**
Various managed care plans have filed grievances or appeals challenging the rates the Department has established for the managed care programs. Every six months the Department develops an estimate of likely settlements for these disputes.

The Department attempts to claim federal funding, however, this policy change adjusts for settlements that are beyond the federal claiming deadline or include payments outside of the actuarially sound rate ranges. These settlements are budgeted at 100% General Fund.

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

**Funding:**
100% General Fund (4260-101-0001)

# MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 65
IMPLEMENTATION DATE: 7/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1588

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | $900,000,000 |
| - STATE FUNDS | $0 | $450,000,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | $900,000,000 |
| STATE FUNDS | $0 | $450,000,000 |
| FEDERAL FUNDS | $0 | $450,000,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the Intergovernmental Transfer (IGT) from Designated Public Hospitals (DPHs) to the Department that will be used as the non-federal share of capitation rate increases.

**Authority:**
Senate Bill 208 (Chapter 714, Statutes of 2010)

**Background:**
Effective June 1, 2011, Medi-Cal managed care began assigning Seniors and Persons with Disabilities (SPDs) as mandatory enrollees in managed care health plans in both Two-Plan and Geographic Managed Care model counties per SB 208. In implementing the mandatory enrollment of SPDs, SB 208 allows DPHs, on a voluntary basis, to provide the State an IGT to be used as the non-federal share of capitation rate increases that will enable Medi-Cal managed care plans to compensate DPHs in amounts that are no less than what they would have received for providing services to these beneficiaries under the Fee-For-Service (FFS) model, including supplemental payments and any additional federally permissible amounts, which are available only under FFS. The purpose of these IGTs is to enable managed care plans to compensate DPHs in a sufficient amount so as to preserve and strengthen the availability and quality of services provided by these DPHs. It is also the intent that transferring public entities elect to provide IGTs in an amount that is at least equivalent to the amount of the nonfederal share that they would have provided under FFS, as adjusted for utilization.

On an annual basis, it is anticipated this will result in IGTs of $277 million and $554 million in increased capitation rates. Because the SPD enrollment transition will occur over a period of time beginning June 1, 2011, the initial IGT is estimated to be $173 million for the period June 1, 2011 through June 30, 2012, which is assumed to be transferred in FY 2012-13 after CMS approval.

# MANAGED CARE PUBLIC HOSPITAL IGTS

## REGULAR POLICY CHANGE NUMBER: 65

| (In Thousands) | IGT | FFP | TF |
|---|---|---|---|
| **FY 2012-13** | | | |
| FY 2011-12 | $173,000 | $173,000 | $346,000 |
| FY 2012-13 | $277,000 | $277,000 | $554,000 |
| **Total** | **$450,000** | **$450,000** | **$900,000** |

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

**Methodology:**
Not applicable.

**Funding:**
Title XIX 100% FFP (4260-101-0890)
Reimbursement GF (4260-610-0995)

# DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 67
IMPLEMENTATION DATE: 1/2013
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1482

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $0 | -$743,000 |
| - STATE FUNDS | $0 | -$371,500 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $0 | -$743,000 |
| STATE FUNDS | $0 | -$371,500 |
| FEDERAL FUNDS | $0 | -$371,500 |

## DESCRIPTION

**Purpose:**
This policy change estimates the costs due to moving undocumented beneficiaries from Partnership Health Plan of California (PHC), a Managed Care plan, into FFS.

**Authority:**
Contract # 08-85215

**Background:**
PHC's Medi-Cal managed care contract covered undocumented beneficiaries in Solano, Napa and Yolo Counties. Managed Care contracts with other health plans do not include undocumented beneficiaries. To ensure all managed care model plans are consistent, PHC is negotiating with the Department to remove the undocumented beneficiaries from their contract. The implementation date of this shift will occur on January 1, 2013.

**Reason for Change from Prior Estimate:**
Changes occurred due to the updated rates and member months.

**Methodology:**
1. It is assumed the annual member months for undocumented beneficiaries will be 3,769 for Solano County, 1,803 for Napa County, and 1,968 for Yolo County.

2. The FY 2012-13 undocumented beneficiary rates are assumed to be $351.19 for Solano County, $529.67 for Napa County, and $550.83 for Yolo County.

3. The FY 2012-13 cost, for period January 1, 2013 through June 30, 2013, for undocumented beneficiaries by county is expected to be:

# DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

## REGULAR POLICY CHANGE NUMBER: 67

Solano County: 3,769 x $351.19 / 12 months x 6 months = $662,000
Napa County: 1,803 x $529.67 / 12 months x 6 months = $477,000
Yolo County: 1,968 x $550.83 / 12 months x 6 months = $542,000

$662,000 + $477,000 + $542,000 = $1,681,000

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

| | |
|---|---|
| $1,681,000 | FFS cost |
| -$1,681,000 | Managed Care savings |
| $0 | Net annual impact of shift to FFS |

5. There will be a net savings in FY 2012-13 due to the capitation payments ending on December 30, 2012. The savings is budgeted in the County Organized Health Systems (COHS) policy change, therefore, the lagged FFS costs is budgeted in this policy change. There will be a lag in FFS payments due to the time it take for providers to bill and be paid for services.

| | FY 2012-13 |
|---|---|
| Managed Care Savings | -$1,681,000 |
| FFS Cost | $1,681,000 |
| FFS Payment Lag | 0.558 |
| Lagged FFS Costs | $938,000 |
| Net costs (Rounded) | **-$743,000** |

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

# FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 68
IMPLEMENTATION DATE: 2/2011
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1586

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

## DESCRIPTION

**Purpose:**
This policy change estimates for the transfer of funds from the Gross Premium Tax Fund to the General Fund.

**Authority:**
AB 1422 (Chapter 157, Statutes of 2009)
ABX1 21 (Chapter 11, Statutes of 2011)

**Background:**
AB 1422 imposed a gross premium tax on the total operating revenue of Medi-Cal Managed Care plans. The proceeds from the tax are used to offset the capitation rates. ABX1 21 has extended the gross premium tax through June 30, 2012. The FY 2011-12 impact of the increase in capitation payments related to the gross premium tax is included in the Increase in Capitation Rates for Gross Premium Tax policy change.

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 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:**
1. Funding adjustments for FY 2010-11 of $57.8 million and $9.0 were made in July 2011 and October 2011, respectively.

2. Annually, the plans are required to file a tax return (reconciliation) by April 1 for the previous calendar year.

# FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

## REGULAR POLICY CHANGE NUMBER: 68

3. Calendar year 2011 payment reconciliation will be paid by April 1, 2012.

4. Calendar year 2012 payment reconciliation will be paid by April 1, 2013.

| | FY 2011-12 |
|---|---|
| January 2011 - June 2011 | $57,800,000 |
| July 2011 - September 2011 | $8,956,000 |
| October 2011 – December 2011 | $40,400,000 |
| January 2012 - March 2012 | $30,167,000 |
| CY 2011 Reconciliation | $26,579,000 |
| **Total Gross Premium Tax** | **$163,902,000** |
| **GF** | **-$163,902,000** |
| **Total** | **$0** |

| | FY 2012-13 |
|---|---|
| **Total Gross Premium Tax** | **$42,657,000** |
| **GF** | **-$42,657,000** |
| **Total** | **$0** |

**Funding:**
100% State GF (4260-101-0001)
3156 Gross Premium Tax (Non-GF) (4260-601-3156)

# FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 69
IMPLEMENTATION DATE: 7/2005
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1082

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

## DESCRIPTION

**Purpose:**
This policy change is for informational purposes only.

**Authority:**
Not applicable.

**Background:**
This policy change specifies the cost of services that are in addition to the managed care capitation rates. FFS expenditures occur for managed care enrollees for covered Medi-Cal services excluded by the health plan contract.

In Fiscal Year 2010-2011 FFS payments for managed care enrollees totaled:

**Expenditures by Aid Category**

| | Other | CCS/GHPP | Total |
|---|---|---|---|
| Families | $399,883,000 | $522,215,000 | $922,098,000 |
| Disabled | $285,434,000 | $368,769,000 | $654,203,000 |
| Aged | $65,118,000 | $45,000 | $65,163,000 |
| 200% Poverty | $7,657,000 | $34,246,000 | $41,903,000 |
| MI Child | $7,073,000 | $23,336,000 | $30,409,000 |
| 133% Poverty | $7,956,000 | $9,013,000 | $16,969,000 |
| Other | $1,717,000 | $6,000 | $1,723,000 |
| 100% Poverty | $7,379,000 | $21,949,000 | $29,328,000 |
| Blind | $3,257,000 | $6,006,000 | $9,263,000 |
| MI Adult | $3,466,000 | $156,000 | $3,622,000 |
| **Totals** | **$788,940,000** | **$985,741,000** | **$1,774,681,000** |

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

# FFS COSTS FOR MANAGED CARE ENROLLEES

## REGULAR POLICY CHANGE NUMBER: 69

**Funding:**
Not applicable.

# MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 70
IMPLEMENTATION DATE: 7/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1601

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

## DESCRIPTION

**Purpose**
This policy change estimates the savings to the General Fund due to the rate range intergovernmental transfers (IGTs) administrative and processing fees assessed to the counties or other approved public entities.

**Authority:**
AB 102 (Chapter 29, Statutes of 2011) provides that all IGTs used to fund increases through the rate range are subject to the fee with the exception of the certain IGTs related to designated public hospitals and IGTs authorized pursuant to Welfare & Institutions Code Sections 14168.7 and 14182.15.

