

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

# ASSUMPTIONS

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**MEDI-CAL ASSUMPTIONS**  
**May 2012**  
**FISCAL YEARS 2011-12 & 2012-13**

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**INTRODUCTION**

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, can be segregated into ~~two~~ **three** main components: (1) the **Fee-for-Service (FFS) base expenditures**, (2) the **base policy changes**, and (23) the ~~adjustments to the base~~ **regular policy changes**. The **FFS** base estimate is the anticipated level of **FFS** program expenditures assuming that there will be no changes in program direction, and is derived from a 36-month historical trend analysis of actual expenditure patterns. **The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures.** The ~~adjustments to the base~~ **regular policy changes** are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the ~~historical data~~ **base expenditures**.

The combination of these ~~two~~-three estimate components produces the final Medi-Cal Estimate.

*Note: A list of acronyms and abbreviations has been provided following the Assumptions Section.*

### **FEE-FOR-SERVICE BASE ESTIMATES**

The **FFS** base expenditure projections for the Medi-Cal estimate are developed using regression equations based upon the most recent 36 months of actual data. Independent regressions are run on user, claims/user or units/user and \$/claim or \$/unit for each of 18 aid categories within 12 different service categories. The general functional form of the regression equations is as follows:

$$\begin{aligned} \text{USERS} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}, \text{Eligibles}) \\ \text{CLAIMS/USER} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}) \\ \$/\text{CLAIM} &= f(\text{TND}, \text{S.DUM}, \text{O.DUM}) \end{aligned}$$

WHERE:	USERS	= Monthly Unduplicated users by service and aid category.
	CLAIMS/USER	= Total monthly claims or units divided by total monthly unduplicated users by service and aid category.
	\$/CLAIM	= Total monthly \$ divided by total monthly claims or units by service and aid category.
	TND	= Linear trend variable.
	S.DUM	= Seasonally adjusting dummy variable.
	O.DUM	= Other dummy variables (as appropriate) to reflect exogenous shifts in the expenditure function (e.g. rate increases, price indices, etc.).
	Eligibles	= Actual and projected monthly eligibles for each respective aid category incorporating various lags based upon lag tables for aid category within the service category.

Following the estimation of coefficients for these variables during the ~~base~~ period **of historical data**, the independent variables are extended into the projection period and multiplied by the appropriate coefficients. The monthly values for users, claims/user and \$/claim are then multiplied together to arrive at the monthly dollar estimates and summed to annual totals by service and aid category.

## ELIGIBILITY: NEW ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

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“PC” refers to “Policy Change”.

“PC-1” means the fiscal impact of this assumption is in Policy Change 1.

“PC-BA” indicates the fiscal impact is a base adjustment or other part of the base.

“PC-CA” means there is a fiscal impact on County Administration.

“PC-OA” means there is a fiscal impact on Other Administration.

“PC-NA” means there is no fiscal impact or that the fiscal impact is unknown.

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		C/Y	B/Y	
E 1	(OA-51) <b><u>(OA-63)</u></b>	X	X	<p><u>Single Point of Entry</u></p> <p>The Department and the Managed Risk Medical Insurance Board (MRMIB) developed an application form for the Healthy Families Program (HFP), which is also used as a screening tool for the Medi-Cal children's percent programs. This form is sent to a Single Point of Entry (SPE), where it is screened to determine whether it should be forwarded to a county welfare department (CWD) for a Medi-Cal determination for the children's percent programs or to MRMIB for a Healthy Families determination.</p> <p>The Department pays the federal Title XIX and the federal Title XXI share for the Medi-Cal applications through an interagency agreement with MRMIB.</p> <p><b><u>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 as targeted low-income children.</u></b></p>
E 2	(PC-4) <b><u>(PC-168)</u></b>	X	X	<p><u>Bridge to HFP</u></p> <p>The one-month Bridge from Medi-Cal to Healthy Families is currently for children who become ineligible for full-scope, zero share-of-cost(SOC) Medi-Cal or are eligible for Medi-Cal with a SOC. To be eligible for this Bridge, a child must have income at or below the Healthy Families income standard of 250% of poverty (although the use of an income disregard effectively raises the upper limit to more than 250% of poverty). Title XXI federal funding is used for this additional coverage. Medi-Cal managed care plan members remain enrolled in the managed care plan during the one month of additional eligibility. Plans receive an additional capitation payment for each of these member months.</p> <p><b><u>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.</u></b></p>
E 3	(PC-13)	X	X	<p><u>Resource Disregard – % Program Children</u></p> <p>Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits. Enhanced federal funding is available through State Children's Health Insurance Program (SCHIP).</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 4	(PC-12)	X	X	<p><u>New Qualified Aliens</u></p> <p>The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), as amended, specifies that federal funding is not available for full-scope Medi-Cal services for most Qualified Nonexempt Aliens who enter the country on or after August 22, 1996, for the first five years they are in the country. Most New Qualified Aliens are only eligible for FFP for emergency services and pregnancy-related services. California is continuing to provide full-scope Medi-Cal services to aliens who have satisfactory immigration status under the pre-Welfare Reform laws. The cost of nonemergency services provided to the New Qualified Aliens is being identified through a retroactive tracking system and the federal government is being reimbursed on a retroactive basis for the FFP paid that is not available for these services.</p> <p><del>Welfare Reform</del> <b>PRWORA</b> requires deeming an alien's sponsor's income and resources for Medicaid. Once a New Qualified Alien has been in the country for five years and the federal sponsored alien rules are applied, FFP is available for all services. The Centers for Medicare &amp; Medicaid Services (CMS) has not issued instructions on how the sponsored alien rules are to be implemented by the states. The Department will continue to claim FFP for nonemergency services for sponsored persons who have been here for more than five years until those instructions are issued.</p>
E 5	(PC-7) (Reworded)	X	X	<p><u>Refugees</u></p> <p>The federal Refugee Act of 1980 provides states with 100% of a State's Medicaid cost of services to Refugee Cash Assistance and Refugee Medical Assistance programs for up to eight months from the date of arrival in the United States, date of final grant of asylum, and date of certification for trafficking victims.</p> <p>California's Refugee Resettlement Program federal grant is administered by the California Department of Public Health (CDPH) and the Department invoices CDPH for the reimbursement of the Medical Assistance Program expenditures.</p>
E 6	(OA-16)	X	X	<p><u>SSA Costs for Health Coverage Information</u></p> <p>The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for SSI/SSP recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 7	(OA-6)	X	X	<u>Postage &amp; Printing</u>
<p>Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Postage and printing costs may be charged to local assistance if the postage and printing is for items that will be sent to or used by Medi-Cal beneficiaries. Beginning in October 2008, the design, translation, focus testing and printing of certain informing and application forms and the mailing to beneficiaries or distribution to community based organizations and counties are performed by the Health Care Options vendor. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees, and at least every 3 years to existing beneficiaries. Postage and printing costs for the HIPAA NPP are included in this item.</p> <p>Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are included as a 100% General Fund cost.</p>				
E 8	(CA-9)	X	X	<u>Systematic Alien Verification Entitlement System</u>
<p>The federally mandated Systematic Alien Verification Entitlement (SAVE) system was implemented in California on October 1, 1988. This system allows State and local agencies to make inquiries from a federal database to obtain information on the immigration status of aliens applying for entitlement benefits. The Department conducted an evaluation of the various modes available to access SAVE, and chose the existing Income and Eligibility Verification System to provide that access. County administrative costs for using the SAVE system for Medi-Cal eligibility purposes are reimbursed 100% by the federal government.</p>				
E 9	(OA-43)	X	X	<u>Maternal and Child Health-CDPH</u>
<p>Federal matching funds are available for county administrative costs relating to the following services for Medi-Cal eligible women, infants, children, and adolescents: (1) reduction of high death rate for African-American infants; (2) case management and follow-up services for improving access to early obstetrical care for pregnant women; (3) recruitment and technical assistance for providers under the Comprehensive Perinatal Services Program; (4) general maternal and child health scope of work local program activities, including perinatal education, services and referral; and (5) case management for pregnant teens, education and prevention of subsequent pregnancies.</p>				

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

				Effective July 1, 2009, all GF was eliminated from the Maternal and Child Health programs. Local agencies continue to match Title XIX funds with Certified Public Expenditures.
E 10	(OA-53)	X	X	<p><u>Outreach – Children</u></p> <p>The Budget Act of 1997 and AB 1572 (Chapter 625, Statutes of 1997 established funding for children’s outreach. Activities included media, public relations, collateral, certified application assistance, and a toll-free line.</p> <p>In the Budget Act of 2003, outreach was limited to funding of a toll-free line. An Interagency Agreement with MRMIB was executed to fund the toll-free line with MAXIMUS starting January 1, 2004.</p> <p><b><u>Children enrolled in the HFP will be transitioned to the Medi-Cal Program beginning October 1, 2012. The Department will continue to fund the toll-free line, but the interagency agreement with MRMIB will be eliminated.</u></b></p>
E 11	(CA-2)	X	X	<p><u>Statewide Automated Welfare System (SAWS)</u></p> <p>The Statewide Automated Welfare Systems (SAWS) consist of three county consortium systems: the Los Angeles Eligibility Automated Determination Evaluation and Reporting (LEADER), the Consortium-IV (C-IV) and the CalWORKs Information Network (CalWIN).</p> <p>The SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.</p> <p>The LEADER is the automated system for Los Angeles County and it is currently in the maintenance and operation phase. The County began the process to replace the LEADER system and has completed contract negotiations with the successful bidder (Accenture). OSI and the County have submitted the LEADER Replacement System (LRS) development contract to the federal oversight agencies for their review and approval. While the replacement system is being developed, the County received state and federal approval to extend the existing LEADER maintenance and operations contract for an additional two years, through April 2013, with up to two optional one-year extensions beyond that date. The two one-year extensions are subject to state and federal approvals.</p> <p>The CalWIN consortium is fully implemented in all 18 counties and is currently in the maintenance and operation phase.</p> <p>The C-IV system is fully implemented in 39 counties and is currently in the maintenance and operation phase.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 12	(CA-1)	X	X	<p><u>CalWORKs Applications</u></p> <p>Beginning in 1998 a portion of the costs for CalWORKs applications can be charged to Medi-Cal. CDSS has amended the claim forms and time study documents completed by the counties to allow CalWORKs application costs that are also necessary for Medi-Cal eligibility to be shared between the two programs.</p>
E 13	(PC-3) (PC-FI)	X	X	<p><u>CHDP Gateway</u></p> <p>In order to help ensure that all children have access to medical care, the CHDP Gateway program was implemented July 1, 2003. Through this program, children receiving a CHDP screen are pre-enrolled in Medi-Cal/Healthy Families for up to two months of full-scope benefits, during which time the family can choose to apply for continuing Medi-Cal/Healthy Families coverage. To facilitate this application, each child for whom the family indicates a desire for continuing Medi-Cal/Healthy Families coverage is sent a CHDP cover letter and Healthy Families application form that is also used to screen for the Medi-Cal children's percent programs. The application contains a toll-free telephone number available to families who have questions about the program, and is printed in twelve languages. The Healthy Families application is returned to the Single Point of Entry (SPE) and is screened for the Medi-Cal children's percent programs and forwarded to the county for a Medi-Cal determination or to Healthy Families.</p> <p>The state-funded CHDP Program continues to provide screens to children eligible for limited-scope Medi-Cal. Effective October 1, 2003, the federal share of funding for the pre-enrollment costs is Title XXI funds, as required by federal statute. Funding ratios are 65% FFP/35% GF for children with income between Medi-Cal limits and 250% of poverty. For children with income below Medi-Cal limits, the sharing ratio is 50% FFP/50% GF.</p> <p>Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment, so claims are no longer Title XXI funded. Children screened to HFP continue to be claimed under Title XXI.</p> <p>Medi-Cal receives funding from the Childhood Lead Poisoning Prevention (CLPP) Fund to cover blood lead testing as part of the CHDP Health Assessment for young children with risk factors for lead poisoning.</p> <p><b><u>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</u></b></p>

**ELIGIBILITY: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y**Program, and children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal.**

E 14	(OA-60)	X	X	<u>Merit System Services for Counties</u>	Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. As many counties do not have a civil service system, the Department contracts with the State Personnel Board for Merit System Services to perform as a personnel board for those counties. Merit System Services administers a civil service system for employment and retention of Medi-Cal staff in 30 County Welfare Departments (CWD) and oversight in the other 28 counties.
E 15	(CA-5) (CA-7)	X	X	<u>County Cost of Doing Business</u>	Based on the Medi-Cal County Administration Cost Control Plan, county welfare department administrative cost increases for Medi-Cal eligibility determinations are limited to a maximum increase of the California Necessities Index (CNI) as calculated by the Department of Finance, or state employee salary increases, whichever is greater. The FY 2011-12 increase is 1.92%. <del>The</del> <u>and</u> FY 2012-13 increase is expected to be <b>increases are 1.92% and will be updated in May 2012 Medi-Cal Estimate 2.98%, respectively.</b>
E 16	(CA-4)	X	X	<u>Los Angeles County Hospital Intakes</u>	Los Angeles County uses Patient Financial Services Workers (PFSWs) to provide intake services for Medi-Cal applications taken in Los Angeles County hospitals. Welfare and Institutions (W&I) Code Section 14154 limits the reimbursement amount for PFSW intakes to the rate that is applied to Medi-Cal applications processed by the Los Angeles County Department of Social Services (DPSS) eligibility workers. The federal share for any costs not covered by the DPSS rate is passed through to the county.
E 17	(CA-3)	X	✕	<u>Eligible Growth</u>	The county administrative cost base estimate does not include costs anticipated due to the growth in the number of Medi-Cal only eligibles. Funds are added through a policy change item based on the cost impact of the expected growth in the average monthly number of Medi-Cal only eligibles. The number is adjusted with each Estimate with updates of the latest base eligible count. The policy change presumes that counties will hire staff to process the new applications and maintain the new cases.

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 18	(OA-48)	X	X	<p><u>Department of Social Services Administrative Costs</u></p> <p>The Department provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS), via interagency agreements (IAs), for the administrative costs related to services provided to Medi-Cal beneficiaries under the In-Home Supportive Services Personal Care Services Program (IHSS PCSP), the Child Welfare Services/Case Management System (CWS/CMS), and the Statewide Automated Welfare System (SAWS), and the Independence Plus Option Section 1915 (j) (IPO) waiver.</p>
E 19	(OA-61)	X		<p><u>Health-e App</u></p> <p>Health-e App is an electronic, web-based Healthy Families application used to screen for Medi-Cal children's percent programs. It is intended to reduce the application processing time so that children can obtain needed Healthy Families or Medi-Cal coverage as quickly as possible and is available to enrollment entities in all California counties. The California Health Care Foundation (CHCF) that owns the system has made system changes to enable the general public to use Health-e App.</p> <p>The Department pays for the federal Title XIX share of this cost through an interagency agreement with MRMIB. MRMIB budgets the federal Title XXI share of the cost. The CHCF grants the matching funds for the federal Title XIX and Title XXI funding.</p> <p>The implementation of Health-e App public access statewide was December 2010. In FY 2011-12 costs include the design of an outreach campaign which will promote the statewide launch of Health-e App public access.</p>
E 20	(PC-15) (OA-25)	X	X	<p><del>Program Integrity and Eligibility Verification</del> <b><u>PARIS-Interstate and PARIS-Federal</u></b></p> <p><del>The Department is implementing two activities to increase program integrity and ensure appropriate enrollment into the Medi-Cal Program. The two areas are the Public Assistance Reporting Information System (PARIS) and Asset and Eligibility Verification.</del></p> <p>The <b><u>PARIS-Public Assistance Reporting Information System (PARIS)</u></b> matches allow states to compare beneficiary information with the U.S. Department of Defense, the U.S. Office of Personnel Management and other states to identify federal pension income or health benefits as well as changes in residence and public assistance benefits in other states.</p> <p><del>Under the Asset and Eligibility Verification program, the Department will procure a direct service contractor beginning in FY 2011-12 to provide</del></p>

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				<del>counties with electronic data on aged, blind and disabled (ABD) applicants and beneficiaries from financial institutions that could indicate assets and property not reported by the applicant or beneficiary.</del>
E 21	(CA-11)	X		<p><u>County Administration Reconciliation</u></p> <p>Within two years following the end of a fiscal year, county administrative expenditures are reconciled to the county administration allocation for the applicable fiscal year. In FY 2012-13, the Department will complete the reconciliation for FY 2010-11 <b>and FY 2011-12</b>.</p>
E 22	(CA-6)	X	X	<p><u>Low-Income Subsidy Applications Treated as Medi-Cal Applications</u></p> <p>Beginning January 1, 2010, the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 requires all states to process SSA Low-Income Subsidy (LIS) applications (Part D) as an application for the Medicare Savings Program (MSP). Counties have also been instructed to use the LIS application as an application for Medi-Cal. The date the SSA receives a LIS application will also be considered the date of the state Medi-Cal application, thus starting the 45-day clock for determining Medi-Cal eligibility. Since the LIS applications do not contain enough information to determine Medi-Cal eligibility, the counties will have to establish files in MEDS and request additional information from all LIS applicants on the SSA lists. This federal requirement will result in an increase in caseload duties for county eligibility workers and additional benefit costs.</p>
E 23	(OA-31)	X	X	<p><u>Q5i Automated Data System Acquisition</u></p> <p>The Department acquired the Q5i automated quality control data system on June 10, 2011. There will be ongoing costs for associated software, maintenance and support. The Q5i system will be used to support quality control efforts for the following state and federally mandated programs: Medi-Cal Eligibility Quality Control, County Performance Standards, Payment Error Rate Measurement and Anti-Fraud/Program Integrity.</p>
E 24	(OA-14)	X	X	<p><u>Medi-Cal Eligibility Data System (MEDS)</u></p> <p>MEDS is currently the only statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status.</p> <p>Funding is required for MEDS master Client Index maintenance, data matches from various federal and state agencies, SSI termination</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

process support, Medi-Cal application alerts, MMA Part D buy-in process improvements, eligibility renewal process, and reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities. Costs **currently** are offset by reimbursements made from other state departments using MEDS.