**Background:**
The counties/public entities transfer funds as IGTs to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds are used for the nonfederal share of capitation rate increases which are budgeted in the Managed Care Rate Range IGT policy change. The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

Beginning July 1, 2011, the Department will charge counties/public entities an administrative and processing fee for their IGTs. The fee will be 20% of each IGT and will offset the support of the Medi-Cal program as well as state support costs. FY 2012-13 savings includes all entities participating in an IGT other than the FY 2010-11 San Mateo IGT.

**Reason for Change from Prior Period:**
Admin fees are only assessed on IGTs in FY 2010-11 and forward and only FY 2009-10 IGTs were paid in FY 2011-12. The amounts for FY 2012-13 are revised based on updated IGTs.

# MANAGED CARE IGT ADMIN. & PROCESSING FEE

## REGULAR POLICY CHANGE NUMBER: 70

**Methodology:**

1. The fee will be 20% of each IGT.

2. The state support costs are budgeted under state support.

| (In Thousands) | IGT | 20% Admin. & Processing Fee | Support Cost Reimbursement to GF | Local Assistance Reimbursement to GF |
|---|---|---|---|---|
| FY 2011-12 | $ 0 | $ 0 | $ 0 | **$ 0** |
| FY 2012-13 | $ 234,345 | $ 45,866 | $ 251 | **$ 45,615** |

**Funding:**

Reimbursement (4260-610-0995)

# GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 71
IMPLEMENTATION DATE: 7/2012
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1605

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

## DESCRIPTION

**Purpose:**
This policy change estimates the reimbursement to the General Fund (GF) by the Designated Public Hospitals (DPHs) for the costs that are built into the managed care capitation rates.

**Authority:**
Senate Bill 208 (Chapter 714, Statutes of 2010)

**Background:**
Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage will be assigned as mandatory enrollees in managed care plans in Two-Plan and Geographic Managed Care model counties. For Medi-Cal beneficiaries under the Fee For Service (FFS) program, payments to DPHs are comprised of Certified Public Expenditures matched with federal funds. For those under managed care, payments to DPHs are comprised of GF and federal funds. Therefore, as SPDs are transitioned into managed care, GF expenditures will increase for DPH services.

Beginning in FY 2012-13, DPHs will reimburse the GF for costs that are built into the managed care capitation rates that would not have been incurred had the SPDs remained in FFS.

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

**Methodology:**
1. Assume the intergovernmental transfer will be phased-in consistent with the enrollment of SPDs into managed care beginning June 1, 2011.

2. Assume the initial General Fund repayment for the period June 1, 2011 through June 30, 2012, will be $93,959,000 and will be made in FY 2012-13.

3. Beginning in FY 2012-13, $150,335,000 will be repaid annually to the General Fund.

# GENERAL FUND REIMBURSEMENTS FROM DPHS

## REGULAR POLICY CHANGE NUMBER: 71

| | FY 2012-13 |
|---|---|
| June 2011 - June 2012 reimbursement from DPHs | $ 93,959,000 |
| FY 2012-13 Reimbursement from DPHs | $ 150,335,000 |
| Total Reimbursement | $ 244,294,000 |
| GF | -$ 244,294,000 |
| **Net Impact** | **$ 0** |

**Funding:**
Reimbursement (4260-610-0995)

# COVERAGE FOR FORMER AGNEWS RESIDENTS

REGULAR POLICY CHANGE NUMBER: 72
IMPLEMENTATION DATE: 7/2007
ANALYST: Candace Epstein
FISCAL REFERENCE NUMBER: 1199

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | -$6,531,000 | $2,682,000 |
| - STATE FUNDS | -$3,265,500 | $1,341,000 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | -$6,531,000 | $2,682,000 |
| STATE FUNDS | -$3,265,500 | $1,341,000 |
| FEDERAL FUNDS | -$3,265,500 | $1,341,000 |

## DESCRIPTION

**Purpose:**
This policy change estimates the cost of negotiated rates less the capitated rates and supplemental payment reconciliations for transitioning Agnews Developmental Center clients to the community.

**Authority:**
Welfare & Institutions (W&I) Code Sections 4500 et seq. (Lanterman Act), W&I Code commencing with 4474.5

**Background:**
Effective April 1, 2009, Agnews closed and a total of 300 Agnews clients have been moved into communities in Alameda, San Mateo, and Santa Clara counties. Of these, 214 are currently enrolled in managed care plans.

Due to the significant behavioral, health, and personal care needs of these clients, previous capitation rates did not provide sufficient funding to meet Agnews clients' needs. Prior to the negotiated rates the Department requested payment for the difference between the capitation payments and the supplemental payments followed by periodic reconciliations. As of December 2010, the Santa Clara Family Health Plan and July 1, 2008 for the Health Plan San Mateo have implemented full-risk capitation rates with the Department. New full risk capitation rates are effective retroactively to January 1, 2008. The Alameda Alliance Health Plan contract was amended in September 2011 with new full risk capitation rates retroactive to January 1, 2008.

**Reason for Change from Prior Estimate:**
Updated rates and eligibles.

# COVERAGE FOR FORMER AGNEWS RESIDENTS

## REGULAR POLICY CHANGE NUMBER: 72

**Methodology:**

1. Assume the Managed Care model plans, Two Plan and COHS, Agnews rates for FY 2011-12 and FY 2012-13 are:

| | Medi-Cal Only | Dual |
|---|---|---|
| Alameda Alliance | $3,136.42 | $999.39 |
| Santa Clara Family Health Plan | $3,209.78 | $1,211.91 |
| Health Plan of San Mateo | $3,353.49 | $1,011.98 |

2. The plans are paid their initial capitation rate for FY 2011-12 based on the Dual and Medi-Cal only Disability:

| | Medi-Cal Only | Dual |
|---|---|---|
| Alameda Alliance | $476.11 | $476.11 |
| Santa Clara Family Health Plan | $401.59 | $401.59 |
| Health Plan of San Mateo | $759.64 | $759.64 |

FY 2012-13 initial capitation rates:

| | Medi-Cal Only | Dual |
|---|---|---|
| Alameda Alliance | $492.96 | $492.96 |
| Santa Clara Family Health Plan | $398.31 | $398.31 |
| Health Plan of San Mateo | $787.06 | $787.06 |

3. The net amount of the Agnews rate less the disabled rate for FY 2011-12 for Two Plan and COHS are:

| | Medi-Cal Only | Dual |
|---|---|---|
| Alameda Alliance | $2,660.31 | $523.28 |
| Santa Clara Family Health Plan | $2,808.19 | $813.60 |
| Health Plan of San Mateo | $2,593.85 | $252.34 |

The net amount of the Agnes rate less the disabled rate for FY 2012-13 for Two Plan and COHS are:

| | Medi-Cal Only | Dual |
|---|---|---|
| Alameda Alliance | $2,643.46 | $506.43 |
| Santa Clara Family Health Plan | $2,811.47 | $813.60 |
| Health Plan of San Mateo | $2,566.43 | $224.92 |

4. The total estimated reconciliation amount was $9,228,766. To date, the department has recovered $7,803,182 from the health plans and the remaining $1,425,584 will be recovered by the Department in FY 2011-12 for the reconciliation of the retroactive period. This amount is included in the amount budgeted for FY 2011-12.

**Funding:**

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

# FQHC/RHC/CBRC RECONCILIATION PROCESS

| | |
|---|---|
| REGULAR POLICY CHANGE NUMBER: | 73 |
| IMPLEMENTATION DATE: | 7/2008 |
| ANALYST: | Ryan Witz |
| FISCAL REFERENCE NUMBER: | 1329 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $177,502,000 | $201,028,000 |
| - STATE FUNDS | $88,751,000 | $100,514,000 |
| PAYMENT LAG | 0.9901 | 0.9935 |
| % REFLECTED IN BASE | 4.97 % | 4.90 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $167,010,200 | $189,935,000 |
| STATE FUNDS | $83,505,110 | $94,967,490 |
| FEDERAL FUNDS | $83,505,110 | $94,967,490 |

## DESCRIPTION

**Purpose:**
This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) according to the Prospective Payment System (PPS). This policy change also estimates the cost to provide a rate increase to Cost-Based Reimbursement Clinics (CBRC) after a reconciliation audit has been completed.

**Authority:**
Welfare and Institutions Code, section 14170

**Background:**
For the dual Medicare/Medi-Cal beneficiaries or beneficiaries enrolled in managed care plans, an interim rate is established and paid to the clinics. Annually, each FQHC/RHC submits a reconciliation request for full reimbursement. The Department calculates the difference between each clinic's final PPS rate and the expenditures already reimbursed (interim rate, managed care plans, and Medicare) in order to prepare a final settlement with the clinic.

Los Angeles County owned or operated CBRCs are reimbursed at 100% of reasonable and allowable costs. An interim rate is paid to the clinics and is adjusted once the audit reports are finalized. That rate is used for subsequent fiscal year claims. The 2006-07 audited levels were used to update the CBRC rates as of July 1, 2011. The Department is scheduled to complete the CBRC reconciliation audit for 2007-08 in 2011-12 and for 2008-09 in 2012-13. Interim rates will be adjusted to the FY 2007-08 audited levels beginning in FY 2011-12, and to the FY 2008-09 audited levels in FY 2012-13. Currently, there are 693 active FQHCs, 287 active RHCs and 29 active CBRCs.

**Reason for Change from Prior Estimate:**
The estimate was updated based on revised audits.

# FQHC/RHC/CBRC RECONCILIATION PROCESS

## REGULAR POLICY CHANGE NUMBER: 73

**Methodology:**

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FQHCs Reconciliation | $92,526,000 | $95,798,000 |
| RHCs Reconciliation | $4,519,000 | $3,661,000 |
| LA CBRCs Reconciliation | $68,457,000 | $80,569,000 |
| July 2011 LA CBRC Rate Increase | $12,000,000 | $12,000,000 |
| July 2012 LA CBRC Rate Increase | | $9,000,000 |
| **Total** | **$177,502,000** | **$201,028,000** |

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

# SB 90 NON-CONTRACT HOSPITAL RATE & PAYMENT CHANGES

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

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

## DESCRIPTION

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

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

**Background:**
SB 90 repealed a number of rate and payment reductions for non-contract hospital inpatient services. These include:

- ABX3 5 (Chapter 3, Statutes of 2008) 10% reduction of non-contract hospital inpatient payments;
- AB 1183 (Chapter 758, Statutes of 2008), the Budget Trailer Bill required additional rate reductions for the inpatient services of certain non-contract hospitals and exempted the inpatient services of non-contract Small and Rural Hospitals from the 10% payment reduction; and,
- ABX4 5 (Chapter 5, Statutes of 2009) 10% payment of certain non-contract Small and Rural Hospital inpatient services.

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

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

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

# SB 90 NON-CONTRACT HOSPITAL RATE & PAYMENT CHANGES

## REGULAR POLICY CHANGE NUMBER: 74

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

**Funding:**

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

# NF-B RATE CHANGES

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

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

## DESCRIPTION

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

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

**Background:**
AB 1629 requires the Department to provide a cost of living adjustment (COLA), implement a facility-specific rate methodology, and impose a quality assurance (QA) fee for freestanding skilled nursing facilities (NF-Bs), including adult subacute days and excluding rural swing days. The Department collects QA fees from licensed NF-Bs as a means to enhance federal financial participation for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities. The sunset date of the fee program has been extended to July 31, 2013. The Department is proposing legislation to permanently extend the QA fee.

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

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

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

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

# NF-B RATE CHANGES

## REGULAR POLICY CHANGE NUMBER: 75

4. CMS mandated that freestanding skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. In order to implement the MDS 3.0 upgrade, the Department will reimburse facilities for the additional costs associated with formal staff training and increased data-entry workload, through a rate "add-on". The rate adjustment will be effective August 1, 2011. The rate increase for FY 2011-12 retroactive to October 1, 2010 will be $1.24, which includes additional start-up costs for IT and training related activities, and $0.51 for FY 2012-13.

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

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

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

# LTC RATE ADJUSTMENT

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

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

## DESCRIPTION

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

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

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

ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 25, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute facilities.

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

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

# LTC RATE ADJUSTMENT

## REGULAR POLICY CHANGE NUMBER: 76

seeking approval to not freeze DP Pediatric Subacute rates.

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

**Methodology:**

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

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

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

4. CMS mandated that freestanding skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. The rate increase will be effective August 1, 2011. The rate increase for FY 2011-12 retroactive to October 1, 2010 will be $1.24 and $0.51 for FY 2012-13.

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

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

# LTC RATE ADJUSTMENT

## REGULAR POLICY CHANGE NUMBER: 76

(In Thousands)

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

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

# AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

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

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

## DESCRIPTION

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

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

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

To determine the QAF assessment, the Department uses two-year old data as the base revenues and applies growth and trending adjustments to project the actual revenues expected for the fiscal year. The incremental increase in the QAF revenues from year to year is used to adjust rates for these facilities, so there will be no cost to the GF on an accrual basis.

The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is effective October 1, 2011, is 6.0% of gross revenues. Changes in the amount of licensing and certification fees for NF-Bs assessed by the California Department of Public Health (CDPH) affect the amount of QAF that can be collected and remain within the federal safe harbor limit.

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

# AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

## REGULAR POLICY CHANGE NUMBER: 77

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

**Methodology:**

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

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

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

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

**FY 2011-12**

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

**FY 2012-13**

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

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

# ANNUAL MEI INCREASE FOR FQHCS/RHCS

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

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

## DESCRIPTION

**Purpose:**
This policy change estimates the annual Medicare Economic Index (MEI) increase for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology.

**Authority:**
Section 1833 of the Social Security Act

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

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

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

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

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

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

# ANNUAL MEI INCREASE FOR FQHCS/RHCS

## REGULAR POLICY CHANGE NUMBER: 78

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

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

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

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

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

# AIR AMBULANCE MEDICAL TRANSPORTATION

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

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

## DESCRIPTION

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

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

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

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

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

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

# AIR AMBULANCE MEDICAL TRANSPORTATION

## REGULAR POLICY CHANGE NUMBER: 79

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

**Methodology:**

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

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

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

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

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

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

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

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

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

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

(In Thousands)

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

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

# HOSPICE RATE INCREASES

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

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

## DESCRIPTION

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

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

**Background:**

1. **Hospice Services**
   Pursuant to state regulations, Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

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

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

**Reason for Change from Prior Estimate:**

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

# HOSPICE RATE INCREASES

## REGULAR POLICY CHANGE NUMBER: 80

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

**Methodology:**

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

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

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

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

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

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

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

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

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

**Funding:**

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

# 10% PYMT REDUCTION RESTORATION FOR AB 1629 FAC.

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

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

## DESCRIPTION

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

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

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

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

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

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

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

# 10% PYMT REDUCTION RESTORATION FOR AB 1629 FAC.

## REGULAR POLICY CHANGE NUMBER: 81

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

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

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

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

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

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

# QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

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

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

## DESCRIPTION

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

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

**Background:**
SB 853 implemented a quality and accountability payments program for NF-Bs. Supplemental payments will begin in rate year 2012-13 and will be paid through the Special Fund. The Special Fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, one percent of the weighted average rate increase on NF-Bs, and the savings achieved from setting the professional liability insurance cost category at the 75$^{th}$ percentile. On an ongoing basis, there will be no net impact to the GF because the GF will receive corresponding increased revenues from the Quality Assurance Fee levied upon NF-B facilities. The California Department of Aging (CDA) has direct appropriation authority of $1.9 million from the Special Fund to pay for the Ombudsman costs. The California Department of Public Health (CDPH) administrative costs will be reimbursed from the Special Fund by the Department.

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

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

2. In FY 2011-12 $4,250,000 and in FY 2012-13 $24,750,000 will be transferred from the GF to the Special Fund for payment of CDA Ombudsman costs, CDPH administrative costs and supplemental payments to nursing facilities.

# QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

## REGULAR POLICY CHANGE NUMBER: 82

3. In FY 2011-12 and FY 2012-13, $1,500,000 in penalties will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund.

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

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

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

# DENTAL RETROACTIVE RATE CHANGES

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

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

## DESCRIPTION

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

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

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

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

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

**Methodology:**
1. Sacramento Geographic Managed Care (GMC) dental rates have changes that are retroactive to July 2009. The prior rate of $10.51 for all eligibles has changed to $10.91 for those under 21 years of age and $2.52 for those 21 or over effective July through December 2009. The rates are $11.16 for those under 21 and $2.58 for those 21 or over effective January through December 2010. The rates are $11.83 for those under 21 and $2.91 for those 21 or over effective January through December 2011.

2. Prepaid Health Plan (PHP) dental rates have changes that are retroactive to July 2009. The prior

# DENTAL RETROACTIVE RATE CHANGES

## REGULAR POLICY CHANGE NUMBER: 83

rate of $10.51 for all eligibles has changed to $10.91 for those under 21 and $2.52 for those 21 or over effective July through December 2009. The rates are $11.16 for those under 21 and $2.58 for those 21 or over effective January through December 2010. The rates are $11.83 for those under 21 and $2.91 for those 21 or over effective January through December 2011.

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

4. The Senior Care Action Network (SCAN) retroactive rate adjustments are reflected in the Senior Care Action Network policy change.

5. The revised rates were implemented on an ongoing basis beginning with the March 2011 capitation payments. This policy change budgets the retroactive changes for the period from July 2009 through February 2011.

6. All retroactive adjustments for the period of July 2009 through December 2009 were made in FY 2011-12.

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

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

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

# DENTAL RETROACTIVE RATE CHANGES

## REGULAR POLICY CHANGE NUMBER: 83

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

# SB 90 PRESERVING CONTRACT HOSPITALS

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

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

## DESCRIPTION

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

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

**Background:**
SB 90 included a provision that required the amount of any Quality Assurance Fee supplemental payment for a contract hospital that converts to noncontract status be reduced by the amount by which that hospital's overall payment for services for Medi-Cal patients during the program period was increased by reason of it becoming a noncontract hospital. This provision will negate any financial benefit from a contract hospital converting to noncontract status.

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

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

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

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

# REDUCTION TO RADIOLOGY RATES

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

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

## DESCRIPTION

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

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

**Background:**
SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80 percent of Medicare rates, effective October 1, 2010. Radiology rates in excess of this amount will be reduced.

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

**Methodology:**
1. Implementation will begin in September 2012.

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

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

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

5. There is no managed care impact as a result of this reduction, because managed care capitation rates are calculated using radiology rates that are at or below 80 percent of Medicare rates.

# REDUCTION TO RADIOLOGY RATES

## REGULAR POLICY CHANGE NUMBER: 85

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

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

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

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

# NON-AB 1629 LTC RATE FREEZE

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

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

## DESCRIPTION

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

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

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

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

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

ABX4 5 eliminated rate increases for these facilities effective August 1, 2009. In the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute providers, effective February 25, 2010.