In addition, maintenance funding is required for the Business Objects (BO) software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS.

E 25	(OA-52)	X	X	<p><u>Veterans Benefits</u></p> <p>AB 1807 (Chapter 1424, Statutes of 1987) permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the Department of Veterans Affairs.</p>
E 26	(PC-11)	X	X	<p><u>CHIPRA – Elimination of 5-Year Bar on Full-Scope Medi-Cal for Children and Pregnant Women</u></p> <p>The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that immigrants who are designated as “Qualified Aliens” are eligible for full-scope Medi-Cal with federal financial participation (FFP) if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the U.S. for less than five years and pays for nonemergency services with 100% State funds if FFP is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services). CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children or pregnant women even if they have been in the U.S. for less than five years. The Department has received federal approval to implement this option effective April 1, 2009.</p>
E 27	(PC-6)	X	X	<p><u>Lanterman Developmental Center Closure</u></p> <p>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 will receive services through the fee-for-service (FFS) system.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 28	(PC-10)	X	X	<p><u>250% Working Disabled Program (WDP) Changes</u></p> <p>The WDP, established in April 2000, allows for employed individuals with disabilities to earn up to 250% of the federal poverty level and receive full scope Medi-Cal benefits. All eligible individuals and couples are required to pay a monthly premium based on their countable income.</p> <p>AB 1269 (Chapter 282, Statute of 2009) requires the Department to implement changes to the program 30 days after ARRA enhanced federal funding ends on June 30, 2011. The provisions are:</p> <ol style="list-style-type: none"> <li>1. Exemption of disability income that converts to retirement income.</li> <li>2. Exemption of retained income from the resource calculation when held in a separately identifiable account and not comingled with other resources.</li> <li>3. Allows beneficiaries to remain eligible for Medi-Cal up to 26 weeks while unemployed, provided premiums continue to be paid.</li> <li>4. Allows the monthly premium calculation to be based on five percent of an individual's countable income.</li> </ol> <p>However, under the Maintenance of Effort (MOE) requirements of the Patient Protection and Affordable Care Act (PPACA) 2010, states cannot implement more restrictive Medicaid eligibility policies, procedures or methodologies without the possibility of losing federal funding for their Medicaid programs; <del>the</del> <b>The</b> MOE provisions are in effect until January 1, 2014 for adults and 2019 for children. Therefore, the Department will not be able to implement provision four at this time, since it would be more restrictive. The first three provisions <del>will be</del> <b>were</b> implemented <b>effective</b> August 1, 2011.</p>
E 29	(CA-10) (CA-8)	X	X	<p><u>Reduction of CNI-Based COLA to Counties</u></p> <p>The Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process will be eliminated for FY 2011-12 and FY 2012-13.</p>
E 30	(PC-8) <u>(OA-65)</u>	X	X	<p><u>Medi-Cal Inpatient Services for Inmates</u></p> <p>AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department and the California Department of Corrections and Rehabilitation (CDCR) to claim federal reimbursement for inpatient hospital services for Medi-Cal eligible adult inmates in State correctional facilities when these services are provided off the grounds of the facility. Effective April 1, 2011, the Department <del>will accept</del> <b>began accepting</b> Medi-Cal applications from the California Correctional Health Care Services (CCHCS) for eligibility determinations. Claims will be processed retroactive to <del>January 1, 2011</del> <b>November 1, 2010</b>. The Department will budget the FFP <b>for</b></p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**services and CDCR administrative costs** and CDCR will continue to budget the GF. Previously these services were paid by CDCR with 100% GF.

E 31 (PC-9)    X        X        Lomeli, et al., v. Shewry

The Department finalized a settlement of the *Lomeli, et al., v. Shewry* lawsuit, which alleged that the Department did not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage. ~~Once system changes are implemented~~ **As a result**, the Department ~~will send~~ **sends** notices to new SSI applicants who did not have Medi-Cal eligibility for all three months before applying for SSI and new SSI recipients, informing them of the availability of retroactive coverage.

E 32 (PC-5)    X        Craig v. Bontá Disallowance

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

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 for the period of April 2003 through September 2004.

E 33 (PC-14)    X        X        PARIS-Veterans Match

The federal Public Assistance and Reporting Information System (PARIS) is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances. The PARIS–Veterans match allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs.

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 healthcare costs from the Medi-Cal program to the United States Department of Veterans Affairs (USDVA). The Department implemented a Veterans Match Pilot Program on July 1, 2009, which filters the PARIS match results and focuses outreach efforts on veteran Medi-Cal beneficiaries receiving long term care services in three counties.

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 34	(PC-168) (CA-12) (OA-63) <b>(PC-FI)</b>	<u>X</u>	X	<p><u>Shift of Healthy Families Children to Medi-Cal</u></p> <p>Effective October 1, 2012, children <b>enrolled</b> in the HFP <del>who have attained six years of age but not attained 19 years of age, with incomes above 100% and up to and including 250% of the federal poverty level</del> will be shifted to the Medi-Cal program <b><u>over a nine-month phased-in period</u></b>. Coverage of this population under Medicaid programs is permissible pursuant to <del>Section 1902(a)(10)(A)(ii)(XIV) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIV))</del> to provide full scope Medi-Cal benefits <del>with no share of cost to such eligible children who are optional targeted low-income children pursuant to 1905(u)(2)(B) of the Social Security Act (42 U.S.C. section 1396d(u)(2)(B))</del>, with family incomes <del>above 100% and up to and including 250%</del><b>200%</b> of the federal poverty level (<b>FPL</b>).</p> <p><b><u>Assets will be exempt for these children and an income disregard will be applied for children with incomes between 200% and 250% of the FPL, creating an effective income level not to exceed 200% of the FPL. Individuals with incomes above 150% and up to 200% of the FPL will be subject to premiums at the same level of the Community Provider Plan (CPP) option as used under the current HFP.</u></b></p> <p>Consistent with the ACA, <del>these</del> children <b><u>with incomes up to 133% of the FPL</u></b> will be mandatorily enrolled into Medicaid programs beginning January 1, 2014. <del>Under</del><b><u>In pursuing</u></b> this option <b><u>to cover these targeted low income children</u></b>, the benefits provided to these children are eligible for enhanced federal funding of 65% under Title XXI, and the associated administrative costs are eligible for 50% federal funding under Title XIX. To the extent possible, the children will be mandatorily enrolled into Medi-Cal managed care delivery systems; and to the extent such delivery models are not available, benefits will be provided under Medi-Cal fee-for-service arrangements. Implementation is contingent upon enactment of State statute and receiving necessary federal approvals.</p> <p><del>MAXIMUS, the HCO enrollment broker, will be required to send informing materials to each eligible beneficiary.</del> <b><u>The Department will provide written notice to beneficiaries enrolled in Healthy Families of their transition to the Medi-Cal program and changes they should anticipate prior to their movement into Medi-Cal.</u></b></p>

**BENEFITS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

B 0.1 (OA-74)                    X    Quitline Administrative Services

Quitline provides a free telephone-based counseling program to help smokers quit. CMS is allowing the State to receive a 50% match of funds attributable to the administrative costs associated with Quitline providing services to Medicaid individuals. Since CDPH funds the helpline, the Department will claim the FFP and reimburse CDPH via an interagency agreement.

**BENEFITS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 1	(OA-44)	X	X	<p><u>Public Health Nurses for Foster Care</u></p> <p>The Budget Act of 1999 included funds for the CDSS to establish a program utilizing foster care public health nurses in the child welfare program to help foster care children gain access to health-related services. The public health nurses are employed by the counties and funded through CDSS General Funds and Title XIX matching funds. The program is administered by the Children's Medical Services Branch in DHCS, via an interagency agreement with CDSS.</p> <p>On October 7, 2008, P.L. 110-352, the Fostering Connections to Success and Increasing Adoptions Act of 2008, was signed into law. P.L. 110-351 is an amendment to the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, and improve incentives for adoption. On January 1, 2010, the Department, through CDSS, implemented the new requirements to provide Health Oversight and Coordination.</p>
B 2	(PC-19)	X	X	<p><u>Local Education Agency (LEA) Providers</u></p> <p>Through the LEA Billing Option, LEAs can become Medi-Cal providers and submit claims for services to Medi-Cal beneficiaries within their jurisdiction. LEA providers may bill retroactively for services rendered up to one year prior to their date of enrollment as long as claims are billed within the statutory billing limit. LEAs claim FFP for specific services as authorized in W&amp;I Code Section 14132.06. LEA providers are paid an interim rate based on pre-established billing allowances and audits are performed to reconcile actual costs with interim payments.</p>
B 3	(PC-139)	X	X	<p><u>Medi-Cal TCM Program</u></p> <p>The Targeted Case Management (TCM) program provides funding to counties and chartered cities/local government agencies (LGAs) for assisting Medi-Cal beneficiaries in accessing needed medical, social, educational, and other services. Through rates established in the annual cost reports, local governments claim FFP for these case management services. TCM providers are paid an interim rate based on pre-established billing allowances and audits are performed to reconcile actual costs with interim payments.</p>
B 4	(PC-137)	X	X	<p><u>Targeted Case Management Services – CDDS</u></p> <p>The Department provides Title XIX FFP for regional center case management services, as provided to eligible developmentally disabled clients via contract with the California Department of Developmental Services (CDDS) and authorized by the Lanterman Act. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case</p>

**BENEFITS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible. FFP for Medi-Cal eligibles is authorized by a SPA.

B 5    (OA-38)    X

Disease Management Program

W & I Code Section 14132.27 requires the Department to test the efficacy of providing a disease management (DM) pilot benefit to fee-for-service Medi-Cal beneficiaries. In response to CMS and industry input, the Department has elected to implement the pilot program to test the disease management benefit through an administrative model that does not require CMS approval. The effectiveness of this benefit included demonstration of the cost neutrality of the DM program. The Department entered into contracts to cover various conditions within the pilot program. UCLA has been contracted to conduct an independent evaluation of the DM program administered through a contract with McKesson Health Solutions.

B 6    (OA-1)    X    X

Medi-Cal Administrative Activities

AB 2377 (Chapter 147, Statutes of 1994) authorized the State to implement the Medi-Cal Administrative Claiming process. The Medi-Cal program submits claims on behalf of local governmental agencies (LGAs) to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the Medi-Cal program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of Medi-Cal services.

Both LGAs and local educational "consortiums"(LECs) contract with the Department for reimbursement and may amend prior year contracts up to the two-year retrospective federal claiming limitation. Prior year contract amendments are generated when additional funds, such as special local initiatives and Proposition 10 fund spending determination of LGA status, are made available as the certified public expenditure.

SB 308 (Chapter 253, Statutes of 2003) redefines LGAs to include Native American Indian tribes and tribal organizations, as well as subgroups of these entities. This allows these tribes to participate in the Medi-Cal Administrative Activities (MAA) program. CMS approved the California Tribal MAA Implementation Plan on January 9, 2009, which allows Tribal Entities and Tribal Organizations to participate in the MAA program by contracting with the State to receive reimbursement. On December 18, 2009, CMS approved reimbursement for non-emergency, non-medical transportation expenditures for Tribal entities.

**BENEFITS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
B 7	(PC-26)	X	X	<p><u>SCHIP Funding for Prenatal Care</u></p> <p>In order to maximize revenues, the Budget Act and Health Trailer Bill of 2005, require MRMIB to file a SPA in the SCHIP to claim 65% federal funding for prenatal care provided to women currently ineligible for federal funding for this care. The cost for this care is currently 100% General Fund. The SPA which was filed on June 30, 2005 allows SCHIP funding to be claimed for both 2004-05 and 2005-06 in 2005-06. Funding is being claimed for undocumented women, and for legal immigrants who have been in the country for less than five years. CMS approved the SPA in March 2006.</p>
B 8	(OA-13)	X	X	<p><u>Coordinated Care Management Pilot</u></p> <p>The Budget Act of 2006 includes approval to establish and implement a Coordinated Care Management (CCM) Demonstration Project. The key elements of the CCM Project include maintaining access to medically necessary and appropriate services, improving health outcomes, and providing care in a more cost-effective manner for two populations enrolled in the fee-for-service Medi-Cal Program who are not on Medicare:</p> <ul style="list-style-type: none"> <li>• <u>CCMP-SPD (CCM-1)</u>:Seniors and persons with disabilities (SPDs) who have chronic conditions, or who may be seriously ill and near the end of life; and</li> <li>• <u>CCMP-SMI (CCM-2)</u>:Persons with chronic health condition(s) and serious mental illnesses.</li> <li>• <b><u>CBAS (CCM-2): This contract has been amended to include Adult Day Health Care (ADHC) services as the Department transitions eligible ADHC beneficiaries into the new Community Based Adult Services (CBAS) Medi-Cal benefit.</u></b></li> </ul> <p>APS Healthcare Inc. has been awarded both CCM-1 and CCM-2 contracts, which began in January 2010 and April 2010 respectively.</p>
B 9	(PC-155)	X	X	<p><u>CLPP Funding for EPSDT Lead Screens</u></p> <p>Medi-Cal receives funding from the CLPP Fund to cover <b><u>Early Periodic Screening, Diagnosis and Treatment (EPSDT)</u></b> blood lead testing for beneficiaries with risk factors for lead poisoning. CLPP funding will be used for the non-federal share of the cost.</p>
B 10	(PC-32)	X	X	<p><u>Elimination of OTC Acetaminophen Drugs</u></p> <p>SB 853 (Chapter 717, Statutes of 2010) eliminated specific nonprescription acetaminophen-containing products as Medi-Cal benefits for adults.</p>