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

# NON-AB 1629 LTC RATE FREEZE

## REGULAR POLICY CHANGE NUMBER: 86

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

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

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

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

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

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

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

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

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

# 10% PAYMENT REDUCTION FOR LTC FACILITIES

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

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

## DESCRIPTION

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

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

**Background:**
Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent reduction. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers. Therefore, this policy change budgets a 10% payment reduction for FFS providers receiving fully restored payments and an additional 9% or 5% payment reduction for FFS providers whose payments are currently reduced by 1% or 5%.

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

# 10% PAYMENT REDUCTION FOR LTC FACILITIES

## REGULAR POLICY CHANGE NUMBER: 87

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

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

**Methodology:**

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

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

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

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

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

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

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

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

# 10% PROVIDER PAYMENT REDUCTION

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

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

## DESCRIPTION

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

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

**Background:**
AB 97 requires the Department to implement a 10% provider payment reduction, which will affect all services except hospital inpatient and outpatient services, critical access hospital, federal rural referral centers and FQHCs/RHCs, services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs, and hospice services. Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services and payments funded by certified public expenditure and intergovernmental transfer are exempt.

Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and fee-for-service (FFS) provider payments were reduced by 1%. Managed care providers payments were reduced by an actuarially equivalent reduction. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers. Therefore, this policy change budgets a 10% payment reduction for FFS providers receiving fully restored payments and an additional 9% or 5% payment reduction for FFS providers whose payments are currently reduced by 1% or 5%.

Managed care provider payments will be reduced by the actuarial equivalent amount of the FFS payment reductions retroactive to July 1, 2011.

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

# 10% PROVIDER PAYMENT REDUCTION

## REGULAR POLICY CHANGE NUMBER: 88

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

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

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

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

(In Thousands)

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

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

# MH/UCD & BTR—DSH PAYMENT

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

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

## DESCRIPTION

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

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

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

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100 percent of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and nonfederal DSH funds through intergovernmental transfer-funded payments for expenditures above 100 percent of costs, up to 175 percent of the hospitals' uncompensated Medi-Cal and uninsured costs.

- Nondesignated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act (OBRA) limits.

- Private DSH hospitals, under the Special Terms and Conditions, are allocated a total of $160.00 from the federal DSH allotment and State General Fund (GF) each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the $160.00.

# MH/UCD & BTR—DSH PAYMENT

## REGULAR POLICY CHANGE NUMBER: 89

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

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

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

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

(In Thousands)

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

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

# BTR—DELIVERY SYSTEM REFORM INCENTIVE POOL

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

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

## DESCRIPTION

**Purpose:**
This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the Delivery System Reform Incentive Pool (DSRIP) to support California's public hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve.

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

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

There are four areas for which funding is available under the DSRIP:

(1) Infrastructure Development
(2) Innovation and Redesign
(3) Population-focused Improvement
(4) Urgent Improvement in Care

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

The total federal funding for DSRIP shall not exceed total computable expenditures of $6.506 billion over the five Demonstration Years (DYs). Annual federal funds available will be the applicable FMAP of annual total computable expenditure limits as following:

# BTR—DELIVERY SYSTEM REFORM INCENTIVE POOL

## REGULAR POLICY CHANGE NUMBER: 90

(In Thousands)

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

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

**Methodology:**

1. For DY 2010-11, all payments were made in Fiscal Year 2010-11. In subsequent demonstration years, payments are expected to be made in March of the same fiscal year and September of the subsequent fiscal year.

2. DSRIP payments are estimated to be:

(In Thousands)

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

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

# BTR—LOW INCOME HEALTH PROGRAM - MCE

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

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

## DESCRIPTION

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

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

**Background:**
The LIHP is effective November 1, 2010, through December 31, 2013, under the BTR and consists of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE will cover eligibles with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those with family incomes above 133% through 200% of Federal Poverty Level. Both are elective programs at the local government level and are statewide. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (CI) which expired on August 31, 2010, and was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

Local government CPEs and IGTs are used to obtain the federal funding for the LIHP. The Department has used the CI cost claiming protocol for the MH/UCD as the basis for the new cost claiming protocol submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. The MCE program is not subject to a federal funding cap while HCCI funding is subject to a cap of $180 million each full demonstration year.

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

# BTR—LOW INCOME HEALTH PROGRAM - MCE

## REGULAR POLICY CHANGE NUMBER: 91

**Methodology:**

1. The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's FMAP by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The additional federal funding of $13,900,000 in FY 2011-12 due to ARRA is budgeted in this policy change.

The estimated MCE payments on a cash basis are:

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

**Funding:**

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

# BTR—SAFETY NET CARE POOL

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

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

## DESCRIPTION

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

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

**Background:**
Effective for dates of service on or after November 1, 2010, based on the Special Terms and Conditions of the BTR, a new SNCP was established to support the provision of services to the uninsured. The SNCP is to be distributed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) was extended for two months, until October 31, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in the new BTR demonstration. This policy change estimates the SNCP for the DPHs for the two-month extension for the prior demonstration and for the BTR. SNCP funding for the State-Only Funded Programs under the BTR is budgeted in the BTR—Designated State Health Programs policy change.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. The additional federal funding due to ARRA is $78,671,000 for the DY 2010-11 payments and this is included in this policy change.

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

# BTR—SAFETY NET CARE POOL

## REGULAR POLICY CHANGE NUMBER: 92

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

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

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

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

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

# MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

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

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

## DESCRIPTION

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

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

**Background:**
As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The payments are determined using the formulas and methodology that were previously in effect for the 2004-05 fiscal year. These payments along with the $160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute.

The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

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

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

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

# MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

## REGULAR POLICY CHANGE NUMBER: 93

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

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

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

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

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

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

# MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

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

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

## DESCRIPTION

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

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

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

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund, intergovernmental transfers (IGTs), interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments, and 33.60% of the Stabilization funding for private hospitals as calculated by the formulas set forth in SB 1100 and SB 474 (Chapter 548, Statutes of 2007). This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 688).

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

# MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 94

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

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

**Methodology:**

1. The State Funds (SF) item includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs. The annual appropriation has been reduced to reflect that the expenditures, from the Fund, are on a cash basis.

2. Interest earned in a fiscal year will be available for distribution in the following fiscal year.

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

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

5. Distribution of the Private Hospital Supplemental Fund will be determined through negotiations with the CMAC. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.

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

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

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

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

# MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 94

| | TF | SF | FFP |
|---|---|---|---|
| **FY 2010-11** | | | |
| FY 2009-10 Ending Balance | $100,466,000 | $50,233,000 | $50,233,000 |
| Appropriation (from GF) | $236,800,000 | $118,400,000 | $118,400,000 |
| FY 2009-10 interest | $166,000 | $83,000 | $83,000 |
| Total | $337,432,000 | $168,716,000 | $168,716,000 |
| Cash Expenditures in FY 2010-11 | $201,620,000 | $100,810,000 | $100,810,000 |
| FY 2010-11 Ending Balance | $135,812,000 | $67,906,000 | $67,906,000 |
| | | | |
| **FY 2011-12** | | | |
| FY 2010-11 Ending Balance | $135,812,000 | $67,906,000 | $67,906,000 |
| Appropriation (from GF) | $236,800,000 | $118,400,000 | $118,400,000 |
| FY 2010-11 interest | $282,000 | $141,000 | $141,000 |
| Est. 2005-06 Stabilization Transfer | $3,556,000 | $1,778,000 | $1,778,000 |
| IGT | $40,000,000 | $20,000,000 | $20,000,000 |
| Total | $416,450,000 | $208,225,000 | $208,225,000 |
| **Cash Expenditures to Hospitals** | **$232,530,000** | **$116,265,000** | **$116,265,000** |
| Cash Expenditures to GF | $65,400,000 | $32,700,000 | $32,700,000 |
| FY 2011-12 Ending Balance | $118,520,000 | $59,260,000 | $59,260,000 |
| | | | |
| **FY 2012-13** | | | |
| FY 2011-12 Ending Balance | $118,520,000 | $59,260,000 | $59,260,000 |
| Appropriation (from GF) | $236,800,000 | $118,400,000 | $118,400,000 |
| Est. FY 2011-12 interest | $239,000 | $119,500 | $119,500 |
| Est. 2006-07 Stabilization Transfer | $6,432,000 | $3,216,000 | $3,216,000 |
| Est. 2008-09 Stabilization Transfer | $1,308,000 | $654,000 | $654,000 |
| Est. 2010-11 Stabilization Transfer | $24,784,000 | $12,392,000 | $12,392,000 |
| IGT | $10,000,000 | $5,000,000 | $5,000,000 |
| Total | $398,083,000 | $199,041,500 | $199,041,500 |
| **Cash Expenditures to Hospitals** | **$266,764,000** | **$133,382,000** | **$133,382,000** |
| **Redirect Stabilization Fund to GF** | **$36,080,000** | **$18,040,000** | **$18,040,000** |
| Cash Expenditures to GF | $35,000,000 | $17,500,000 | $17,500,000 |
| FY 2012-13 Ending Balance | $60,239,000 | $30,119,500 | $30,119,500 |

**Funding:**

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

# BTR—LOW INCOME HEALTH PROGRAM - HCCI

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

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

## DESCRIPTION

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

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

**Background:**
The LIHP is effective November 1, 2010, through December 31, 2013, under the BTR and consists of two components, the Medicaid Coverage Expansion (MCE) and the HCCI. The MCE will cover eligibles with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those with family incomes above 133% through 200% of Federal Poverty Level. Both are elective programs at the local government level and are statewide. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (CI) which expired on August 31, 2010, and was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

Local government certified public expenditures (CPEs) and intergovernmental transfers (IGTs) are used to obtain the federal funding for the LIHP. The Department has used the CI cost claiming protocol as the basis for the new cost claiming protocol submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. The MCE program is not subject to a federal funding cap while HCCI funding is subject to a cap of $180 million each full demonstration year. Federal funding will be provided through the Health Care Support Fund (HCSF).

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

# BTR—LOW INCOME HEALTH PROGRAM - HCCI

## REGULAR POLICY CHANGE NUMBER: 95

**Methodology:**

1. The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's FMAP by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The additional federal funding of $4,981,000 in FY 2011-12 due to ARRA is budgeted in this policy change.

The estimated HCCI payments on a cash basis are:

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

**Funding:**

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

# MH/UCD & BTR—CCS AND GHPP

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

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

## DESCRIPTION

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

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

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

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

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

# MH/UCD & BTR—CCS AND GHPP

## REGULAR POLICY CHANGE NUMBER: 96

**Methodology:**

1. Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF savings is reflected in the Family Health Estimate. The GF savings created will be used to support safety net hospitals under the MH/UCD and BTR.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change budgets those federal funds that are claimed using CPEs from the CCS and GHPP programs.

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

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

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

# MH/UCD & BTR—CCS AND GHPP

## REGULAR POLICY CHANGE NUMBER: 96

The estimated CCS/GHPP federal reimbursements are:

| | CCS | GHPP | Total |
|---|---|---|---|
| FY 2005-06 | $ 15,523,000 | $ 8,485,000 | $ 24,008,000 |
| FY 2006-07 | $ 46,856,000 | $ 15,300,000 | $ 62,156,000 |
| FY 2007-08 | $ 18,000,000 | $ 8,000,000 | $ 26,000,000 |
| FY 2008-09 | $ 20,958,000 | $ 21,336,000 | $ 42,294,000 |
| FY 2009-10 | $114,023,000 | $ 41,073,000 | $155,096,000 |
| FY 2010-11 | $ 59,959,000 | $ 25,613,000 | $ 85,572,000 |
| **FY 2011-12** | | | |
| DSHP-BTR (DY 2010-11) | $ 56,158,000 | $ 26,469,000 | $ 82,627,000 |
| DSHP-BTR (DY 2011-12) | $ 59,324,000 | $ 27,647,000 | $ 86,971,000 |
| Total Claiming | $115,482,000 | $ 54,116,000 | $169,598,000 |
| DY 2008-09 Final Reconciliation | ($ 13,436,000) | $ 903,000 | ($ 12,533,000) |
| **Total** | **$102,046,000** | **$ 55,019,000** | **$157,065,000** |
| **FY 2012-13** | | | |
| DSHP-BTR (DY 2012-13) | $ 59,324,000 | $ 27,647,000 | $ 86,971,000 |
| DY 2009-10 Final Reconciliation | ($ 11,372,000) | ($ 4,595,000) | ($ 15,967,000) |
| **Total** | **$ 47,952,000** | **$ 23,052,000** | **$ 71,004,000** |

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

# BTR—DESIGNATED STATE HEALTH PROGRAMS

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

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

## DESCRIPTION

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

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

**Background:**
The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below (exceptions as noted):

# BTR—DESIGNATED STATE HEALTH PROGRAMS

## REGULAR POLICY CHANGE NUMBER: 97

| State Only Medical Programs |
|---|
| California Children Services (CCS) |
| Genetically Handicapped Persons Program (GHPP) |
| Medically Indigent Adult Long Term Care (MIA-LTC) |
| Breast & Cervical Cancer Treatment Program (BCCTP) |
| AIDS Drug Assistance Program (ADAP) |
| Expanded Access to Primary Care (EAPC) |
| County Mental Health Services Program |
| Department of Developmental Services (DDS)* |
| Every Woman Counts (EWC)* |
| Prostate Cancer Treatment Program (PCTP)* |
| **Workforce Development Programs** |
| Office of Statewide Health Planning & Development (OSHPD)<br>· Song-Brown HealthCare Workforce Training<br>· Steven M. Thompson Physician Corps Loan Repayment Program<br>· Mental Health Loan Assumption Program<br>University of California**<br>California State University**<br>California Community Colleges** |
| County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11. |

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

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

The annual limit the State-Only programs may claim for DSHP is $400 million each Demonstration Year (DY) for a five year total of $2 billion. In addition to the above programs, proposed trailer bill language will allow the DPHs to voluntarily provide excess CPEs as necessary for the State to claim the full $400 million.

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

**Methodology:**

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

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

3. The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the MH/UCD & BTR–MIA-LTC and MH/UCD & BTR–BCCTP policy changes. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR–

# BTR—DESIGNATED STATE HEALTH PROGRAMS

## REGULAR POLICY CHANGE NUMBER: 97

CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF savings are reflected in that estimate.

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

The estimated BTR DSHP federal reimbursements are as follows:

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

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

# MANDATORY SPD ENROLLMENT INTO MANAGED CARE

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

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

## DESCRIPTION

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

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

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

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

**Methodology:**
1. Mandatory enrollment of SPDs into Medi-Cal managed care plans in Two-Plan and GMC counties began June 2011.

2. Assume the 341,800 affected SPD beneficiaries will be phased-in, by birth month, over twelve months.

3. The average fee-for-service expenditure for this population is $575.89 per member per month (PMPM), excluding services that will not be capitated under mandatory enrollment.

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

# MANDATORY SPD ENROLLMENT INTO MANAGED CARE

## REGULAR POLICY CHANGE NUMBER: 98

5. Deferral of the June 2011 capitation payment for the Two-Plan and GMC model plans is no longer included in this policy change.

6. Assume that current managed care operating policies will be applied to these new eligibles, e.g., Long Term Care (LTC) coverage in managed care for the month of admission and the following month only. However, individuals that are currently in LTC will not move to managed care.

7. Assume there is no selection bias during the enrollment process—all acuity levels will be randomly enrolled.

8. Mandatory enrollment of California Children Services (CCS) eligible children will be suspended until the CCS pilot counties are determined. Once the pilot counties are selected, CCS children in the remaining two Plan model and GMC counties will be subject to mandatory enrollment.

9. All other children except foster children will be included in the mandatory enrollment.

10. Assume Home and Community-Based Services waiver eligibles will be included in the mandatory enrollment.

11. Upon request, exemptions may be allowed for continuity of care reasons when the eligible is being treated for complex medical conditions and the treating provider is not participating in the managed care plan. These exemptions could significantly affect the savings.

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

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

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

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

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

# MANDATORY SPD ENROLLMENT INTO MANAGED CARE

## REGULAR POLICY CHANGE NUMBER: 98

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

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

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

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

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

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

## DESCRIPTION

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

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

**Background:**
As part of the MH/UCD and BTR, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, pursuant to State Plan Amendment (SPA) 05-023, DPHs received reimbursement based on certified public expenditures (CPEs) for their uncompensated costs incurred for physician and non-physician practitioner professional services. The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's physician and non-physician costs will be reconciled to the Medi-Cal 2552-96 cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

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

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

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

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

## REGULAR POLICY CHANGE NUMBER: 99

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

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

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

# MH/UCD—DPH INTERIM & FINAL RECONS

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

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

## DESCRIPTION

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

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

**Background:**
Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the Special Terms and Conditions of MH/UCD and BTR, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 cost report for the respective fiscal year ending. Payments resulting from the Interim Reconciliation will be funded with federal funds. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, and Medi-Cal administrative day, crossover, and interim payments.

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

# MH/UCD—DPH INTERIM & FINAL RECONS

## REGULAR POLICY CHANGE NUMBER: 100

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

**Methodology:**

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

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

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

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

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

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

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

# MH/UCD—SOUTH LA PRESERVATION FUND

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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $39,167,000 | $0 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $39,167,000 | $0 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $39,167,000 | $0 |

## DESCRIPTION

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

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

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

To ensure adequate funding for the continued health care services to the uninsured population of South Los Angeles, which had been provided by Martin Luther King Jr.-Harbor Hospital prior to its closure, SB 474 created the SLAMSP Fund. Federal funds will be claimed from the SNCP using the CPEs of the County of Los Angeles or its DPHs. This funding will be used by the County for compensating other providers for health services rendered to the uninsured population of South Los Angeles that would have been served at Martin Luther King Jr.-Harbor Hospital had it remained opened. The County of Los Angeles can also use this funding to cover indirect costs associated with adequately maintaining the hospital building for reopening.

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

**Methodology:**
1. SNCP monies for 2007-08, 2008-09, and 2009-10 have been allocated towards the South Los Angeles Medical Services Preservation. For 2007-08, Martin Luther King Jr.-Harbor Hospital was

# MH/UCD—SOUTH LA PRESERVATION FUND

## REGULAR POLICY CHANGE NUMBER: 101

operational for 45 days and received SNCP funding directly. For 2007-08, $87.700 million was allocated to the SLAMSP fund and paid in FY 2008-09. For 2008-09, $100 million was allocated to the SLAMSP Fund. Of the $100 million, $50 million was paid in FY 2008-09 and $50 million was paid out in FY 2009-10.

2. ABX3 5 (Chapter 20, Statutes of 2009) reduced the payments to DPHs and the SLAMSP Fund by 10%, effective July 1, 2009. The SLAMSP Fund allocation for 2009-10 was reduced by $10 million, for an estimated allocation of $90 million. Of the $90 million, $67.5 million was paid out in FY 2009-10 and $22,500,000 is expected to be paid out in FY 2011-12.

3. The MH/UCD was extended to October 31, 2010. It is estimated that the SLAMSP funding allocation for the 60-day extension is $16.667 million which is expected to be paid in FY 2011-12. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform section 1115(a) Medicaid Demonstration effective November 1, 2010, and funding for SLAMSP ceases as of October 31, 2010.