**BENEFITS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
B 11 (PC-30)	X	X	<p><u>Physician and Clinic Seven Visits Soft Cap</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) caps the number of physician visits and clinic visits (including <b>visits at</b> Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)) <b>allowed at seven per fiscal year</b> per Medi-Cal beneficiary at seven per year. <b>Visits that meet one of the five exception circumstances are not counted in the seven cap.</b> <del>The This cap applies to</del> <b>on the number of physician visits and clinic visits is for adults 21 years of age or older, except those in nursing facilities, pregnant women, presumptive eligibility and FFACT beneficiaries. The cap applies in both the <u>only to Medi-Cal fee-for-service (FFS); and managed care settings plans already control utilization more tightly than the cap process.</u></b></p>
B 12 (PC-27)	X	X	<p><u>Hearing Aid Cap</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements a \$1,510 cap per beneficiary for hearing aid expenditures. Hearing aid reimbursements are composed of three primary categories: 1) repairs, 2) ear molds, and 3) hearing aids. The majority of the reimbursements are for the actual costs of hearing aids. Hearing aids may be dispensed individually (monaural) or as a pair (binaural). The hearing aid cap is for adults 21 years of age or older who are not in nursing facilities or pregnant women.</p>
B 13 (PC-36)		X	<p><u>Copayment for Non-Emergency ER Visits</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of \$50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented without exemptions in <del>both the fee-for-service and managed care settings</del> <b>setting</b>. The hospital will collect the \$50 copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$50 copayment. <b>The Department is proposing legislation to revise the copayment from \$50 to \$15 for non-emergency use of emergency rooms.</b></p>
B 14 (PC-37)		X	<p><u>Pharmacy Copayments</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) requires mandatory copayments of \$3 for preferred drugs and \$5 for non-preferred drugs. This copayment will be implemented without exemptions in <del>both the fee-for-service and managed care settings</del> <b>setting</b>. The pharmacy will collect the \$3 or \$5 copayment from the beneficiaries at the time of service and be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$3 or \$5 copayment. <b>The Department is proposing legislation to revise the copayments from \$3 for preferred drugs or \$5 for non-preferred drugs to only a \$3.10 copayment for non-preferred drugs.</b></p>

**BENEFITS: OLD ASSUMPTIONS**

		Applicable F/Y <u>C/Y</u>	<u>B/Y</u>	
B 15	(PC-40)	X	X	<p><u>Eliminate ADHC Services</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program.</p>
B 16	(PC-33)	X	X	<p><u>Limit Enteral Nutrition to Tube Feeding</u></p> <p><b>Effective October 1, 2011</b>, AB 97 (Chapter 3, Statutes of 2011) limited enteral nutrition products to those products to be administered through a feeding tube. The Department <del>may deem as</del> <b>deems</b> enteral nutrition <del>product</del> <b>products</b> not administered through a feeding tube a benefit for patients with diagnoses including, but not limited to, malabsorption syndromes or inborn errors of metabolism. <del>Pregnant women, beneficiaries in LTC facilities, and children</del> <b>Children</b> eligible for EPSDT are exempt from this limitation.</p>
B 17	(PC-29)	X	X	<p><u>Elimination of OTC Cough and Cold Products</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) eliminated selected nonprescription cough and cold products as Medi-Cal benefits for adults and children. Children eligible for EPSDT are exempt from this provision.</p>
B 18	(PC-140)	X	X	<p><u>EPSDT Screens</u></p> <p>The Child Health and Disability Prevention (CHDP) program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.</p>
B 19	(PC-148) (OA-56)	X	X	<p><u>CDDS Dental Services</u></p> <p>The Lanterman Act requires the California Department of Development Services (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 interagency agreement 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 processing claims and benefits will be reimbursed by CDDS. <b><u>Processing of CDDS claims started on January 12, 2012.</u></b></p>
B 20	(OA-18)	X	X	<p><u>Prevention of Chronic Disease Grant Project</u></p> <p>Section 4108 of the Patient Protection and Affordable Care Act authorizes the five-year Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project. The Department was awarded 100% federal funds to implement Increasing Quitting among Medi-Cal Smokers project the MIPCD grant project. This project will use outreach and incentives to encourage access to smoking cessation services for Medi-Cal beneficiaries. The Department will enter into a contract with UCSF</p>

**BENEFITS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

for the administration, implementation and evaluation of the MIPCD project.

B 21 (PC-167)

X

Value Based Purchasing

The Medi-Cal health care delivery system must have the capacity to respond to the rapidly changing field of health care and be able to change benefits, services, rates methodologies and payments policies faster than the current regulatory process allows. Examples of potential program changes include reducing laboratory rates, no longer funding avoidable hospital admissions, and no longer paying for services of limited value. **Value Based Purchasing would establish a process within the Medi-Cal FFS and managed care systems, under which the Department would use its significant buying power to maximize the quality and value of the services received by Medi-Cal beneficiaries. The Department seeks to adopt a value-based approach in its service and payment policies, and implement value-based purchasing in the context of three interlinked goals of: (1) improving health; (2) enhancing quality; and (3) reducing or containing cost. Value-based purchasing includes a wide variety of approaches to increase the efficiency and effectiveness of the health care services managed and funded by the Department. For benefits, examples include modifications to the way in which services are delivered and implementation of new care delivery models, whereas for changes in rate methodologies and payment policies, the Department may use provider financial incentives and disincentives and bundled payment approaches. The Department would adopt these and other innovative approaches that prove to be effective in providing the best value for patients.**

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

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 0.1	(PC-190) (OA-66)		X	<p><u>Community First Choice Option</u></p> <p>Section 2401 of the ACA establishes a new State Plan option to provide home and community-based attendant services and supports. These services and supports may be offered through the federal Community First Choice Option (CFCO). The CFCO, which was available October 1, 2010, allows States to receive a 6% increase in federal match for expenditures related to this option.</p> <p>CMS has not released final regulations. On December 1, 2011, the Department and CDSS, submitted a SPA proposing to transition eligible participants in the Personal Care Services and In-Home Supportive Services Plus Option programs into CFCO. Once approved by CMS, the additional Title XIX funds available under CFCO.</p>
H 0.2	(PC-209)		X	<p><u>Trigger Cuts to CDSS for IHSS</u></p> <p>The Department of Social Services (CDSS) will budget a 7% across the board reduction to the In-Home Supportive Services (IHSS) program service hours.</p> <p>CDSS will also eliminate domestic and related services for IHSS program recipients living in shared living arrangements, excluding those IHSS recipients who reside only with other IHSS participants.</p> <p>The Department provides the FFP match for IHSS costs.</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y

C/Y    B/Y

H 1

### Home and Community-Based Services

Home and Community-Based Services (HCBS) are services designed to keep persons needing long-term care supported and safe in their homes or other community settings, in lieu of placing them in long-term care facilities like nursing homes, subacute or acute care hospitals, and intermediate care facilities for persons with developmental disabilities, or State Developmental Centers. HCBS also provide support for residents in long-term care facilities to return to their homes or communities.

HCBS encompass State Plan services, including Personal Care Services provided through CDSS' In-Home Supportive Services program and Adult Day Health Care; **which will be eliminated on February 29, 2012 and replaced by Community-Based Adult Services.** ~~Full~~ Full risk managed care services **are also provided** through Programs of All-inclusive Care for the Elderly (PACE) and Senior Care Action Network (SCAN); a ~~four~~ **eight**-year federal demonstration to transition LTC facility residents back to their homes and communities. ~~and several~~ **Several** different waiver programs ~~providing~~ **provide** a range of services like private duty nursing, personal care, case management, habilitation, emergency response systems, respite, and home modifications for accessibility and safety.

(PC-132) X    X    A. Home and Community Based Services– CDDS

This waiver serves persons with developmental disabilities who are regional center clients and reside in community settings instead of intermediate care facilities for the developmentally disabled.

CMS approved the renewal of the waiver for another five years, effective October 1, 2006 through September 30, 2011. The enrollment cap for the first year of the waiver was 75,000, and the cap will increase to 95,000 by the fifth year. On June 29, 2011, the Department submitted a waiver renewal application to CMS for the term of October 1, 2011 through September 30, 2016. **CMS approved an extension of the waiver through March 28, 2012.**

(PC-20) X    X    B. Multipurpose Senior Services Program – CDA  
(OA-50)

On June 23, 2009, CMS approved the renewal of the Multipurpose Senior Services Program (MSSP) Waiver for the period of July 1, 2009 through June 30, 2014. Under the waiver, CDA contracts with local government or nonprofit agencies to provide waiver services to individuals 65 years or older who are Medi-Cal eligible and who, in the absence of this waiver and as a matter of medical necessity, would otherwise require care in a nursing facility. MSSP services include health care and personal care assistance, respite care, housing assistance,

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

meal services, transportation, protective services, emergency response systems, and chore services.

The Department pays the MSSP claims. The GF is budgeted in the CDA budget and at the beginning of each fiscal year the reimbursement is transferred to the Department to pay the MSSP claims. The budgeted amount for FY 2011-12 and 2012-13 includes savings from a permanent reduction to the MSSP.

H 2	(PC-NA)	X	X	<p><u>In-Home Operations Waiver</u></p> <p>CMS approved the IHO Waiver renewal effective January 1, 2010 through December 31, 2014. The IHO Waiver “grandfathered in” Medi-Cal beneficiaries who were continuously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and continue to receive direct-care services primarily rendered by licensed nurses, and whose HCBS costs exceed the Level of Care (LOC) cost cap under the NF/AH Waiver. Each IHO participant’s LOC and waiver costs will remain the same as previously authorized.</p>
H 3	(PC-141)	X	X	<p><u>Waiver Personal Care Services</u></p> <p>AB 668 (Chapter 896, Statutes of 1998) requires Medi-Cal to add waiver personal care services (WPCS) to NF A/B and NF SA Levels of Care. This service is not available to those individuals at the Hospital LOC due to their extensive medical needs. WPCS is one option on the Menu of Health Services (MOHS) that NF/AH and IHO waiver participants may choose from, to the extent that waiver cost neutrality is assured.</p>
H 4	(PC-128) (OA-39)	X	X	<p><u>Personal Care Services</u></p> <p>As of April 1993, the Medi-Cal program has covered personal care services as a benefit. This is accomplished by making Title XIX funds available to the IHSS Program under the administrative control of CDSS.</p> <p>CMS revised its interpretation of the State Plan Personal Care Services Program (PCSP) to include protective supervision and domestic and related services, effective August 1, 2004.</p> <p><b><u>Legislation is being proposed to mandatorily enroll dual eligible into managed care for their Medi-Cal benefits. Those benefits include IHSS; see policy change Transition of Dual Eligibles-LTC for more information. IHSS costs are currently budgeted in this policy change, but due to the transitions of IHSS recipients to managed care, IHSS costs will be paid through managed care capitation beginning March 1, 2013. IHSS cost related to the recipients</u></b></p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

### transitioning to managed care are budgeted in the Transition of Dual Eligibles-LTC policy change.

H 5	(PC-22) (PC-31) (PC-21)	X	X	<p><u>California Community Transitions (CCT)</u></p> <p>In January 2007, CMS awarded the Department a Money Follows the Person Rebalancing Demonstration Grant for \$130 million in federal funds. The demonstration, called California Community Transitions, is effective from January 1, 2007 through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 1,500 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. The revised award is \$104million in federal funds. During the 12 months a participant is enrolled in the demonstration, the Department will receive enhanced FFP for the provision of certain HCB services approved by CMS. After 12 months participants are disenrolled from the demonstration but will continue to receive HCBS under the State Plan or via an appropriate HCBS waiver for which they are eligible. Transition work began in September 2008.</p> <p>The Department established IAs with CDDS and CDSS to provide enhanced FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services.</p>
H 6	(PC-NA)	X	X	<p><u>AIDS Waiver</u></p> <p>This waiver serves Medi-Cal eligible beneficiaries with mid-to-late stage HIV Disease or AIDS as an alternative to NF or acute hospital care. CMS first approved the waiver effective January 1, 1989, after which clients began receiving services in early June of 1989. On December 26, 2006, CMS approved the most recent renewal for the term January 1, 2007 through December 31, 2011. A waiver renewal application <del>will</del> <b>be-was</b> submitted for the waiver period of January 1, 2012 through December 31, 2016. <b>CMS approved an extension of the waiver through March 30, 2012.</b> The AIDS waiver is administered by the CDPH, Office of AIDS through an interagency agreement with the Department.</p>
H 7	(OA-40)	X	X	<p><u>Health-Related Activities</u></p> <p>Health-related activities are services that aid Medi-Cal eligibles to gain access to medical services or to maintain current levels of treatment. Title XIX federal funds are passed through to CDSS for health-related activities performed by social workers in the counties.</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 8	(PC-16) (OA-50)	X	X	<p><u>Adult Day Health Care – CDA</u></p> <p>ADHC is a community-based day program providing a variety of health, therapeutic, and social services designed to serve those at risk of institutionalization. ADHC became an optional Medi-Cal benefit in 1978. ADHC rates are adjusted effective August 1 of each year based on the weighted average NF-A increase. The ADHC program <del>will</del><b>was to</b> be eliminated effective December 1, 2011 pursuant to AB 97 (Chapter 3, Statutes of 2011).</p> <p><b><u>The Department settled the lawsuit <i>Darling et al. v. Douglas et al.</i> which challenged the elimination of the optional ADHC benefit. Under the settlement, the ADHC benefit will be extended until February 29, 2012. The federal government later approved to further extend the ADHC benefit until March 31, 2012 per the Department's request.</u></b></p>
H 9	(PC-57)	X	X	<p><u>PACE: Program of All-Inclusive Care for the Elderly</u></p> <p>The Department contracts with five PACE organizations in various counties for risk-based capitated care of the frail elderly. PACE programs provide all medical services, home and community-based long-term care (including adult day health care and in-home support) to Medi-Cal and Medi-Cal/Medicare beneficiaries who are determined by the Department to be at the skilled nursing or intermediate care facility level of care. PACE rates are based upon Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits. PACE rates are set on a calendar year basis, to coincide with the time period of the contracts. The 2011 rates are calculated using the Upper Payment Limit (UPL) for each year including 2011. The 2012 and 2013 rate setting methodology will use a mix of IHSS and long-term care facility actual cost-based data. <del>One new PACE organization will become operational in FY 2011-12 and four</del><b><u>Six new PACE organizations</u></b> will become operational in FY 2012-13.</p>
H 10	(PC-59)	X	X	<p><u>Senior Care Action Network</u></p> <p>The Senior Care Action Network (SCAN) is a Medicare Advantage Special Needs Plan located in Long Beach and coordinates and provides services in designated areas of Los Angeles, San Bernardino, and Riverside Counties. The Department received approval from CMS to prepare a comprehensive risk managed care contract authorized under 1915a to fund State Plan Only Medi-Cal services to its members. SCAN provides medical, social, and case management services to Medicare beneficiaries ages 65 and over in Medi-Cal's aged, disabled, and long term care aid group categories (dual eligibles). All necessary medical</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y

<u>C/Y</u>	<u>B/Y</u>
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services are provided by SCAN. Enrollees who are SNF or ICF certifiable are eligible for additional HCBS. SCAN holds a five-year contract with the Department. The term of the current SCAN contract is January 1, 2008 through December 31, 2012.

Rates are determined by federal law on an actuarially sound basis. In addition, California state law requires that rates be no more than the rates determined on a FFS equivalent basis. Beginning January 1, 2009, SCAN's rates are re-determined on a calendar year basis to coincide with the time period covered by its contract. To determine 2009 rates for dually eligible enrollees, SCAN provided the Department with a bid based upon its costs for Medi-Cal services rendered to this population. To determine 2009 rates for nursing home eligible participants, the Department used cost data for MSSP as a point of comparison and made adjustments to SCAN's bid. Rates through 2012 will be developed based on the ~~2009 methodology~~ **plans' actual experience**. FY 2011-12 and 2012-13 funding includes projected costs for the annual rate redetermination. AB 1422 (Chapter 175, Statutes of 2009) imposed an additional tax (Gross Premium tax) on the total operation revenue of Medi-Cal Managed Care plans. Beginning January 1, 2010, the Gross Premium tax revenue was incorporated into the SCAN rates retroactive to January 1, 2009. The Gross Premium tax was extended to June 30, 2011. ABX1 21 (Chapter 11, Statutes of 2009) extended the Gross Premium tax through June 30, 2012.

H 11	(OA-29)	X	X
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### Pediatric Palliative Care Waiver

AB 1745 (Chapter 330, Statutes of 2006) required the Department to submit an application to CMS for a federal waiver for a Pediatric Palliative Care Pilot Project. The waiver was approved on December 3, 2008 for three years, beginning April 1, 2009 through March 31, 2012. The waiver was implemented and began enrollment on January 1, 2010. **The Department has submitted a waiver renewal application to CMS for the period of April 1, 2012 through March 31, 2017.**

The waiver makes available services comparable to those available through hospice that can be provided at the same time that the child would receive curative services.