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

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

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

# MH/UCD—STABILIZATION FUNDING

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

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

## DESCRIPTION

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

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

**Background:**
Stabilization funding is provided as follows:

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

- Private Hospitals will receive total funds payment equal to the difference between:
  a. The Private Hospitals' aggregate payment increase, and
  b. The sum of $42.228 million and an additional amount, based on the formulas specified in W&I Code 14166.20.

- Distressed Hospitals will receive total funds payments equal to the lesser of $23.5 million or 10 percent of the total stabilization funding, with a minimum of $15.3 million.

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

# MH/UCD—STABILIZATION FUNDING

## REGULAR POLICY CHANGE NUMBER: 102

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

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

**Methodology:**

1. Stabilization funding is calculated after the interim reconciliation of the DPH interim payments is completed.

2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.

3. Stabilization funding to NDPHs, private hospitals, and distressed hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.

4. Once the final reconciliation is finalized, the Department will be able to determine the distribution of the stabilization funds.
   - Stabilization funds to DPHs, if any, will be GF only. DPHs will not receive the federal fund match.
   - Stabilization funds to NDPHs, if any, will be split. The Department will distribute 75% of any allocated NDPH stabilization funds directly and the remaining 25% will be transferred to the NDPH Supplemental Fund. Payments through the NDPH Supplemental fund are negotiated between the hospitals and the California Medical Assistance Commission (CMAC).
   - Stabilization funds to Private Hospitals, if any, will be split. The Department will distribute 66.4% of any allocated Private Hospital stabilization funds directly and the remaining 33.6% will be distributed to the Private Hospital Supplemental Fund. Payments through the Private Hospital Supplemental fund are negotiated between the hospitals and CMAC.
   - Distressed Hospital payments will be distributed as negotiated between the hospitals and CMAC.

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

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

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

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

# MH/UCD—STABILIZATION FUNDING

## REGULAR POLICY CHANGE NUMBER: 102

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

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

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

# MH/UCD—STABILIZATION FUNDING

## REGULAR POLICY CHANGE NUMBER: 102

The estimated stabilization payments are:

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

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

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

# MH/UCD—SAFETY NET CARE POOL

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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $1,949,000 | $42,735,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $1,949,000 | $42,735,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $1,949,000 | $42,735,000 |

## DESCRIPTION

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

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

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

In 2007, SB 474 (Chapter 518, Statutes of 2007) allocated an annual $100,000,000 of the SNCP FFP for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds were claimed using the CPEs of the County of Los Angeles or its DPHs. Expenditures from this fund are budgeted in the MH/UCD – South LA Preservation Fund policy change.

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

# MH/UCD—SAFETY NET CARE POOL

## REGULAR POLICY CHANGE NUMBER: 103

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

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

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

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

(In Thousands)

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

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

(In Thousands)

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

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

# BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

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

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

## DESCRIPTION

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

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

**Background:**
AB 1628 and SB 92 authorize the Department to claim federal funding for inpatient hospital services for certain inmates of CDCR correctional facilities. The inpatient hospital services would be those that are provided at hospitals that are off the grounds of the correctional facilities and the inmates would be those with family incomes at or below 133% of the Federal Poverty Level determined eligible by the Department for either the Medi-Cal program or the LIHP operated by the counties. The LIHP is established under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

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

CDCR/California Correctional Health Care Services (CCHCS) will forward applications to the Department for the purpose of determining LIHP eligibility. CDCR/CCHCS will pay the hospitals under contract for covered inpatient services. CDCR/CCHCS will provide paid claims data to the individual county programs for certification and attestation of the Certified Public Expenditures (CPEs) and allowable inpatient hospital services for reimbursement of federal funding at the usual FMAP.

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

# BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

**REGULAR POLICY CHANGE NUMBER: 104**

**Methodology:**

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

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

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

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

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

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

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

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

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

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

The estimated payments for inmates on a cash basis are:

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

**Funding:**

Title XIX FFP (4260-101-0890)

# MH/UCD—HEALTH CARE COVERAGE INITIATIVE

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

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

## DESCRIPTION

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

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

**Background:**
Under the MH/UCD, $180 million in federal funds is available annually to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10.

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

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

**Reason for Change from Prior Estimate:**
Updated claims information.

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

# MH/UCD—HEALTH CARE COVERAGE INITIATIVE

## REGULAR POLICY CHANGE NUMBER: 105

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

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

The estimated HCCI payments on a cash basis are:

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

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

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

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

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

## DESCRIPTION

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

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

**Background:**
Under the MH/UCD, $180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, $360 million of the funding was unused. On February 1, 2010, The Centers for Medicare and Medicaid Services (CMS) approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the SNCP.

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

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

2. AB 1653 (Chapter 218, Statutes of 2010) allows the State to retain up to $420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of the federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and

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

## REGULAR POLICY CHANGE NUMBER: 106

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

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

4. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional federal financial participation (FFP) for FY 2010-11 and FY 2011-12. The additional FFP due to these changes in FMAP is budgeted in the Federal Flex. & Stabilization – SNCP ARRA policy change.

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

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

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

# MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

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

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

## DESCRIPTION

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

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

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

Payments to the NDPHs will be from the NDPH Supplemental Fund using State General Fund and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers).

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

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

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

# MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 107

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

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

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

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

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

| | TF | SF | FFP |
|---|---|---|---|
| **FY 2010-11** | | | |
| FY 2009-10 Ending Balance | $1,802,000 | $901,000 | $901,000 |
| Appropriation (GF) | $3,800,000 | $1,900,000 | $1,900,000 |
| FY 2009-10 Interest Earned | $14,000 | $7,000 | $7,000 |
| Total | $5,616,000 | $2,808,000 | $2,808,000 |
| Cash Expenditures in FY 2010-11 | $2,274,000 | $1,137,000 | $1,137,000 |
| FY 2010-11 Ending Balance | $3,342,000 | $1,671,000 | $1,671,000 |
| **FY 2011-12** | | | |
| FY 2010-11 Ending Balance | $3,342,000 | $1,671,000 | $1,671,000 |
| Appropriation (GF) | $3,800,000 | $1,900,000 | $1,900,000 |
| FY 2010-11 Interest Earned | $6,000 | $3,000 | $3,000 |
| Total | $7,148,000 | $3,574,000 | $3,574,000 |
| **Cash Expenditures in FY 2011-12** | **$6,250,000** | **$3,125,000** | **$3,125,000** |
| FY 2011-12 Ending Balance | $898,000 | $449,000 | $449,000 |
| **FY 2012-13** | | | |
| FY 2011-12 Ending Balance | $898,000 | $449,000 | $449,000 |
| Appropriation (GF) | $3,800,000 | $1,900,000 | $1,900,000 |
| Est. FY 2011-12 Interest Earned | $4,000 | $2,000 | $2,000 |
| Est. 2007-08 Stabilization Transfer | $538,000 | $269,000 | $269,000 |
| Total | $5,240,000 | $2,620,000 | $2,620,000 |
| **Cash Expenditures in FY 2012-13** | **$4,698,000** | **$2,349,000** | **$2,349,000** |
| **Redirect Stabilization Fund to GF** | **$538,000** | **$269,000** | **$269,000** |
| FY 2012-13 Ending Balance | $4,000 | $2,000 | $2,000 |

# MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 107

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

# MH/UCD—DISTRESSED HOSPITAL FUND

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

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

## DESCRIPTION

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

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

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

- Emergency Services and Supplemental Payments (ESSP) Fund, Item 4260-601-0693 9SB 1255. Voluntary Governmental Transfer);
- Medi-Cal Medical Education Supplemental Payment Fund, Item 4260-601-0550;
- Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Fund, Item 4260-601-0549;
- Small and Rural Hospital Supplemental Payment Fund, Item 4260-601-0688.

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

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

# MH/UCD—DISTRESSED HOSPITAL FUND

## REGULAR POLICY CHANGE NUMBER: 108

**Methodology:**

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

2. The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR), effective November 1, 2010. No additional funding for the Distressed Hospital Fund was included in the BTR.

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

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

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

| **FY 2010-11** | **TF** | **SF** | **FFP** |
|---|---|---|---|
| FY 2009-10 Ending Balance | $ 3,444,000 | $ 1,722,000 | $ 1,722,000 |
| Transfer from Prior Supplement Funds | $ 4,788,000 | $ 2,394,000 | $ 2,394,000 |
| Estimated Interest Earned in Distressed Fund | $ 40,000 | $ 20,000 | $ 20,000 |
| Distressed Funds Available | $ 8,272,000 | $ 4,136,000 | $ 4,136,000 |
| Cash Expenditures in FY 2010-11 | $ 6,050,000 | $ 3,025,000 | $ 3,025,000 |
| FY 2010-11 Ending Balance | $ 2,222,000 | $ 1,111,000 | $ 1,111,000 |
| | | | |
| **FY 2011-12** | | | |
| FY 2010-11 Ending Balance | $ 2,222,000 | $ 1,111,000 | $ 1,111,000 |
| Transfer from Prior Supplement Funds | $ 20,000 | $ 10,000 | $ 10,000 |
| Estimated Interest Earned in Distressed Fund | $ 6,000 | $ 3,000 | $ 3,000 |
| Distressed Funds Available | $ 2,248,000 | $ 1,124,000 | $ 1,124,000 |
| **Cash Expenditures in FY 2011-12** | **$ 2,248,000** | **$ 1,124,000** | **$ 1,124,000** |
| FY 2011-12 Ending Balance | $ - | $ - | $ - |

**Funding:**

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

# LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

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

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

## DESCRIPTION

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

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

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

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

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

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

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

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

# LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

## REGULAR POLICY CHANGE NUMBER: 109

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

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

(In Thousands)

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

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

# MH/UCD & BTR—MIA-LTC

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

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

## DESCRIPTION

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

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

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

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

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

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

# MH/UCD & BTR—MIA-LTC

## REGULAR POLICY CHANGE NUMBER: 110

under the MH/UCD and BTR.

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the MIA-LTC programs.

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

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

The MIA-LTC federal reimbursements are:

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

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

# MH/UCD & BTR—BCCTP

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

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

## DESCRIPTION

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

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

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

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

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

# MH/UCD & BTR—BCCTP

## REGULAR POLICY CHANGE NUMBER: 111

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

**Methodology:**

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

2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the BCCTP program.

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

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

# MH/UCD & BTR—BCCTP

## REGULAR POLICY CHANGE NUMBER: 111

The BCCTP federal reimbursements are:

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

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

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

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

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

## DESCRIPTION

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

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

**Background:**
Under ARRA, the California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual Safety Net Care Pool (SNCP) federal funds allotment under the MH/UCD will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional $423.769 million federal funds available in the SNCP.

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

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

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

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

## REGULAR POLICY CHANGE NUMBER: 112

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

2. AB 1653 (Chapter 218, Statutes of 2010) allowed the state to retain up to $420 million from the portion of the Hospital Quality Assurance Revenue Fund (HQARF) set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for the QAF Hospital payment. $284.917 million of the total $420 million was applied to this policy change and paid in FY 2010-11.

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

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

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

The final reconciliations are as follows:

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

**Funding:**
Not Applicable

# MH/UCD & BTR—DPH INTERIM RATE

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

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

## DESCRIPTION

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

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

**Background:**
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, based on SPA 05-021, DPHs no longer received the California Medical Assistance Commission (CMAC) negotiated per diem rates for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds matching the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

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

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

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

# MH/UCD & BTR—DPH INTERIM RATE

## REGULAR POLICY CHANGE NUMBER: 113

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

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

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

# MH/UCD & BTR—DPH INTERIM RATE GROWTH

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

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

## DESCRIPTION

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

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

**Background:**
In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, based on SPA 05-021, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in hospital's costs. This growth increase is expected to be different from the former California Medical Assistance Commission (CMAC) negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

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

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

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

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

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

# MH/UCD & BTR—DPH INTERIM RATE GROWTH

## REGULAR POLICY CHANGE NUMBER: 114

5. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/50% FFP and are budgeted as 50% GF/50% FFP. The full adjustment is shown in the MH/UCD & BTR—DPH Interim Rate policy change.

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

The estimated additional costs for DPH interim rates are:

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

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

# HOSPITAL QAF - HOSPITAL PAYMENTS

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

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

## DESCRIPTION

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

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

**Background:**
AB 1383 authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 2009 through December 2010. The fee was deposited into the Hospital Quality Assurance Revenue Fund (HQARF) created by AB 188 (Chapter 645, Statutes of 2009). This fund is used to provide supplemental payments to private and non-designated public hospitals (NDPHs), grants to designated public hospitals (DPHs), and increased payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1653 (Chapter 218, Statutes of 2010) and SB 208 (Chapter 714. Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383. AB 1653 altered the methodology, timing, and frequency of supplemental payments, increased capitation payments, and increased payments to mental health plans. AB 1653 also allowed the State to retain up to $420 million from the portion of the QAF fund set aside for direct grants to DPHs for the State's use while the bill is in effect. In exchange, a portion of federal flexibility funding was allocated to the DPHs and was identical to the amount of the sum retained by the State from the QAF fund. The Department claimed these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and distributed those funds in conformity with the Hospital QAF payment schedule. SB 208 compressed the timeframe for collection of the QAF and distribution of supplemental payments, allowed accumulation of fees in the HQARF in order to make managed care payments, and altered the priority of payments.

# HOSPITAL QAF - HOSPITAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 115

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

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

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

**Methodology:**

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

2. First payment of the quality assurance fee from the hospitals was due October 8, 2010. On an accrual basis, this fee is expected to generate $0.44 billion in FY 2008-09, $1.76 billion in FY 2009-10, $1.9 billion in FY 2010-11, $2.6 billion in FY 2011-12, $2.8 billion in FY 2012-13, and $1.5 billion in FY 2013-14.

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

4. The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased Medi-Cal's Federal Medical Assistance Percentage (FMAP) by 11.59% from October 1, 2008, to December 31, 2010. HR 1586 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The additional federal funding of $25,326,000 due to ARRA, for SB 90 managed care payments in FY 2011-12, is budgeted in this policy change.

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

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

# HOSPITAL QAF - HOSPITAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 115

Payments to the hospitals are estimated to be:

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

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

# FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

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

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

## DESCRIPTION

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

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

**Background:**
Under this program, freestanding, non-hospital based clinics that are enrolled as Medi-Cal providers and are owned or operated by the State, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down FFP is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities.

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

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

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

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

# FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 116

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

Program payment amounts are estimated to be:

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

| | FY 2012-13 |
|---|---|
| Freestanding Outpatient Clinics for FY 2008-09 | $63,000,000 |
| Freestanding Outpatient Clinics for FY 2009-10 | $66,000,000 |
| Freestanding Outpatient Clinics for FY 2010-11 | $66,000,000 |
| **Total FFP** | **$195,000,000** |

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

# HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

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

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

## DESCRIPTION

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

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

**Background:**
A supplemental reimbursement program was created for publicly owned or operated hospital outpatient departments. Hospitals now receive outpatient supplemental payments based on CPEs for providing outpatient hospital care to Medi-Cal beneficiaries. The supplemental amount, when combined with the amount received from all other sources of Medi-Cal Fee for Service reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries by the participating facilities. The non-federal share used to draw down federal financial participation (FFP) is paid exclusively with funds from the participating facilities.

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

**Methodology:**
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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

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

# HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 117

Estimated costs are as follows:

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

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

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

# CAPITAL PROJECT DEBT REIMBURSEMENT

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

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

## DESCRIPTION

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

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

**Background:**
SB 1732 and SB 2665 authorize Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying hospital facilities, i.e., disproportionate share contract hospitals.

SB 1128 authorizes a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code.

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

**Methodology:**
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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

# CAPITAL PROJECT DEBT REIMBURSEMENT

## REGULAR POLICY CHANGE NUMBER: 118

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

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

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

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

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

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

# SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

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

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

## DESCRIPTION

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

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

**Background:**
This program creates a provision to allow an eligible public agency receiving reimbursement for specialty mental health services provided to Medi-Cal beneficiaries to also receive supplemental Medi-Cal reimbursement.

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

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

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

**Methodology:**
The Department will submit an attachment to the State Plan Amendment to the Center of Medicare and Medicaid Services to obtain approval for the new supplemental payment program. Upon approval, supplemental payments will be authorized retroactive to January 2009 and are expected to begin in FY 2012-13. Annual payments are estimated to be $110,886,000.

# SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

## REGULAR POLICY CHANGE NUMBER: 119

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

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

# NDPH IGT SUPPLEMENTAL PAYMENTS

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

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

## DESCRIPTION

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

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

**Background:**
AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset GF costs of Medi-Cal children's health services.

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

**Methodology:**
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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

(In Thousands)

# NDPH IGT SUPPLEMENTAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 120

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

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

# IGT FOR NON-SB 1100 HOSPITALS

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

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

## DESCRIPTION

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

**Authority:**
Welfare and Institutions Code, section 14164

**Background:**
This program provides general authority for the Department to accept IGTs from a governmental entity in the State in support of the Medi-Cal program.

Non-SB 1100 hospitals may request that the Department accept an IGT for federal matching and return the IGT transfer funds and federal match funds to the non-SB 1100 hospital. This policy change provides authority to accept the IGTs and match them with federal funds, and is a placeholder for possible IGT requests.

The Department may enter into an interagency agreement (IA) with a county to accept an IGT to the Department to be matched with federal funds and distributed to a hospital designated by the county or health care district.

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

**Methodology:**
Not applicable

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

# IGT FOR NON-SB 1100 HOSPITALS

## REGULAR POLICY CHANGE NUMBER: 121

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

# FFP FOR LOCAL TRAUMA CENTERS

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

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

## DESCRIPTION

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

**Authority:**
Welfare and Institutions Code Sections 14164 and 14087.3

**Background:**
Under this program, Los Angeles and Alameda Counties submit IGTs to the Medi-Cal program to be used as the non-federal share of costs in order to draw down Title XIX federal funds. The Department uses the funds to make enhanced payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

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

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

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

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

# CERTIFICATION PAYMENTS FOR DP-NFS

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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| FULL YEAR COST - TOTAL FUNDS | $40,678,000 | $32,000,000 |
| - STATE FUNDS | $0 | $0 |
| PAYMENT LAG | 1.0000 | 1.0000 |
| % REFLECTED IN BASE | 0.00 % | 0.00 % |
| APPLIED TO BASE | | |
| TOTAL FUNDS | $40,678,000 | $32,000,000 |
| STATE FUNDS | $0 | $0 |
| FEDERAL FUNDS | $40,678,000 | $32,000,000 |

## DESCRIPTION

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

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

**Background:**
The acute care hospital must be owned and operated by a public entity, such as a city, county, or health care district. This program is designed to allow DP-NFs to claim FFP on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. This bill provides supplemental reimbursement to a DP-NF of an acute care hospital, as described above, for delivering services to Medi-Cal beneficiaries.