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

H 12	(PC-24)	X	X
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### SF Community-Living Support Benefit Waiver

The **San Francisco** (SF) Community Supported Living Waiver implements AB 2968 (Chapter 830, Statutes of 2006), which requires the

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

Department to develop and implement a community-living support benefit for Medi-Cal beneficiaries ~~22~~ **21** years of age and older, residing in the City and County of SF who would otherwise be residing in ~~Laguna Honda Hospital, San Francisco General Hospital, skilled nursing facilities~~ or be rendered homeless. ~~The~~ **In the proposed new waiver , is the Department is working with the SF Department of Public Health to propose service delivery under** a 1915(c) Home and Community Based Services-HCBS waiver.

Eligible participants will have full-scope Medi-Cal or share-of-cost Medi-Cal for services to be rendered in Residential Care Facilities for the Elderly (RCFEs) or in residency units made available by the Direct Access to Housing Program (DAH).

~~Benefits will include a community supported living benefit in the RCFE or ARF setting and a home health agency-rendered service in a DAH supplied unit.~~ The City and County of San Francisco will pay for the non-federal share of the waiver costs. A draft waiver application is pending with CMS. The Department will utilize CPEs to obtain federal funding for this project.

H 13 (PC-17)    ✕    X    Additional Services for HCBS Clients

In December 2009, the Department submitted to CMS a 1915(i) Home and Community-Based Services (HCBS) state plan amendment (SPA) to include certain services provided by the State's Regional Center (RC) network of non-profit providers to persons with developmental disabilities. RC clients who have previously received or currently receive certain services will continue to be eligible for these services even ~~if they are not under~~ **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 ~~2011-12~~ **2012-13**, with a retroactive date of October 1, 2009. **Non-emergency medical transportation and services for adults, which were eliminated from the Medi-Cal scope of services, will be 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.**

H 14 (OA-22)    X    X    CCT Enrollment-Administrative Costs

Pursuant to the Patient Protection and Affordable Care Act, the Department applied for and was awarded grant funding to cover

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

			administrative costs needed to increase California Community Transitions (CCT) participation. The grant requires the Department to foster collaborations between the existing Aging and Disability Resource Connection (ADRC) programs and CCT lead organizations to increase CCT enrollment. The costs incurred for these activities are 100% federally funded.
H 15 (PC-23)	X	X	<p><u>Quality of Life (QoL) Surveys for Money Follows the Person Program Participants</u></p> <p>CMS requires the Department to conduct QoL surveys with CCT participants within specified timeframes and follow a specific methodology. CCT lead organizations, which are Medi-Cal home and community-based services waiver providers, conduct QoL surveys designed to measure seven domains: living situation, choice and control, access to personal care services, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. The costs of conducting the surveys are 100% federally funded.</p>
H 16 (OA-45)	X	X	<p><u>Administrative Costs for CCT</u></p> <p>In January 2010, CMS announced the availability of 100 percent FFP for certain administrative costs under the Money Follows the Person (MFP) Rebalancing Demonstration Grant. The Department requested and was approved for 100 percent federal funding for 34 Regional Center positions that will focus on transitioning beneficiaries from the Lanterman Developmental Center to the community via the California Community Transitions (CCT), the MFP Grant.</p> <p><del>The Department will be requesting 100% federal funding for local level positions overseen by the California Department of Aging (CDA), the California Department of Rehabilitation (CDOR) and CDDS that will focus on transitioning eligible individuals from nursing facilities or State Developmental Centers to the community via the CCT Grant.</del></p>
H 17 (PC-18) (OA-8) <u>(PC-FI)</u>	X	X	<p><u>ADHC Transition</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program in FY 2011-12. As a result of the settlement of the lawsuit <i>Darling et al. v. Douglas et al.</i> which challenged the elimination of ADHC services, the ADHC benefit was extended until <del>February 29</del> <b>March 31</b>, 2012. Beginning <del>March</del> <b>April</b> 1, 2012, the ADHC program will end as an optional Medi-Cal benefit and a new program called Community-Based Adult Services (CBAS) will <del>become</del> <b>be</b> available to eligible individuals <u>under the Medi-Cal Fee-For-Service (FFS) program.</u></p>

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

Applicable F/Y

C/Y    B/Y

**Beginning July 1, 2012, CBAS services will transition into managed care and the costs will be built into the capitation rate at the actuarial equivalent.**

**For those CBAS eligible beneficiaries residing in geographic areas where managed care is not available, Medi-Cal FFS will provide CBAS coverage. CBAS eligible beneficiaries in managed care counties who do not qualify for managed care enrollment or have an approved medical exemption will be eligible to receive CBAS services if a CBAS Center is available in their geographic area, or Enhanced Case Management (ECM) services if there are no CBAS Centers in their geographic areas.**

**Beneficiaries not eligible for CBAS services may be eligible for ECM services through Medi-Cal FFS or a Medi-Cal Managed Care Health Plan.**

**As stipulated in the settlement, the Department will develop and send out beneficiary notices informing beneficiaries of their eligibility for CBAS services, how to receive CBAS services, and how to receive other services such as ECM for beneficiaries that are not eligible for CBAS.**

**There will be associated costs to the State due to the special mailings/letters, updates to informing material packets, and provider directories.**

**FAMILY PACT: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y   B/Y

**FAMILY PACT: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FP 1	(PC-1)	X	X	<p><u>Family PACT Program</u></p> <p>Originally implemented as a state-only program in 1997, Family PACT became a Section 1115 demonstration project effective December 1, 1999. It provides family planning services to eligible, uninsured Californians with income at or below 200% of poverty. FFP at 90% has been assumed for most family planning services, testing for sexually transmitted infections (STIs), and sterilizations. The Federal Medical Assistance Percentage (FMAP) has been assumed for treatment of STIs and other family planning companion services. No FFP has been assumed for the treatment of some family planning-related medical conditions, including inpatient care for complications from family planning services. Costs for undocumented persons are assumed to be 13.95% of the Family PACT costs, as agreed upon by CMS and are budgeted at 100% GF. Family PACT drugs will be included in the Medicaid Drug Rebate Program.</p> <p>A State Plan Amendment (SPA), to replace the Family PACT waiver in accordance with the Federal Patient Protection and Affordable Care Act was approved on March 24, 2011. Under the SPA, effective retroactively to July 1, 2010, eligible family planning services and supplies formerly reimbursed with 100% General Funds will receive a 90% federal matching rate for certain eligible procedure codes, and family planning-related services will receive reimbursement at the State's regular FMAP rate.</p>
FP 2	(OA-55) (OA-68)	X	X	<p><u>Family PACT Evaluation</u></p> <p>An important component of the Family PACT Program is evaluating the effectiveness of the program. The University of California, San Francisco conducts the program evaluation. The evaluation includes, but is not limited to, analyzing: the changes in birth rates; access by targeted populations; change in provider base for targeted geographical areas; provider compliance; claims analysis; and the cost effectiveness of the services.</p> <p>A new contract to provide data, to monitor and evaluate the Family PACT program was negotiated for a five year term beginning July 1, 2010.</p> <p>The Department budgets the Title XIX federal Medicaid funds for the contract. The matching GF is budgeted in the CDPH budget.</p> <p><b><u>Legislation is being proposed to transfer the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13.</u></b></p>

**FAMILY PACT: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FP 3	(OA-58) (OA-69)	X	X	<p><u>Family PACT Support, Provider Education and Client Outreach</u></p> <p>The Family PACT Program has two main objectives. One is to increase access to services in targeted populations of adolescents, males, and medically underserved women. The other is to increase the number of providers who serve these clients. Education and various support services are provided to Family PACT providers and potential providers, as well as clients and potential clients. The Office of Family Planning contracts with a variety of entities to provide these services.</p> <p>A contract to provide Family PACT support, provider education, and outreach was negotiated for a three-year term beginning April 1, 2009.</p> <p>The Department budgets the Title XIX federal Medicaid funds for these activities. The matching GF is budgeted in the CDPH budget.</p> <p><b><u>Legislation is being proposed to transfer the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13.</u></b></p>
FP 4	(PC-FI)	X	X	<p><u>Family PACT Materials Distribution</u></p> <p>An important component of the Family PACT Program is the distribution of client education materials to providers. The state, through the fiscal intermediary, has the responsibility to develop, print, purchase, and distribute over 125 different publications.</p>
FP 5	(PC-FI)	X	X	<p><u>Family PACT Systems</u></p> <p>The establishment of the Family PACT Program required fiscal intermediary systems enhancements and modifications. The system changes have been made and are ongoing, as required for program maintenance.</p>
FP 6	(OA-54)	X	X	<p><b><u>CDPH I&amp;E Program and Evaluation</u></b></p> <p>The Health Trailer Bill of 2003 authorized the Department to require contractors and grantees under the Office of Family Planning, and the Information and Education (I&amp;E) Program to establish and implement clinical linkages to the Family PACT program, effective in the 2003-04 fiscal year. This linkage includes planning and development of a referral process for program participants, to ensure access to family planning and other reproductive health care services.</p> <p>The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.</p>

**FAMILY PACT: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FP 7 (OA-6)	X	X	<p><u>Family PACT HIPAA Privacy Practices Beneficiary Notification</u></p> <p>Under the federal HIPAA, it is a legal obligation of the Medi-Cal program to provide a NPP to each Family PACT beneficiary explaining the rights of beneficiaries regarding the protected health information created and maintained by the program. Medi-Cal has an ongoing responsibility to provide this Notice to all new enrollees, and inform all beneficiaries about how to get a copy of this Notice at least every 3 years, or whenever a substantial change is made to the Notice. Due to confidentiality concerns, distribution of the NPP to these beneficiaries is accomplished by distribution at the clinic. This assumption is to cover the cost of printing and mailing the NPPs to the clinics.</p>
FP 8 (PC-25)	✗	X	<p><u>Increased Federal Matching Funds for FPACT</u></p> <p>On March 24, 2011, CMS approved a State Plan Amendment (SPA) for the Family PACT Program, in accordance with the Federal Patient Protection and Affordable Care Act. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund will receive a 90% federal matching rate, and family planning related services will receive reimbursement at the State's regular FMAP rate, effective retroactively to July 1, 2010.</p>

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

Applicable F/Y  
C/Y    B/Y

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
BC 1 (PC-2)	X	X	<p><u>Breast and Cervical Cancer Treatment Program</u></p> <p>The Budget Act of 2001 includes funding for the creation of the BCCTP effective January 1, 2002, for individuals with a diagnosis of breast and/or cervical cancer who need treatment and have income at or below 200% of FPL. Enhanced Title XIX funding is claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope, no cost Medi-Cal benefits for the duration of treatment for women under age 65 who are citizens or immigrants with satisfactory immigration status and who have no other health coverage. The BCCTP also includes a state-funded program that provides cancer and cancer-related treatment services only to persons not eligible for Medi-Cal. The state-funded program is 100% GF, but may receive Safety Net Care Pool funding under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver. Coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Women with inadequate health coverage, women over the age of 65, undocumented women of any age, and males are eligible for the state funded program. Undocumented women under age 65 are also eligible for federally funded emergency services and pregnancy-related and state-only long-term care services for the duration of their cancer treatment.</p> <p>Enrollment of BCCTP applicants is performed by Centers for Disease Control (CDC)-approved screening providers, which in California are Every Woman Counts and Family PACT Program providers, using an electronic Internet-based application form. Those women who appear to meet federal eligibility requirements receive immediate temporary full-scope no cost Medi-Cal coverage under accelerated enrollment. DHCS Eligibility Specialists (ES) review the Internet-based application forms and determine regular BCCTP eligibility under the state and federal components. The ES may need to request additional information from the applicant to determine appropriate eligibility under the BCCTP.</p> <p>With additional staffing, the Department began processing annual redeterminations. Redeterminations are done for beneficiaries in the BCCTP federally-funded aid codes, as well as for those in the BCCTP State-funded aid codes who receive federally-funded emergency coverage. Those persons determined no longer BCCTP program eligible are referred to the counties to determine if they are eligible for any other Medi-Cal program. For those determined by the counties not to be eligible for any other Medi-Cal program, a determination will be made if they are eligible for the State-funded BCCTP.</p> <p>Current managed care rates fully incorporate BCCTP costs.</p>

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
BC 2 (PC-2)	X	X	<p><u>Breast and Cervical Cancer Treatment Program – Premium Payment</u></p> <p>Effective January 1, 2002, under the state funded portion of the Breast and Cervical Cancer Treatment Program funded by the Budget Act of 2001, the Department began payment of the premium cost for individuals with breast and/or cervical cancer who have other health insurance but are underinsured. Eligibility is limited to 18 months for breast cancer and 24 months for cervical cancer. The criteria for participation in the state funded premium payment program include the following:</p> <ul style="list-style-type: none"> <li>• Family income at or below 200% of FPL as determined by the enrolling provider</li> <li>• California resident</li> <li>• Other health coverage with premiums, deductibles and copayments exceeding \$750 in a 12-month period beginning from the month in which the Eligibility Specialist commences the eligibility determination</li> <li>• Diagnosis of breast and/or cervical cancer and in need of treatment</li> <li>• Not eligible for full-scope, no cost Medi-Cal</li> </ul>
BC 3 (OA-6)	X	X	<p><u>BCCTP Postage and Printing</u></p> <p>Postage and printing costs related to the eligibility determination process for the Breast and Cervical Cancer Treatment Program are budgeted in local assistance, including postage-paid return envelopes for counties to mail copies of DRA/citizenship documentations received from BCCTP beneficiaries. Costs for the state funded component of the program are 100% General Fund, and are included in the Postage and Printing policy change. Mailings include annual redetermination packets to beneficiaries in the federal BCCTP program, retroactive Medi-Cal applications, letters to all applicants to request additional information, notices of approval or denial of eligibility, and referral packets to the counties for redetermination under other Medi-Cal programs as required under SB 87 when a federal BCCTP beneficiary is determined ineligible for full-scope Medi-Cal under BCCTP.</p>

**PHARMACY: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

PH 0.1 (PC-189)	X	X	<u>EPC for Average Wholesale Price Frozen Rates</u>  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). 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.
PH 0.2 (PC-191)	X	X	<u>Kalydeco for Treatment of Cystic Fibrosis</u>  Effective January 31, 2012, the U.S. Food and Drug Administration approved Kalydeco for the treatment of patients, six years and older, with cystic fibrosis (CF) who have a specific mutation in the CF regulator gene.

## PHARMACY: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
PH 1 (PC-131)	X	X		<p><u>Part D–Phased-Down Contribution</u></p> <p>With the implementation of Medicare Part D, the federal government requires a phased down contribution from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal program. In 2006, the phased-down contribution was 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015. An annual inflation factor is also applied to the phased-down contribution. The phased-down contribution, annual CMS-determined inflation factor, and PMPM are adjusted annually.</p>
PH 2 (PC-42)	X	X		<p><u>Non FFP Drugs</u></p> <p>Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid Programs if the manufacturer of the drug has not signed a rebate contract with CMS. The Department has established claiming procedures to ensure that FFP is claimed correctly. Effective March 2007, an automated quarterly report identifies the costs of drugs for which there is no FFP. This report is used to reduce the FFP. In October 2010, an analysis of the non-FFP drug reports determined that these reports were not accurately capturing non-FFP drug claims. The reports were revised and then re-run for the period FY 2004-05 through FY 2009-10. As a result, a larger number of claims were identified as being <del>not eligible</del> <b>ineligible</b> for FFP. The Department will reimburse CMS for the identified non-FFP drug costs, retroactive to FY 2004-05.</p>
PH 3 (PC-47)	X	X		<p><u>Family PACT Drug Rebates</u></p> <p>The Department collects rebates for family planning drugs covered through the Family PACT program.</p> <p>The Department began invoicing for Family PACT drug rebates on June 7, 2001. These invoices covered all quarters back to December 1, 1999.</p> <p>Beginning October 2008, the Department no longer collects rebates for drugs that are not eligible for FFP.</p>
PH 4 (PC-50)	X	X		<p><u>State Supplemental Drug Rebates</u></p> <p>The Department negotiates state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels. As with the federal drug rebates, the Department estimates the state supplemental rebate amounts by using actual fee-for-service trend data for drug expenditures and applying a historical percentage of actual amounts collected to the trend projection.</p>

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 5 (PC-51)	X	X	<p><u>Federal Drug Rebate Program</u></p> <p>Federal law requires drug manufacturers to provide rebates to the federal government and the states as a condition of FFP in the states' coverage of manufacturers' drug products. The manufacturers have 38 days to make payment after being billed.</p>
PH 6 (PC-45)	X	X	<p><u>Medical Supply Rebates</u></p> <p>The Department negotiates diabetic medical supply rebates with diabetic supply manufacturers to provide savings to the Department. Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are sent quarterly to manufacturers.</p> <p>The product reimbursement rates for diabetic supply products are based on the contracted Maximum Acquisition Cost (MAC). Reimbursement on the MAC has resulted in additional savings to the Department.</p> <p><b><u>On December 31, 2012, MAC contracts (those with and without rebates) for diabetic supplies will expire. The Department will negotiate terms to reduce net costs for contracts effective January 1, 2013.</u></b></p>
PH 7 (PC-46)	X	X	<p><u>Aged and Disputed Drug Rebates</u></p> <p>The Department collects drug rebates as required by federal and state laws. 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 the majority of the amount in dispute, before closing out the time period. The Department has begun work on disputes for the 1997-2002 time period.</p> <p>Rebate invoices are sent quarterly to drug manufacturers, and manufacturers may dispute the amount owed. <del>Effective FY 2010-11, disputed</del> <b>Disputed</b> rebates are defined as being 90 days past the invoice postmark date. The Department works to resolve these disputes and to receive rebate payments.</p> <p>Collection and closure of outstanding disputes has been slowed and workload increased at times due to a few large disputes with several large pharmaceutical manufacturers who have hired contractors to dispute payments made during these years.</p>
PH 8 (OA-33)	X	X	<p><u>Epocrates</u></p> <p>The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) in the Epocrates system. Epocrates RX™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country. Epocrates</p>

**PHARMACY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

provides the Department with an opportunity to reach a large network of health professionals via a point-of-care clinical reference for physicians and other health professionals. Epocrates' formulary is free to health professional users.

PH 9 (PC-43)	X	X	<p><u>BCCTP Drug Rebates</u></p> <p>Enhanced Title XIX Medicaid funds (65% FFP/35% GF) are claimed for drugs under the federal Medicaid BCCTP program. The Department is required by federal law to collect drug rebates whenever there is federal participation. Beginning January 2010, the Department is collecting drug rebates for the federal BCCTP program. Manufacturers were invoiced retroactively to January 1, 2002. By agreement with CMS, rebates for beneficiary drug claims for the federal portion of the BCCTP program (emergency and prenatal services) for those without satisfactory citizenship or immigration status will not be invoiced.</p>
PH 10 (PC-44) (OA-30)	X	X	<p><u>Physician-Administered Drug Reimbursement</u></p> <p>The current rate of reimbursement for physician-administered drugs is the Average Wholesale Price (AWP) minus 5%. SB 853 (Chapter 717, Statutes of 2010) 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 January 2011. The new methodology is expected to generate savings beginning in April 2012 for claims from September 2011 and ongoing. To ensure these rates are in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.</p>
PH 11 (OA-24)	X	X	<p><u>Rate Studies for MAIC and AAC Vendor</u></p> <p>The Welfare and Institutions Code, Section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies' acquisition costs and to update the MAICs at least every three months. AB 102 (Chapter 29, Statutes of 2011) authorized the Department to develop a new reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC), to replace the Average Wholesale Price (AWP), <del>which is expected to no longer be available beginning September 29, 2014.</del> In order to obtain the information from the providers necessary to establish the MAICs and AACs, the Department will hire a contractor to survey drug price information from the Medi-Cal pharmacy providers and update AACs and MAICs on an ongoing basis. Currently, the Department is subject to a court injunction which precluded implementation of the MAIC methodology, as amended by ABX4 5 (Chapter 5, Statutes of 2009). However, MAICs based on the new reimbursement benchmark, AACs, are not subject to that injunction.</p>

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 12 (PC-41)	X	X	<p><u>Federal Drug Rebate Change</u></p> <p>The ACA increases the mandated federal rebate to 23.1% of the Average Manufacturer's Price (AMP) from the previous 15.1% for single source drugs and increased the multi-source drug rebate from 11% of AMP to 13%. CMS is claiming one hundred percent of the 8% single source and 2% multi-source differential in the rebate increases. This will result in a cost to the Medi-Cal program because California currently collects rebates at the higher percentage for most drugs and retains the GF share at the current FMAP rate, for all rebates collected.</p>
PH 13 (PC-49)	X	X	<p><u>Managed Care Drug Rebates</u></p> <p>The ACA and the Health Care and Education Reconciliation Act of 2010 (HCERA), extend the federal drug rebate requirement to Medicaid managed care outpatient covered drugs. Medi-Cal drug rebates are now also provided by:</p> <ul style="list-style-type: none"> <li>• Geographic Managed Care (GMC) and</li> <li>• Two-Plan model plans, and the</li> <li>• Health Plan of San Mateo (HPSM), a County Organized Health System (COHS).</li> </ul> <p>Previously, only COHS plans except for HPSM were subject to the rebate requirement.</p> <p>The Department will invoice for these rebates, retroactive to March 23, 2010, beginning in <del>March 2012</del> <b>August 2012</b>.</p>

## 1115 WAIVER—MH/UCD & BTR

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

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

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

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

Applicable F/Y  
C/Y    B/Y

W 0.1 (PC-193)	X	<p><u>BTR – Low Income Health Program – HIV Transition Incentive Program</u></p> <p>According to the Ryan White Care Act requirements, Ryan White funded services can no longer be available to individuals living with Human Immunodeficiency Virus (HIV) once they are determined eligible for and enrolled in a local Low Income Health Program (LIHP). These individuals will, upon enrollment in a local LIHP, be required to receive their medical care, pharmaceuticals, and mental health services under the LIHP.</p> <p>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. Each local LIHP that elects to participate in the HIV Transition Incentive Program will receive incentive payments under the Safety Net Care Pool upon achievement of project milestones. The LIHP provides the non-federal share of the payments through intergovernmental transfers. The LIHP HIV Transition Incentive Program will be effective for 30 months from July 1, 2011, through December 31, 2013.</p>
W 0.2 (PC-201) (PC-202) (PC-203) (PC-204) (PC-205)	X	<p><u>NDPH Payments Changes</u></p> <p>Currently, NDPHs receive either CMAC negotiated per dime rates for contract facilities or cost-reimbursement for non-contract facilities with 50% FFP and 50% GF for Medi-Cal hospital inpatient services. The Department has proposed to</p> <ul style="list-style-type: none"> <li>• Replace the current reimbursement with CPEs based reimbursement,</li> <li>• Eliminate NDPH SB 1100 and AB 113 IGT supplemental payments, and</li> <li>• Request federal approval to increase Safety Net Care Pool (SNCP) and DSRIP funding available for NDPHs</li> </ul>
W 0.3 (PC-207) (PC-210) (PC-211)	X	<p><u>BTR-Health Care Coverage Initiative Rollover Funds</u></p> <p>HCCI, one component of BTR, covers individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to a cap of \$360 million total computable annually each full Demonstration Year (DY). The Department has requested federal approval to reallocate the unspent HCCI money to the SNCP Uncompensated care component. The reallocated fund to SNCP will be shared 50/50 between DPHs and the State.</p>

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

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 1	(PC-103) (PC-92)	X	X	<p><u>MH/UCD &amp; BTR—Safety Net Care Pool</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions (STCs) of the MH/UCD, a Safety Net Care Pool (SNCP) was established to support the provision of services to the uninsured. SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503.</p> <p>The federal funds that the Department claims from the SNCP are based on the following Certified Public Expenditures (CPEs):</p> <ul style="list-style-type: none"> <li>• The CPEs of the Designated Public Hospitals (DPHs).</li> <li>• The CPEs of the following four state-only programs: <ul style="list-style-type: none"> <li>○ Medically Indigent Adult Long-Term Care Program</li> <li>○ Breast and Cervical Cancer Treatment Program</li> <li>○ Genetically Handicapped Person’s Program</li> <li>○ California Children’s Services Program</li> </ul> </li> </ul> <p>Funds that pass through the HCSF are to be paid in the following order:</p> <ul style="list-style-type: none"> <li>• Meeting the baseline of the DPHs.</li> <li>• Federalizing the four state-only programs, and</li> <li>• Providing stabilization funding.</li> </ul> <p>The reconciliation process for each Demonstration Year may result in an overpayment or underpayment to a DPH, which will be handled as follows:</p> <ul style="list-style-type: none"> <li>• For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.</li> <li>• For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the SNCP payments that the DPHs have received and the SNCP payments estimated in the interim reconciliation process.</li> </ul> <p>The new BTR effective November 1, 2010, makes several changes to the SNCP funding. SNCP payments to DPHs are for uncompensated care provided to individuals with no source of third party coverage for the services they received. AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the BTR to determine (1) the federal disproportionate share hospital allotment for DPHs (2) SNCP Uncompensated Care payments, (3) DSRIP payment to DPHs. SNCP funding for the DSRIP, Designated State Health Programs (DSHP), the Low Income Health Program—Medicaid Coverage Expansion (LIHP-MCE) and the Low Income Health Program-Health Care Coverage Initiative (LIHP-HCCI) are included in separate assumptions.</p>

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

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 2	(PC-89)	X	X	<u>MH/UCD &amp; BTR—DSH Payments</u>

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

DPHs claim reimbursement from the DSH allotment for up to 100 percent of their uncompensated care costs based on CPEs. These CPEs constitute the non-federal share of payments. Under this new methodology, each DPH certifies its Medi-Cal Managed Care and psychiatric inpatient and outpatient shortfall and its uninsured costs to the Department. The Department submits claims for federal reimbursement based on the DPHs' CPEs. The federal reimbursement that is claimed based on the CPEs is drawn from the Federal Trust Fund and passes through the Demonstration DSH Fund, Item 4260-601-7502.

DPHs also may claim up to 175 percent of uncompensated care costs. (Two University of California hospitals are not eligible for 175 percent reimbursement.) Intergovernmental transfers (IGTs) from the government entity with which the DPH is affiliated constitute the non-federal share of these payments. These IGTs are deposited into the MIPA Fund, Item 4260-606-0834 and are used to claim federal reimbursement. The federal reimbursement that is claimed based on the IGTs is drawn from the Federal Trust Fund.

Non-Designated Public Hospitals (NDPHs) will claim reimbursement from the DSH allotment for up to 100 percent of their uncompensated Medi-Cal and uninsured costs using GF as the non-federal share of payments. The federal reimbursement that is claimed based on the GF is drawn from the Federal Trust Fund.

Based on SPA 05-022, private hospitals on the final DSH list receive a total funds payment of \$160.00 in annual DSH payments. The total payment of \$160.00 is comprised of 50 percent FFP payments from the federal DSH allotment and 50 percent GF. CMS required that some portion, no matter how small, of the annual DSH allotment go to the private hospitals. They indicated that the amount designated to private hospitals could be as little as \$1.00 per hospital. Since there were approximately 160 private hospitals eligible for DSH payments, it was agreed that \$160.00 would be specified in the SPA. This dollar amount was also agreed to by the DSH Task Force. The requirements of sections 1396a(a)(13)(A) and 1396r-4 of Title 42 of the United States Code shall be satisfied through the provision of payment adjustments as described in this paragraph.

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Applicable F/Y  
C/Y    B/Y

Each DPH's interim Disproportionate Share Hospital (DSH) payments will be reconciled to its filed Medi-Cal 2552-96 cost report for the fiscal year.

The reconciliation process may result in an overpayment or underpayment to a DPH, which will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DSH payments that the DPHs have received and the DSH payments determined in the reconciliation process.

AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the successor demonstration project to determine the federal DSH allotment for DPHs.

W 3	(PC-93)	X	X	<p><u>MH/UCD &amp; BTR—Private Hospital DSH Replacement</u></p> <p>Effective for dates of service on or after July 1, 2005, private hospitals receive DSH replacement payments, the non-federal share of which is funded by the GF. The DSH replacement payments, along with \$160.00 of the DSH payments (see assumption for Hospital Financing DSH Payments), will satisfy the payment obligations with respect to those hospitals under the Federal DSH statute. The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment.</p>
W 4	(PC-94)	X	X	<p><u>MH/UCD &amp; BTR—Private Hospital Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, private hospitals receive payments from the Private Hospital Supplemental Fund, Item 4260-601-3097. SB 1100 provides a continuous appropriation of \$118,400,000 annually from the GF to the Private Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. This funding replaces the aggregate amount the private hospitals received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/Voluntary Governmental Transfers (VGT)), Graduate Medical Education Supplemental Payment (Teaching Hospitals), and Small and Rural Hospital Supplemental Payment programs.</p>
W 5	(PC-107)	X	X	<p><u>MH/UCD &amp; BTR—NDPH Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, NDPHs receive payments from the Non-designated Public Hospital Supplemental Fund, Item 4260-601-3096. SB 1100 provides a continuous appropriation of \$1,900,000 annually</p>

**1115 WAIVER—MH/UCD & BTR: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

from the GF to the Non-designated Public Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. This funding replaces the aggregate amount the NDPHs received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/VGT) program.

W 6 (PC-99) X X MH/UCD & BTR—DPH Physician and Non-Physician Costs

Effective for dates of service on or after July 1, 2005 reimbursement based on CPEs will be available to each DPH for the costs incurred for physician and non-physician practitioner professional services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. SPA 05-023 that authorizes federal funding for this reimbursement was approved by CMS in December 2007. CMS approved the “Physician and Non-Physician Practitioner Time Study Implementation Plan” on December 15, 2008.

For certain DPHs, the reimbursement under the SPA constitutes total payment. For other DPHs, the reimbursement is a supplemental payment for the uncompensated care costs associated with the allowable costs under the SPA. Due to the timing for the submission of the cost reporting and other data, there are significant lags between the date of service and the payments.

W 7 (PC-108) X ✕ MH/UCD—Distressed Hospital Fund

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, “distressed hospitals” receive supplemental payments from the Distressed Hospital Fund, Item 4260-601-8033. SB 1100 requires the transfer of 20 percent per year over five years of the balance of the prior supplemental funds, including the ESSP Fund (SB 1255/VGT),(Item 4260-601-0693), the Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0550), the Large Teaching Emphasis Hospital and Children’s Hospital Medi-Cal Medical Education Supplemental Payment Fund (Item 4260-601-0549), and the Small and Rural Hospital Supplemental Payments Fund (Item 4260-601-0688),to the Distressed Hospital Fund. Contract hospitals that meet the following requirements, as determined by CMAC, are eligible for distressed funds:

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

The Distressed Hospital Fund ended on October 31, 2010 with the expiration of the MH/UCD waiver. Under the BTR, no separate funding is allocated to this fund. The final payment from the above four prior supplemental funds will be made in FY2011-12 depleting any remaining accumulated interest and fund balance. The stabilization funding

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

Applicable F/Y  
C/Y B/Y

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 DSH payments, and interim SNCP payments for each FY under the MH/UCD and ~~paid in FY 2012-~~  
~~13~~**budgeted in the Stabilization Funding policy change.**

W 8	(PC-110)	X	X	<p><u>MH/UCD&amp; BTR—MIA LTC Program– Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded Medically Indigent Adult Long-Term Care program.</p>
W 9	(PC-111)	X	X	<p><u>MH/UCD&amp; BTR—BCCTP – Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded portion of the Breast and Cervical Cancer Treatment Program.</p>
W 10	(PC-96)	X	X	<p><u>MH/UCD&amp; BTR—CCS AND GHPP – Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on SB 1100, the Department may claim federal reimbursement for the CCS Program and Genetically Handicapped Persons Program (GHPP) from the SNCP established by the MH/UCD and the BTR. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.</p>
W 11	(PC-100)	X	X	<p><u>MH/UCD&amp; BTR—DPH Interim and Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the STCs of the MH/UCD, each DPH's 2005-06 interim per diem rate is comprised of 100 percent federal funds, based on the reconciliation of each inpatient hospital costs for Medi-Cal beneficiaries to its filed Medi-Cal 2552-96 cost report.</p> <p>The reconciliation process for each Demonstration Year may result in an overpayment or underpayment to a DPH and will be handled as follows:</p>

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Applicable F/Y  
C/Y    B/Y

- 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 the share of cost, third liability and Medi-Cal payments.