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

**Methodology:**
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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

# CERTIFICATION PAYMENTS FOR DP-NFS

## REGULAR POLICY CHANGE NUMBER: 123

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

4. Payments are not made through the fiscal intermediary; consequently, they are not reflected in the Medi-Cal base trend data and must be budgeted in this policy change.

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

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

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

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

# MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

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

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

## DESCRIPTION

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

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

**Background:**
A supplemental program was created for hospitals providing a disproportionate share of outpatient services. Eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year. Since the Department accelerated the fourth quarter payment in FY 2010-11 in order to maximize federal matching funds under the Education, Jobs and Medicaid Assistance Act of 2010, there will be one less quarterly payment in FY 2011-12.

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

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

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

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

# MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

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

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

## DESCRIPTION

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

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

**Background:**
This program was created to provide SRHs with increased reimbursement rates. Eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year. Since the Department accelerated the fourth quarter payment in FY 2010-11 in order to maximize federal matching funds under the Education, Jobs and Medicaid Assistance Act of 2010, there will be one less quarterly payment in FY 2011-12.

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

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

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

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

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

# STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

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

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

## DESCRIPTION

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

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

**Background:**
Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are operated by the State are also eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. Since facilities must submit cost reports and the Department must certify expenditures before FFP can be claimed, supplemental payments for services provided during a fiscal year will not be issued until the following fiscal year. Supplemental payments for state veterans' homes began in FY 2010-11.

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

**Methodology:**
1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.

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

# STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 126

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

Program payment amounts are estimated to be:

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

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

# ARRA HITECH - PROVIDER PAYMENTS

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

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

## DESCRIPTION

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

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

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

The Department will expand the current Medicaid Management Information Systems (MMIS) Health Information Exchange (HIE) for e-prescribing to ensure Medi-Cal providers are qualified for meaningful use of their electronic health records and to add automated consent features available to the Medi-Cal beneficiary community. It is estimated that approximately 20,000 to 22,000 providers and 435 hospitals will be eligible for incentive payments over the life of the program. Provider payments are paid with 100% federal funds.

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

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

# ARRA HITECH - PROVIDER PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 133

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

**Methodology:**

1. Payments to the providers began in December 2011.

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

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

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

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

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

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

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

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

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

# ARRA HITECH - PROVIDER PAYMENTS

## REGULAR POLICY CHANGE NUMBER: 133

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

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

# ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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**

| | DHCS FFP | County Match | IA # |
|---|---|---|---|
| **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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 |
|---|---|---|---|---|
| $8,074 | $32,294 | **$40,368** | **$16,935** | **$23,433** |

**FY 2012-13** (In Thousands)

| ICF-DD Admin Fee | QA Fee Reimbursement | Total Funds | DHCS GF | Total FFP |
|---|---|---|---|---|
| $2,284 | $9,134 | **$11,418** | **$5,709** | **$5,709** |

**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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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:**

| | FY 2011-12 |
|---|---|
| Total General Fund Cost | **$7,620,000** |

**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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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.

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | Reimbursement | IA # |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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) | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | $510 | $1,463 |
| FY 2010-11 Base expenditures | $19,677 | $19,677 |
| Total expenditures | $20,187 | $21,140 |

**Funding:** (In Thousands)

| **FY 2011-12:** | | TF | GF | FFP |
|---|---|---|---|---|
| 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**: | | TF | GF | FFP |
|---|---|---|---|---|
| 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

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

## DESCRIPTION

**Purpose:**
This policy change 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 | $24,589,000 |
| Total CTPS/Prop. 99 | $95,287,000 |
| GF | -$95,287,000 |
| **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 | $24,589,000 |
| Total CTPS/Prop. 99 | $83,640,000 |
| GF | -$83,640,000 |
| **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

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

## DESCRIPTION

**Purpose:**
This policy change 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

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

## DESCRIPTION

**Purpose:**
This policy change 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:

| | Total Funds | CLPP Funds |
|---|---|---|
| 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.

| | Total Funds | CLPP Funds |
|---|---|---|
| **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

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

## DESCRIPTION

**Purpose:**
This policy change estimates the 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) | TF | GF | Hosp. QA Rev Fund |
|---|---|---|---|
| **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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | TF | GF |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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:**

| Project Number | Impl. Date | Title | FY 2012-13 Savings |
|---|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | **$5,823,000** | **$6,500,000** |

**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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 ÷ 12 months x 4 months = $6,667,000 TF

| (In Thousands) | FY 2011-12 | | FY 2012-13 | |
|---|---|---|---|---|
| | TF | GF | TF | GF |
| Provider Overpayments | $ -667 | $ -333 | $ -2,000 | $ -1,000 |
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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:

| | Original PMPM | ARRA PMPM | Difference |
|---|---|---|---|
| 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**

| Fiscal Year applied | Credit |
|---|---|
| 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**

| | Estimated Savings |
|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 that 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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)<br>**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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | -$122,466,000 | -$61,233,000 |
| Defer Managed Care Payment | $24,060,000 | $12,030,000 |
| **Total** | **-$98,406,000** | **-$49,203,000** |

**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

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

## DESCRIPTION

**Purpose:**
This policy change estimates the 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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:**
1. 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:

| | FY 2012-13 |
|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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) | Gross Premium Tax | FFP | TF |
|---|---|---|---|
| **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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

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

## DESCRIPTION

**Purpose:**
This policy change estimates the 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

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

## DESCRIPTION

**Purpose:**
This policy change estimates the 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:

| | FY 2012-13 |
|---|---|
| **Total Gross Premium Tax** | **$169,847,000** |
| **GF** | **-$169,847,000** |
| **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 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 |
|---|---|---|
| *California Hospital Association, et al. v. Douglas et al.* | $37,100 | $9,671 |
| *Managed Pharmacy Care, et al. v. Sebelius, et al.* | $359,508 | $88,311 |
| *California Medical Transportation Association v. Douglas, et al.* | $14,116 | $3,726 |
| *California Medical Association, et al. v. Douglas, et al.* | $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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 annual x 0.5 year x 0.662 (lag) = $100,456,000 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 annual x 0.5 year = $195,047,000 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 October 2012.

   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 $77,489,000 TF ($38,744,500 GF) costs 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) | **Annual FFP** |
|---|---|
| FFS | $303,493 |
| Managed care | $390,093 |
| | $693,586 |

| **FY 2012-13** | **TF** |
|---|---|
| FFS (lagged) | $100,456 |
| Managed care | $195,047 |
| Total FFP | $295,503 |
| Rates Costs | $77,489 |
| **Total** | **$372,992** |

**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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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.

| Date of Overpayment Discovery | FY 2011-12 Repayment | | FY 2012-13 Repayment | |
|---|---|---|---|---|
| 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** | GF | **$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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | | CPE | Regular FFP | ARRA | Total FFP |
|---|---|---|---|---|---|
| | 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 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | ($16,916,000) |
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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** | **$411,121,000** |

**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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 x 4% = 16 beneficiaries with specific mutation

   16 x $300,000 = $4,800,000 TF annually

   $4,800,000 ÷ 12 x 5 = $2,000,000 TF ($1,000,000 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 |

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

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

## DESCRIPTION

**Purpose:**
This policy change estimates the 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 | **$0** |

**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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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**

| | TF | GF | FF | IGT |
|---|---|---|---|---|
| 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**

| | Net Payment |
|---|---|
| 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**

| | TF | GF | FF | IGT |
|---|---|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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)

| Demonstration Year (DY) | Due to NDPHs |
|---|---|
| 2012-13 | $30,000 |

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

(In Thousands)

| FY 2012-13 | TF | FF |
|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | TF | FF | IGT |
|---|---|---|---|
| DY 2012-13 | $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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 SUPPLEMETAL PAYMENT

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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 SUPPLEMETAL PAYMENT

## REGULAR POLICY CHANGE NUMBER: 205

**Methodology:**
The estimated fiscal impact is:

**FY 2012-13**

| | TF | SF | FFP |
|---|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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)

| 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 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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 | TF | FF | GF | SF(HQARF) |
|---|---|---|---|---|
| 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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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) | DHCS FFP | CDSS GF | County |
|---|---|---|---|
| **FY 2012-13** | $142,417 | $92,571 | $49,846 |

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

| (In Thousands) | DHCS FFP | CDSS GF | County |
|---|---|---|---|
| **FY 2012-13** | $183,003 | $118,952 | $64,051 |

| Total FY 2012-13 Savings | DHCS FFP |
|---|---|
| 7% Across-the-Board Reduction to IHSS Hours | $142,417 |
| Eliminate Domestic and Related Services for Recipients Living in SLR | $183,003 |
| **Total DHCS FFP for FY 2012-13** | **$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

| | FY 2011-12 | FY 2012-13 |
|---|---|---|
| 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)

# MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX


| POLICY CHANGE NUMBER | POLICY CHANGE TITLE |
|---|---|
| | **ELIGIBILITY** |
| 1 | FAMILY PACT PROGRAM |
| 2 | BREAST AND CERVICAL CANCER TREATMENT |
| 3 | CHDP GATEWAY - PREENROLLMENT |
| 4 | BRIDGE TO HFP |
| 5 | CRAIG V. BONTA DISALLOWANCE |
| 6 | LANTERMAN DEVELOPMENTAL CENTER CLOSURE |
| 7 | REFUGEES |
| 8 | MEDI-CAL INPATIENT HOSP. COSTS FOR INMATES |
| 9 | LOMELI V. SHEWRY |
| 10 | 250% WORKING DISABLED PROGRAM CHANGES |
| 11 | CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN |
| 12 | NEW QUALIFIED ALIENS |
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