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

W 12 (PC-102) X      X

MH/UCD—Stabilization Funding

Effective for dates of service on or after July 1, 2005 through October 31, 2010, a portion of the total stabilization funding, comprised of FFP and GF, as specified in Section 14166.20 of the W&I code, will be determined as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between the sum of \$0.544 million and 0.64 percent of the total stabilization funding and the aggregate payment increase in the fiscal year, compared with their aggregate baseline.
- Private hospitals will receive total funds payments equal to the difference between the aggregate payment increase in the fiscal year, compared with their aggregate baseline, and the sum of \$42.228 million and an additional amount based on the formulas specified in W&I Code 14166.20.
- Distressed hospitals will receive total funds payments equal to the lesser of \$23.5 million or 10 percent of the total stabilization funding with a minimum of \$15.3 million.
- DPHs will receive GF payments to the extent that the state-funded programs' CPEs are used for FFP from the SNCP and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, private hospitals, and distressed hospitals.

Stabilization funding to NDPHs, private hospitals, and distressed hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Stabilization funding is also available to DPHs through the SNCP.

The stabilization funding amounts to NDPHs, private hospitals, and distressed hospitals will be calculated following the completion of the final reconciliations of the interim Medicaid inpatient hospital payment rates, interim DSH payments, and interim SNCP payments. CMAC determines the actual stabilization payments for a portion of the total stabilization amount due to NDPHs and private hospitals and all of the distressed hospital stabilization amount. The Department distributes these payments.

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

Applicable F/Y  
C/Y    B/Y

Stabilization funding ended on October 31, 2010 with the expiration of the MH/UCD waiver. The final reconciliations for FY 2005-06 ~~and FY 2006-07~~ **are is** expected to be complete in FY 2011-12. The remaining reconciliations for MH/UCD FYs are expected to be complete in FY 2012-13 **and FY 2013-14**.

W 13 (PC-105) X      X      MH/UCD—Health Care Coverage Initiative

An amount of \$180 million in federal funds is available each year in Demonstration Years 3-5 to expand health care coverage to eligible low-income, uninsured persons. SB 1448 (Chapter 76, Statutes of 2006) provided the statutory framework for the Health Care Coverage Initiative (CI) and directed the Department to issue a Request for Applications to enable a county, a city and county, a consortium of more than one county, or a health authority to apply for an allocation of this federal funding. A total of ten programs have been selected to participate in the CI program.

The federal funds available will reimburse the CI counties an amount equal to the applicable FMAP of their CPEs for health care services provided to eligible low-income, uninsured persons. The CI counties will submit their CPEs to the Department for verification and the Department will submit the claim for FFP that will reimburse the CI counties. No GF will be expended for this program.

In FY 2008-09, the Department began reimbursement and interim quarterly payments to the CI counties. The final reconciliation and settlement process may result in payment and recovery in future years.

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

W 14 (PC-113) X      X      MH/UCD & BTR—DPH Interim Rate

Effective July 1, 2005, based on SPA 05-021, DPHs no longer received CMAC negotiated per diem rates (50% GF/50% FFP.) DPHs receive interim per diem rates based on estimated costs using the hospitals' Medi-Cal costs trended forward. The interim per diem rates are funded using the hospitals' CPEs to match federal funds. The interim per diem rates consist of 100% federal funds; however, the Medi-Cal inpatient base estimate assumes costs are 50% GF/50% FFP. Therefore, an adjustment is necessary to shift the funding from 50% GF/50% FFP to 100% FFP.

W 15 (PC-114) X      X      MH/UCD & BTR—DPH Interim Rate Growth

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

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C/Y    B/Y

forward annually. The trend used is to reflect increased costs and is expected to be different from the former CMAC negotiated rate trend for some DPHs. The interim per diem rate consists of 100% FFP.

W 16	(OA-4)	X	X	<p><u>MH/UCD—Health Care Coverage Initiative – Administrative Costs</u></p> <p>FFP is available for costs incurred on or after March 29, 2007 through October 31, 2010, that are associated with the start-up, implementation and closeout administration of approved CI programs. The federal funds will reimburse the CI counties an amount equal to 50% of their CPEs for administrative costs. The administrative activities for which FFP is being requested were submitted to CMS on December 22, 2006, and approved in October 2007.</p> <p>The required administrative cost claiming protocol was approved by CMS in October 2008 for prospective costs after the implementation of the time study. The Department implemented the time study in February 2009 for prospective costs and began reimbursement to the CI counties in FY 2009-10. The Department received CMS approval in August 2010 for the cost claiming methodologies for the administrative costs for the period prior to the implementation of the time study, along with the start-up and close-out costs.</p> <p>Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the Low Income Health Program. See assumption BTR-Low Income Health Program – Administrative Costs for more information.</p>
W 17	(OA-17)	X	X	<p><u>MMA –DSH Annual Independent Audit</u></p> <p>MMA requires an annual independent certified audit that primarily certifies:</p> <ul style="list-style-type: none"> <li>• That DSH (approximately 150+ hospitals) have reduced their uncompensated care costs by the amount equal to the total amount of claimed expenditures made under section 1923 of the MMA.</li> <li>• That hospitals' DSH payments do not exceed the costs incurred by the hospitals in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital and payments made by uninsured patients.</li> </ul> <p>CMS released the final regulation and criteria for the annual independent certified audit. Each year's annual report is due to CMS by December 31.</p>

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		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 18	(PC-89) (PC-93)	X	X	<p><u>MH/UCD &amp; BTR—ARRA – DSH Allotment and DSH Replacement Payments</u></p> <p>California's annual allotment of federal funds for the Disproportionate Share Hospital (DSH) temporarily increased for FY 2008-09 and FY 2009-10 by 2.5%, due to the enactment of the ARRA. The distribution of the DSH allotment is determined by a formula specified in State statute and the State Medi-Cal Plan. When the DSH allotment is increased and more federal funds are available for distribution, the formula results in an increase in General Funds needed as the non-federal share of the DSH payments for NDPHs and DSH replacement payments to private hospitals.</p> <p>The remaining DSH ARRA payments cannot be paid to the hospitals until the entire original DSH allotment is paid out per federal rules, therefore the Department expects to continue to pay DSH ARRA payments in FY 2011-12 and FY 2012-13.</p>
W 19	(PC-112)	X	X	<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool ARRA</u></p> <p>ARRA temporarily increased California's FMAP by 11.59% from October 1, 2008 to December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The annual SNCP federal funds allotment increased accordingly. This increase in federal funds was claimed by the State through the Safety Net Care Pool via certified public expenditures. Effective November 1, 2010, under the BTR, this federal flexibility funding is no longer applicable.</p> <p>Interim claims were completed in FY 2010-11. The Department will conduct the final reconciliation for Demonstration Year 4 in FY 2011-12 and Demonstration Year 5 in FY 2012-13.</p>
W 20	(PC-106)	X	X	<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool</u></p> <p>The MH/UCD made available \$180 million in federal funds via the SNCP annually. This funding was contingent on the Department meeting specific milestones. In Demonstration Years 1 and 2, this funding was unused. The Department will utilize this funding in FY 2009-10, FY 2010-11, and FY 2011-12 to claim federal funds via certified public expenditures. The final reconciliation is expected to begin in FY 2012-13.</p>
W 21	(PC-90)	X	X	<p><u>BTR—Delivery System Reform Incentive Pool</u></p> <p>The BTR was approved by CMS effective November 1, 2010. Based on the STCs of the demonstration, the SNCP includes a Delivery System</p>

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Applicable F/Y  
C/Y    B/Y

Reform Incentive Pool (DSRIP). The DSRIP is established to support California public hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve. Funding is available in four areas:

1. Infrastructure development
2. Innovation and redesign
3. Population-focused improvement
4. Urgent improvement in care

Intergovernmental transfers (IGTs) will be used as the non-federal share to claim the federal funding.

AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the BTR to determine DSRIP payment to DPHs.

W 22 (PC-95) X X  
 (PC-91)

BTR—Low Income Health Program

The BTR was approved by CMS effective November 1, 2010. The BTR modifies the existing HCCI to expand health care coverage to low income adults through the Low Income Health Program (LIHP). AB 342 (Chapter 723, Statutes of 2010) and AB 1066 (Chapter 86, Statutes of 2011) authorize the local LIHPs to provide health care services to eligible individuals.

LIHP consists of two components, the Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). These are county-based elective programs, which will terminate on December 31, 2013, when these individuals will become eligible for Medi-Cal or the Health Benefits Exchange, as appropriate under Health Care Reform.

The counties will use certified public expenditures or capitation rates through the use of intergovernmental transfers to obtain federal funding for the LIHP. If counties that participate in the HCCI under the MH/UCD elect not to participate in the HCCI component of the LIHP, they must continue to provide health care services for existing enrollees and receive federal funding for these services.

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

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	Applicable F/Y		
	C/Y	B/Y	
W 23 (PC-97)	X	X	<p><u>BTR—SNCP Designated State Health Programs</u></p> <p>The BTR was approved by CMS effective November 1, 2010. Under the new demonstration, the State may claim up to \$400 million federal funds for certain state-only programs. This claiming has first priority on the SNCP funds.</p> <p>CPEs from the following programs may be used to draw the federal funds:</p> <ul style="list-style-type: none"> <li>• State Only Medical Programs <ul style="list-style-type: none"> <li>○ California Children’s Services (CCS)*</li> <li>○ Genetically Handicapped Persons Program (GHPP)*</li> <li>○ Medically Indigent Adult Long Term Care (MIA-LTC)*</li> <li>○ Breast &amp; Cervical Cancer Treatment Program (BCCTP)*</li> <li>○ AIDS Drug Assistance Program (ADAP)</li> <li>○ Expanded Access to Primary Care (EAPC)</li> <li>○ County Mental Health Services Program</li> <li>○ Department of Developmental Services (DDS)</li> <li>○ Every Woman Counts (EWC)</li> <li>○ Prostate Cancer Treatment Program (PCTP)</li> <li>○ County Medical Services Program (CMSP); effective November 1, 2010 to December 31, 2011.</li> </ul> </li> <li>• Workforce Development Programs <ul style="list-style-type: none"> <li>○ Office of Statewide Health Planning and Development (OSHDP) <ul style="list-style-type: none"> <li>• Song-Brown Healthcare Workforce Training</li> <li>• Health Professions Education Foundation Loan Repayment</li> <li>• Health Professions Education Foundation Mental Health Loan Assumption Program</li> </ul> </li> <li>○ University of California</li> <li>○ California State University</li> <li>○ California Community Colleges</li> </ul> </li> <li>• Miscellaneous programs.</li> </ul> <p>*Separate assumptions address the federal funds for these programs</p>
W 24 (OA-2)	X	X	<p><u>BTR—Low Income Health Program – Administrative Costs</u></p> <p>Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the LIHP. These costs will involve both MCE and the HCCI. FFP is available for costs incurred on or after November 1, 2010, through December 31, 2013, that are associated with the start-up, implementation and closeout administration for the LIHP. The federal funding will reimburse the programs an amount equal to 50% of their certified public expenditures for administrative costs.</p>

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	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
W 25 (PC-104)	X	X	<p><u>BTR—Low Income Health Program – Inpatient Hospital Services for Inmates</u></p> <p>The BTR Demonstration was approved by CMS effective November 1, 2010. The BTR and AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department to claim federal funding for inpatient hospital services for certain State inmates in the California Department of Corrections and Rehabilitation (CDCR) correctional facilities <b>who are enrolled under the LIHP</b>. The inpatient hospital services would be those that are provided at hospitals that are off the grounds of the correctional facilities and the inmates would be those determined eligible by the Department for the LIHP program operated by the counties. The CPEs incurred by the CDCR for inpatient hospital services provided to those inmates eligible for the LIHP will be certified by CDCR. The county LIHP in which the eligible inmate is enrolled will attest to the CDCR CPEs for federal reimbursement. The Department budgets the FFP based on the counties' attestation of the CDCR CPEs.</p>
W 26 (PC-101)	X	X	<p><u>MH/UCD –South LA Preservation Fund</u></p> <p>SB 474 (Chapter 518, Statutes of 2007) created the South Los Angeles Medical Services Preservation (SLAMSP) Fund to ensure adequate funding for the continued health care services to the uninsured population of South Los Angeles, which had been provided by Martin Luther King Jr.-Harbor Hospital. In 2007, Martin Luther King Jr.-Harbor hospital, a DPH receiving SNCP funds, was closed. Through the SLAMSP Fund, the County of Los Angeles will be able to receive federal funds using the county's CPEs related to compensating other providers for health services rendered to the uninsured population of South Los Angeles that would have been served at Martin Luther King Jr.-Harbor Hospital. The County of Los Angeles can also use this funding to cover indirect costs associated with adequately maintaining the hospital building for reopening. Up to \$100 million in SNCP federal funds for the last three years of the Demonstration Project are to be allocated to the SLAMSP fund. This funding ends October 31, 2010, with the expiration of the Demonstration Project. Under the BTR, no separate funding is allocated to SLAMSP.</p>
W 27 (PC-171)		X	<p><u>Hospital Stabilization</u></p> <p>The Department is proposing legislation to redirect private and NDPH stabilization funding that has not yet been paid. A portion of the GF savings achieved from this legislation will be used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 through FY 2006-07.</p>

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## MANAGED CARE

### Medi-Cal Managed Care Rates

Base Rates are developed through encounter and claims data available for each plan for the most recent 12 months (December 31, 2010) and plans' self-reported utilization and encounters by category of service (i.e. Inpatient, ER, Pharmacy, PCP, Specialist, FQHC, etc) for each rate category for the same period. Medi-Cal eligibility and paid claims data are used to identify all births occurring in each county and health plan. The expenditures associated with labor and delivery services are then removed from the base expenditure data. The delivery events and associated maternity costs are carved out of the Family/Adult, and Seniors and Persons with Disabilities (SPDs) Medi-Cal Only aid categories to establish a budget neutral county specific maternity supplemental payment.

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

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

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

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

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

Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Family/Adult or (SPD) Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the SPD Medi-Cal only rate. A county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate. The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the 2011-12 rates, 25 percent of this county specific rate was taken and multiplied by each plan's respective risk score and 75 percent of each plan's plan specific rate was retained and added to the 25 percent risk adjusted rate to establish a risk adjusted plan specific rate. For FY 2012-13 rates, the percentage of county specific rates used in the risk adjustment will increase from 25 percent to 35 percent. This percentage blend was chosen in order to prevent rate shock and allow the managed care plans to adjust their operations and demonstrates the Department's ~~move~~ commitment towards using a greater percentage of the risk adjusted county average rates.

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## MANAGED CARE

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

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

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

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

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

**For further information, see policy change FFS Costs for Managed Care Enrollees.**

### **2011-12 and 2012-13 Rates**

Overall, the rates represent a ~~3.61%~~ **1.4%** increase in FY 2011-12 over the previous rates (based on a fiscal year comparison), **which includes the impact of AB 97 10% provider rate reductions.** Rates for FY 2012-13 have not yet been determined; however, a placeholder of 3.61% will be included in ~~November Estimate~~ **at this time.**

### MANAGED CARE: NEW ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

M 0.1 (PC-192)    X

Rate Increases due to SB 90 IGTs

SB 90 (Chapter 19, Statutes of 2011) requires the Department to design and implement an intergovernmental transfer program. This program is for Medi-Cal managed care services provided by designated and non-designated public hospitals. The program increases capitation payments and raises the hospitals' reimbursement. Participation in the intergovernmental transfers is voluntary on the part of the transferring entities. These transfers are for 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.

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 1	(PC-52)	X	X	<u>Two-Plan Model</u>
<p>Under the Two-Plan Model program, the Department contracts with two managed care plans in a county. One plan is a locally developed or designated managed care health plan referred to as the Local Initiative (LI). The other plan is a non-governmentally operated Health Maintenance Organization referred to as the Commercial Plan (CP). <del>(An exception exists in Fresno County where there are currently two Commercial Plans and no Local Initiative.)</del> Currently, fourteen counties are fully operational under the Two-Plan Model.</p> <p><del>A regional Two-Plan Model, including Fresno (an existing managed care county), Kings and Madera Counties was implemented in March 2011.</del></p> <p>FY 2011-12 <u>and FY 2012-13</u> capitation rates include the <b>annual</b> rate redetermination effective <del>10/1/11</del> <b>redeterminations</b>.</p>				
M 2	(PC-53) (PC-67)	X	X	<u>County Organized Health Systems</u>
<p>Six County Organized Health Systems (COHSs) are operational in fourteen counties. Effective February 1, 2010, Health Plan of San Mateo added long term care services to their contract. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries. PHC is negotiating with the Department to remove undocumented beneficiaries from their contract effective January 1, 2013.</p> <p>Health plans and counties currently operating under the COHS model:</p> <p>CalOPTIMA Orange County</p> <p>Santa Barbara San Luis Obispo Regional Health Authority (SBSLORHA); dba: Cen Cal Health Santa Barbara County San Luis Obispo County</p> <p>Health Plan of San Mateo (HPSM) San Mateo County</p> <p>Partnership Health Plan of California (PHC) Solano County Napa County Yolo County Sonoma County (October 2009) Marin County (July 2011) Mendocino County (July 2011)</p> <p>Central California Alliance for Health (CAAH)</p>				

**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Santa Cruz County  
 Monterey County  
 Merced County (October2009)

Gold Coast Health Plan  
 Ventura County (July 2011)

FY 2011-12 **and FY 2012-13** capitation rates include the **annual** rate ~~redetermination effective 10/1/11~~ **redeterminations.**

M 3    (PC-62)    X    X

AIDS Healthcare Centers

Managed Care Organization (MCO): Positive Healthcare Services (dba AIDS Healthcare Centers) is located in Los Angeles.

All drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) prior to January 1, 2002 are included in the plan's contracted scope of services except for new drugs which do not fit into one of the current therapeutic classes and for which the Department does not have sufficient utilization data to determine the financial impact of the use of those drugs will have on the managed care plan. New rates developed effective January 1, 2011, pending CMS approval, include all drugs used to treat HIV/AIDS approved by the FDA prior to January 1, 2007.

Savings Sharing/Incentive Distributions: Prior obligations exist for AIDS Healthcare Centers. These are obligations that are owed to the contractor for cost savings created when actual costs are less than FFS equivalent costs. The process of making final determinations of the amount of savings sharing can take up to one year. The Department has determined there will not be a savings sharing for calendar year 2009. Because of the long period of time needed to make the final determinations, savings sharing has not been determined for calendar year 2010 and beyond.

~~The current contract has been extended through December 31, 2011. The~~ **On January 1, 2012, the** Department is currently negotiating a new contract with rates effective January 1, 2012 **entered into a new five year contract with AFH.**

M 4    (PC-54)    X    X

Geographic Managed Care

Sacramento: Geographic Managed Care (GMC), as authorized by AB 336 (Chapter 95, Statutes of 1991), was implemented in Sacramento County as of April 1994. The contractors are: Health Net Community Solutions, Inc., Anthem Blue Cross Partnership Plan, KP Cal, LLC, and Molina Healthcare of California Partner Plan, Inc.

San Diego: GMC, as authorized by SB 2139 (Chapter 717, Statutes of 1996), was implemented in San Diego County as of August 1998.

**MANAGED CARE: OLD ASSUMPTIONS**Applicable F/Y  
C/Y    B/Y

Contractors are: Health Net Community Solutions, Inc., KP Cal, LLC, Molina Healthcare of California Partnership Plan, Inc., Care 1<sup>st</sup> Partnership Plan, LLC, and Community Health Group Partnership Plan.

FY 2011-12 **and FY 2012-13** capitation rates include the **annual** rate ~~redetermination effective 10/1/11~~ **redeterminations**.

M 5    (PC-63)    X    X    Family Mosaic Capitated Case Management

Family Mosaic Project (FMP): Located in San Francisco, this program case manages emotionally disturbed children and adolescents at risk for out of home placement. Enrollment began in June 1993. FMP provides, coordinates, and oversees mental health treatment for children and youth with severe emotional and behavioral problems, targeting children who are at high risk for out-of-home placement or incarceration. FMP uses the capitation payments to provide the required services and also purchase and monitor other services from a network of private providers and community-based organizations in order to keep families together.

The Family Mosaic Project contract with the Department is expected to be effective January 1, 2008 through December 31, 2013.

M 6    (OA-19)    X    X    San Diego County Administrative Activities

The County of San Diego provides administrative services for the San Diego Geographic Managed Care program. These administrative activities include health care options presentations, explaining the enrollment and disenrollment process, customer assistance, and problem resolution. Federal funding for these activities was discontinued as of August 1, 2003.

M 7    (PC-55)    X    X    Managed Care **Rate Range** Intergovernmental Transfers

Counties will transfer funds under an Intergovernmental Transfer(IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds will be used for the nonfederal share of capitation rate increases. **The 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.**

The following counties' IGT will continue on an ongoing basis:

<u>COHS</u>	<u>Effective Date</u>
San Mateo	July 1, 2005
Santa Barbara	July 1, 2009
Santa Cruz	July 1, 2009
Solano	July 1, 2009
Monterey	July 1, 2009

**MANAGED CARE: OLD ASSUMPTIONS**Applicable F/Y  
C/Y    B/Y

Sonoma	October1, 2009
Merced	October 1, 2009
Orange	July 1, 2010
Yolo	July 1, 2010
Marin	July 1, 2011

<u>Two Plan Model</u>	<u>Effective Date</u>
Los Angeles	October 1, 2006
Alameda	October 1, 2008
Contra Costa	October 1, 2008
Kern	October 1, 2008
Riverside	October 1, 2008
San Bernardino	October 1, 2008
San Francisco	October 1, 2008
San Joaquin	October 1, 2008
Santa Clara	October 1, 2008

M 8    (PC-69)    X        X

FFS Costs for Managed Care Enrollees

Managed care contracts specify that certain services are carved out of the rates paid for managed care enrollees. These services are provided through the fee-for-service system. The most significant carve-outs for most plans are CCS services and anti-psychotic drugs. Additionally, the Department pays federally qualified health care centers and rural health clinics under the fee-for service system for certain costs associated with serving Medi-Cal managed care enrollees which are not fully paid by Medi-Cal managed care plans.

M 9    (PC-NA)    X

Annual Redetermination of Capitation Rates

Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends.

M 10    (PC-72)    X        X

Coverage for Former Agnews Residents

The CDDS submitted a plan to the Legislature in January 2005 to close the Agnews Developmental Center. Agnews closed in March 2009 and all consumers have been transitioned to the community. The Department has developed agreements with three health plans, regional centers and CDDS to address the medical health needs of consumers transitioning from Agnews into Alameda, San Mateo, and Santa Clara counties pursuant to the Agnews Closure Plan, whose Individual Program Plans document the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal fee-for-service system and who choose to enroll in a managed care plan. The Department established a mechanism whereby the plans were paid

**MANAGED CARE: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

a supplemental payment in addition to the capitation rate for these individuals, followed by periodic reconciliations to reimburse the plans for reasonable costs. In December 2010, the Department implemented new full risk rates retroactively to July 1, 2008 for the Health Plan of San Mateo and January 1, 2008 for Santa Clara, Family Health Plan. The Alameda Alliance for Health contract ~~will be was~~ amended **in September 2011** with new full risk rates retroactive to January 1, 2008; ~~pending CMS approval.~~

M 11 (PC-61) X

Court-Ordered Managed Care Rate Adjustments

In the case of *HealthNet of California v. Department of Health Services*, due to a ruling by the Third District Court of Appeal, the Department paid \$17.59 million, including post-judgment interest, to Health Net for a dispute over Two Plan Model capitation rates for years ranging from 1997 to 2002. In FY 2009-10, \$14.6 million was paid to Health Net and the remaining \$2.99 million was paid to the health plan in December 2010. The Department will pay the prejudgment interest in February 2012, estimated to be ~~\$31,674,000~~ **which is \$32.4 million.**

M 12 (PC-65)

X

Managed Care Public Hospital IGTs

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage are being assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. In conjunction with this, SB 208 (Chapter 714, Statutes of 2010) allows public entities, such as Designated Public Hospitals (DPH), to transfer funds under Intergovernmental Transfers (IGT) to the Department, pending CMS approval. The funds will be used as the non-federal share of capitation rate increases. This will enable plans to compensate DPHs in amounts that are no less than what they would have received for providing services to these beneficiaries under the FFS model, including supplemental payments, CPEs and any additional federally permissible amounts, which are available only under FFS.

M 13 (PC-68) X

X

Funding Adjustment of Gross Premium Tax Funds to GF

AB 1422 (Chapter 157, Statutes of 2009) imposed an additional tax on the total operating revenue of Medi-Cal Managed Care Organizations (MCOs). The taxes are then placed in a special Tax fund and are used to increase the capitation rates to reimburse the cost of the tax to the plans.

Capitation rate increases due to the tax are initially paid from the General Fund. ~~The General Fund is then reimbursed on a quarterly basis through a funding adjustment from the Tax Fund.~~ **The Department then requests quarterly reimbursement of the General Fund through a funding adjustment from the Tax Fund.**

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 14	(PC-70)	✗	X	<p><u>Managed Care IGT Administrative and Processing Fee</u></p> <p>Counties may transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds are used for the nonfederal share of capitation rate increases. Beginning <b><u>with FY 2010-11 rate range IGTs processed</u></b> after July 1, 2011, <b><u>and all subsequent rate range IGTs occurring after July 1, 2011,</u></b> the Department will charge counties an administrative and processing fee for their IGTs. The fee will be 20% of each IGT and will offset the cost of medical services provided under the Medi-Cal program.</p> <p>AB 102 (Chapter 29, Statutes of 2011) provides that all IGTs are subject to the fee with the exception of the IGTs related to Designated Public Hospitals (DPHs). <b><u>If the IGT is replacing the CPE previously claimed in fee-for-service, no fee will be charged.</u></b></p>
M 15	(PC-71)		X	<p><u>General Fund Reimbursements from DPHs</u></p> <p>Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) who are not covered under other health care coverage will be assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. For Medi-Cal beneficiaries under the FFS program, payments to Designated Public Hospitals (DPHs) are comprised of CPEs matched with federal funds. For Medi-Cal beneficiaries under managed care, payments to DPHs are comprised of General Fund and federal funds. Therefore, as SPDs are transitioned into managed care, GF expenditures will increase for DPH services.</p> <p>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.</p>
M 16	(PC-56)	X	X	<p><u>Increase in Capitation Rates for Gross Premium Tax</u></p> <p>AB 1422 (Chapter 157, Statutes of 2009) has imposed a Gross Premium tax on the total operating revenue of Medi-Cal Managed Care plans. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. The provision pertaining to this tax is effective retroactively to January 1, 2009 and will sunset June 30, 2012. Managed Care plans affected by this new legislation are:</p> <ul style="list-style-type: none"> <li>• Two Plan Model</li> <li>• County Organization Health Systems</li> </ul>

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			<ul style="list-style-type: none"> <li>• Geographic Managed Care</li> <li>• AIDS Healthcare Centers</li> <li>• SCAN</li> </ul>
M 17 (PC-98)	X	X	<p><u>Mandatory SPD Enrollment into Managed Care</u></p> <p>Effective June 1, 2011, it is mandatory for all Medi-Cal Seniors and Persons with Disabilities (SPDs) residing in managed care counties, and not dually eligible for Medicare, to enroll in a managed care plan. Previously, only SPDs in County Organized Health System counties were required to enroll in managed care.</p>
M 18 (PC-60)	X	X	<p><u>Managed Care Cost Based Reimbursement Clinics (CBRC)</u></p> <p>The Department is required to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. Currently, tentative settlements are prepared by the Department after review of reconciliation requests and final settlements or recoveries are invoiced within three years after the submission of the original reconciliation reports.</p> <p>Effective October 1, 2011, CBRCs that provide services to Seniors and Persons with Disabilities (SPDs) who reside in Los Angeles County and are enrolled in managed care plans will be reimbursed through managed care capitation rates.</p>
M 19 (PC-170)		X	<p><u>FQHC Payment Reform</u></p> <p>Currently, the Department is required to provide additional reimbursement through the FFS Medi-Cal program to FQHC and RHC providers who have rendered care to beneficiaries enrolled in managed care plans. These providers are reimbursed for the difference between their prospective payment system rate and the amount they receive from managed care health plans. These FFS expenditures are referred to as FQHC "wrap-around" payments.</p> <p>The Department is proposing legislation to integrate all FQHC and RHC costs into managed care capitated rates, thereby eliminating the need for the FQHC and RHC wrap-around payments.</p>
M 20 (PC-169) <b><u>(PC-FI)</u></b>		X	<p><u>Annual Open Enrollment Period</u></p> <p>The Department is proposing legislation to change the managed care enrollment policy to allow managed care enrollees in Two-Plan and Geographic Managed Care counties to switch plans once a year rather than every month. New beneficiaries will have a 90-day period from their initial enrollment date to select <b><u>a-or change their</u></b> managed care plan.</p>

**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**On an annual basis, based on their redetermination date, existing members will be provided a 60-day period to change plans.**

**Notices and packets will be mailed to beneficiaries to inform them of changes in the enrollment policy.**

M 21 (PC-172)	X	<p><u>Managed Care Default Assignment</u></p> <p>The Department is proposing legislation that would require beneficiaries in the Family or Seniors and Persons with Disabilities (SPD) aid categories who do not choose a plan to be defaulted in a plan based on default ratios which consider health plan quality of care and cost. Savings would be recognized by rewarding plans with lower costs with additional default enrollments.</p>
M 22 (PC-173)	X	<p><u>Align Managed Care Benefit Policies</u></p> <p>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.</p>
M 23 (PC-165) (Reworded)	X	<p><u>Transition of Dual Eligibles-Medicare Savings</u></p> <p>The Department will identify demonstration projects to integrate Medicare and Medicaid services under a new 1115 Demonstration Project Waiver. The new waiver includes providing long-term care services and supports for dual eligible beneficiaries. The projects will be established in up to ten counties through COHS, two-plan and GMC models.</p> <p>The goals of the pilot projects include:</p> <ul style="list-style-type: none"> <li>• Coordinating Medi-Cal and Medicare benefits across health care settings to improve continuity and access to acute care, long-term care, and HCBS;</li> <li>• Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services;</li> <li>• Increasing the availability of and access to home and community-based alternatives.</li> </ul> <p>The Department expects to identify pilot projects by April 2012 and begin pilot implementation in January 2013. The pilot will assume shared</p>

**MANAGED CARE: OLD ASSUMPTIONS**Applicable F/Y  
C/Y    B/Y

savings between Medicare and Medicaid. A blended rate for health care costs split between Medicare and Medicaid is yet to be determined.

M 24	(PC-166) (PC-178) (PC-179) <b><u>(PC-FI)</u></b> <b><u>(OA-70)</u></b> <b><u>(OA-71)</u></b>	X	X	<p><u>Transition of Dual Eligibles-Long-Term Care Savings</u></p> <p>The Department will achieve savings from transitioning dually eligible beneficiaries who receive Medi-Cal Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS) and other Home and Community-Based Services (HCBS) from fee-for-service into managed care health plans. <b><u>Notices and packets will be mailed to beneficiaries.</u></b></p> <p><b><u>The administrative costs to enroll beneficiaries into the managed care health plans include outreach services, rate setting for newly included long-term services and supports (LTSS), Medicare and Medi-Cal data collection, and quality assurance and monitoring by an External Quality Review Organization (EQRO). Other administrative costs include the Health Insurance Counseling and Advocacy Program (HICAP) which provides one-on-one Medicare counseling services.</u></b></p>
M 25	(PC-174) (PC-177) (PC-180)	X	X	<p><u>Extend Gross Premium Tax – Increase Capitation Rates</u></p> <p>ABX1 21 (Chapter 11, Statutes of 2011) extended the gross premium tax through FY 2011-12. The Administration <b>Department</b> is proposing legislation to eliminate the gross premium tax sunset date on the total operating revenue of Medi-Cal Managed Care plans. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. Managed Care plans affected by this new <b><u>proposed</u></b> legislation are:</p> <ul style="list-style-type: none"> <li>• Two Plan Model</li> <li>• County Organization Health Systems</li> <li>• Geographic Managed Care</li> <li>• AIDS Healthcare Centers</li> <li>• SCAN</li> </ul>
M 26	(PC-176)	X	X	<p><u>Managed Care Expansion to Rural Counties</u></p> <p>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.</p>

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## PROVIDER RATES

### **Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities**

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for ~~Skilled Nursing Facilities (SNFs)~~ **freestanding skilled (level B) nursing facilities, including subacute units which are part of a freestanding skilled nursing facility.** Rates are updated annually and are established based on the most recent cost report data. AB 1629 also imposed a Quality Assurance Fee (QAF) on these facilities and added requirements for discharge planning and assistance with community transitions.

The rate methodology developed by the Department computes facility-specific, cost-based per diem payments for SNFs based on five cost categories, which are subject to limits. Limits are set based on expenditures within geographic peer groups. Also, costs specific to one category may not be shifted to another cost category.

Labor: This category has two components: direct resident care labor costs and indirect care labor costs.

- Direct resident care labor costs include salaries, wages and benefits related to routine nursing services defined as nursing, social services and personnel activities. Costs are limited to the 90<sup>th</sup> percentile of each facility's peer group.
- Indirect care labor includes costs related to staff support in the delivery of patient care including, but not limited to, housekeeping, laundry and linen, dietary, medical records, in-service education, and plant operations and maintenance. Costs are limited to the 90<sup>th</sup> percentile of each facility's peer group.

Indirect care non-labor: This category includes costs related to services that support the delivery of resident care including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, pharmacy consulting costs and fees, plant operations and maintenance costs. Costs are limited to the 75<sup>th</sup> percentile of each facility's peer group.

Administrative: This category includes costs related to allowable administrative and general expenses of operating a facility including: administrator, business office, home office costs that are not directly charged and property insurance. This category excludes costs for caregiver training, liability insurance, facility license fees and medical records. Costs are limited to the 50<sup>th</sup> percentile.

Fair rental value system (FRVS): This category is used to reimburse property costs. The FRVS is used in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major movable equipment used in providing resident care. The FRVS formula recognizes age and condition of the facility. Facilities receive increased reimbursement when improvements are made.

Direct pass-through: This category includes the direct pass-through of proportional Medi-Cal costs for property taxes, facility license fees, caregiver training costs, and new state and federal mandates including the facility's portion of the QAF.

### **Rate Years 2011-12 and 2012-13**

Pursuant to AB 97 (Chapter 3, Statutes of 2011), provider payments will be reduced by 10% for FFS claims, **retroactive to June 1, 2011** and the actuarial equivalent of 10% for managed care claims, retroactive to ~~June~~ **July 1, 2011**.

## PROVIDER RATES

Under ABX19 (Chapter 4, Statutes of 2011), the Department extended the provisions of AB 1629 to July 31, 2013. Also, facilities will receive a rate increase of approximately ~~0.033%~~ **0.426%** for rate year 2011-12 and a rate increase of ~~2.37%~~ **1.973%** for rate year 2012-13 rate-year, for a total increase of 2.4%.

Also, the 10% provider payment reduction for AB 1629 facilities will end on August 1, 2012, and the Department will provide a one-time supplemental payment in rate year 2012-13 that will be equivalent to the 10% reduction applied from June 1, 2011 to July 31, 2012. In addition, in rate year 2012-13, the Department will hold harmless any facility from rates that are less than the rates on file as of May 31, 2011.

### Quality and Accountability Supplemental Payment System

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) System for SNFs by August 1, 2010. The QASP system will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents.

### Rate Years 2011-12 and 2012-13

ABX19 (Chapter 4, Statutes of 2011) requires the Department to delay implementation of the QASP for one year, and establish FY 2011-12 as the base year for data collection. In rate year ~~2012-12~~ **2012-13**, the Department will set-aside 1% of the AB 1629 facilities reimbursement rate, which will be used to make supplemental payments under the QASP to ~~rewarded~~ **reward** facilities.

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### Reimbursement Methodology for Other Long-Term Care Facilities (non-AB 1629)

The current reimbursement methodology is based on a prospective flat-rate system, with facilities divided into peer groups by licensure, level of care, bed size and geographic area in some cases. Rates for each category are determined based on data obtained from each facility's annual or fiscal period closing cost report. Audits conducted by the Department result in adjustments to the cost reports on an individual or peer-group basis. Adjusted costs are segregated into four categories:

Fixed Costs (Typically 10.5 percent of total costs). Fixed costs are relatively constant from year to year, and therefore are not updated. Fixed costs include interest on loans, depreciation, leasehold improvements and rent.

Property Taxes (Typically 0.5 percent of total costs). Property taxes are updated 2% annually, as allowed under Proposition 13.

Labor Costs (Typically 65 percent of total costs). Labor costs, i.e., wages, salaries, and benefits, are by far the majority of operating costs in a nursing home. The inflation factor for labor is calculated by DHCS based on ~~costs~~ reported labor costs.

All Other Costs (Typically 24 percent of total costs). The remaining costs, "all other" costs, are updated by the California Consumer Price Index.

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## PROVIDER RATES

### Methodology by Type of LTC Facility

Projected costs for each specific facility are peer grouped by licensure, level of care, and/or geographic area/bed size.

Intermediate Care Facilities (Freestanding Nursing Facilities-Level A, NF-A) are peer-grouped by location and bed size. Reimbursements are equal to the median of each peer group.

Distinct Part (Hospital-Based) Nursing Facilities-Level B (DP/NF-B) are grouped in one statewide peer group. DP/NF-Bs are paid their projected costs up to the median of their peer group. When computing the median, facilities with less than 20 percent Medi-Cal utilization are excluded.

Intermediate Care Facilities for the Developmentally Disabled, Developmentally Disabled-Habilitative, and Developmentally Disabled-Nursing (ICF/DD, ICF/DD-H, ICF/DD-N) are peer grouped by level of care and bed size. Providers of services to developmentally disabled clients have rates set at the 65th percentile of their respective peer groups.

Subacute Care Facilities are grouped into two statewide peer groups: hospital-based providers and freestanding nursing facility providers. Subacute care providers are reimbursed their projected costs up to the median of their peer group.

Pediatric Subacute Care Units/Facilities are grouped into two peer groups: hospital-based nursing facility providers and freestanding nursing facility providers. There are different rates for ventilator and non-ventilator patients. Reimbursement is based on a model since historical cost data were not previously available.

### Rate Years 2011-12 and 2012-13 Rates

Pursuant to AB 97 (Chapter 3, Statutes of 2011), provider payments will be reduced by 10% for FFS claims, **retroactive to June 1, 2011** and the actuarial equivalent of 10% for managed care claims, retroactive to ~~June~~**July** 1, 2011.

Pursuant to ~~AB~~**ABX1** 19 (Chapter 4, Statutes of 2011), the Department will reduce payments for Freestanding Pediatric Subacute Care Facilities by ~~5.57%~~**5.75%** (rather than 10%) based on the 2008-09 rate-year rates. Effective ~~August 1, 2011~~ **January 1, 2012**, a QAF will be assessed on Freestanding Pediatric Subacute Care Facilities.

**PROVIDER RATES: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
PR 0.1 (PC-183)	X	<u>ACA – Payments to Primary Care Physicians</u>  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 that were in effect as of July 1, 2009 to the Medicare level for primary care services.
PR 0.2 (PC-198)	X	<u>Eliminate 2012-13 Rate Increase &amp; Supp. Payment</u>  The Department is proposing legislation to redirect funding for rate increases and supplemental payments for AB 1629 facilities to the GF in 2012-13.

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
PR 1	✗	✗	<p><u>NF-B Rate Changes and Quality Assurance (QA) Fee</u></p> <p>AB 1629 (Chapter 875, Statutes of 2004) required the Department to change the rate methodology for freestanding skilled nursing facilities (freestanding NF-Bs and freestanding adult subacute facilities, excluding pediatric subacute services and rural swing bed days), to provide an annual cost-of-living adjustment (COLA) and to collect a <u>quality assurance-QA</u> fee from these facilities. The rate methodology and QA fee provisions sunset on July 31, 2013. <b><u>The Department has proposed to permanently extend the QA fee.</u></b></p>
(PC-75)	<u>X</u>	<u>X</u>	<p><u>Rate Changes due to Rate Methodology</u></p> <p>ABX1 19 (Chapter 4, Statutes of 2011) provides an allowable overall rate increase up to 2.4% for the 2011-12 rate year, <b><u>and the difference between what is provided in 2011-12 and 2.4% in the 2012-13 rate year.</u></b> A rate adjustment of <del>approximately 0.4%</del><b><u>0.426% will be was</u></b> provided in the 2011-12 rate year, <del>but no rate adjustment is assumed in the 2012-13 rate year.</del> <b><u>and a rate adjustment of 1.973% will be provided in the 2012-13 rate year.</u></b></p>
(PC-77)	<u>X</u>	<u>X</u>	<p><u>Rate Adjustments due to the QA Fee</u></p> <p>Assessment of the QA fee is based on revenues from Medi-Cal, Medicare and private pay sources. Effective October 1, 2011, the QA fee limit will increase from 5.5% to 6%.</p> <p>QA fee amounts are calculated to be net of the L&amp;C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. L&amp;C fees shift from year to year, which impacts the amount of QA fee the Department can collect. The State uses a portion of the QA fee to draw down FFP and to fund rate increases. Rate increases due to the QA fee are expected to be cost neutral to the General Fund.</p> <p>SB 853 (Chapter 717, Statutes of 2010) requires the Department to expand the amount of revenues upon which the QA fee is assessed by including revenue from Multi-Level Retirement Communities (MLRCs) and revising the QA Fee trending methodology. This will result in rate increases to the facilities. SB 853 established an allowable overall rate increase of up to 2.4% for rate year 2011-12. Under SB 853, the QAF fee sunsets as of July 31, 2012.</p> <p><b><u>ABX1 19 (Chapter 4, Statutes of 2011) provides an allowable overall rate increase up to 2.4% for the 2011-12 rate year, and the difference between what is provided in 2011-12 and 2.4% in the 2012-13 rate year. A rate adjustment of 0.426% was provided in the 2011-12 rate year, and a rate adjustment of 1.973% will be provided in the 2012-13 rate year. ABX1 19 also extended the QA fees sunset date by one year, to August 1, 2013.</u></b></p>

## PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
(PC-82)	<b>X</b>			<p><u>Quality and Accountability Payments Program</u></p> <p>SB 853 (<b><u>Chapter 717, Statutes of 2010</u></b>) implemented a quality and accountability payments program for freestanding nursing facilities (NF-Bs), with the first phase beginning in rate year 2010-11. Payments made under the program will begin in rate year 2012-13 as supplemental to the rates and will be paid through a special fund. The special fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, <del>one percent of the weighted average rate increase for 2012-13</del> <b><u>1% of the AB 1629 facilities reimbursement rate for rate year 2012-13</u></b>, and the savings achieved from setting the professional liability insurance cost category at the 75th percentile.</p>
(PC-75)	<b>X</b>	<b>X</b>		<p><b><u>AB 1629 Add-Ons to the Rates</u></b></p> <p>CMS mandated that <del>freestanding</del> 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 <del>will be</del> <b><u>was</u></b> effective August 1, 2011, and <del>be</del> retroactive to October 1, 2010.</p> <p>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 costs <del>will be</del> <b><u>was</u></b> effective August 1, 2011, and <del>be</del> retroactive to October 2009.</p>
PR 2 (PC-88)	<b>X</b>		<b>X</b>	<p><u>10% Payment Reduction</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) requires the Department to implement a payment reduction of up to 10% to specified providers in FFS, <b><u>effective June 1, 2011</u></b>, and <del>the</del> <b><u>The</u></b> actuarial equivalent of that amount to specified managed care providers, <del>effective June 1, 2011</del>. <b><u>was implemented July 1, 2011.</u></b></p> <p><b><u>On October 27, 2011, the Department received federal approval to reduce provider payments up to 10%.</u></b></p>
PR 3 (PC-78)	X		X	<p><u>Annual MEI Increase for FQHCs and RHCs</u></p> <p>The Department implemented the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) included in the 2000 Benefits Improvement and Protection Act on January 1, 2001. Clinics have been given the choice of a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate</p>

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

adjustment is the percentage increase in the Medicare Economic Index (MEI) and is effective October 1<sup>st</sup> of each year.

PR 4                    ✕       ✕       LTC Rate Adjustments and QA Fees

(PC-76)    X       X       Rate Adjustment

Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of an annual rate study.

The following facilities are included in this assumption:

- Intermediate Care Facilities/Developmentally Disabled (ICF-DD)
- ICF/DD-Habilitative
- ICF/DD-Nursing
- Freestanding Nursing Facilities – Level A (NF-A)
- Distinct Part Nursing Facilities (DP/NF) – Level B
- DP/NF Subacute
- Pediatric Subacute Care
- Rural Swing Beds
- Adult Day Health Care/Community-Based Adult Services

(PC-86)    X       X       Rate Freeze

ABX4 5 (Chapter 5, Statutes of 2009), froze rates for all LTC facilities for rate year 2009-10 and every year thereafter at the 2008-09 levels.

Under *CHA v. David Maxwell-Jolly*, the Department was enjoined from freezing rates for Distinct Part Nursing Facilities Level B, DP/NF adult and DP pediatric subacute and rural swing bed providers. NF-A, ICF-DD (H/N) and FS pediatric subacute facilities were not part of the lawsuit, and their rates continue to be frozen. AB 97 (Chapter 3, Statutes of 2011) requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5.

(PC-87)    X       X       10% Payment Reduction

AB 97 (Chapter 3, Statutes of 2011) also required the Department to reduce payments to long-term care facilities by up to 10% in FFS, **effective June 1, 2011**, and the ~~The~~ actuarial equivalent of that amount in managed care, ~~effective June 1, 2011~~. **was implemented July 1, 2011**. Subsequently, ABX1 19 (**Chapter 4, Statutes of 2011**) requires the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% of rate year 2008-09 rates.

**The following long-term care providers are not subject to the 10% payment reduction:**

- **Distinct Part Adult Subacute Facilities**
- **Distinct Part Pediatric Subacute Facilities**
- **Hospice Providers**

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- Hospice Room and Board Providers

The following long-term care providers are subject to the 10% payment reduction:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A)
- Distinct Part Nursing Facilities, Level B
- Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing – The Department will be submitting a request to CMS to modify the rate-setting methodology which will result in reduced rates of up to 10% for some facilities.

(PC-76)    X    X    QA Fees

Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) are required to pay a ~~Quality Assurance (QA)~~ QA fee. Pursuant to ABX19 (**Chapter 4, Statutes of 2011**), beginning August 1, 2011, Freestanding Pediatric Subacute Care facilities will be required to pay a QA fee. Currently, the QA fee is capped at 5.5% of total gross revenues. Effective October 1, 2011, the federal government will allow states to cap the QA fee at 6% of total gross revenues. The fee is used to draw down FFP and fund rate increases, which are expected to be cost neutral to the GF.

(PC-76)    X    X    Non-AB 1629 Add-Ons to the Rates

CMS mandated that freestanding **and distinct part** skilled nursing facilities, **including Adult and Pediatric Subacute**, 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~~ **was** effective August 1, 2011, and ~~be~~ retroactive to October 1, 2010.

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 costs ~~will be~~ **was** effective August 1, 2011, and ~~will be~~ retroactive to October 2009.

PR 5 (PC-80)    X    X    Hospice Rate Increases

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

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

Effective February 1, 2003, hospice room and board providers are reimbursed at 95% of the Medi-Cal per-diem rate paid to the facility with which the hospice is affiliated. This change in reimbursement methodology was made to reflect the CMS allowable rate, in accordance with 42 USC 1396a(a)(13)(B) and 1902(9a)(13)(B) of the federal Social Security Act.

PR 6 (PC-NA)    X    X    Alternative Birthing Centers

Pursuant to W & I Code Section 14148.8, the Department is required to provide Medi-Cal reimbursement to alternative birthing centers (ABCs) for facility-related costs at a statewide all-inclusive rate per delivery. This reimbursement must not exceed 80% of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts. The reimbursement rates must be updated annually and must be based on an average hospital length of stay of 1.7 days. The ABC rates will increase each year by the same percentage as the CMAC average acute care hospital contract rate.

PR 7 (PC-85)    ✕    X    Reduction to Radiology Rates

SB 853 (Chapter 717, Statutes of 2010) reduced Medi-Cal rates for radiology services to 80% of Medicare rates, effective October 1, 2010. Rate reductions will be implemented, retroactive to October 1, 2010 following assessment of the impact of the reduction.

PR 8 (PC-79)          X    Air Ambulance Medical Transportation

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

**AB 215 (Chapter 392, Statutes of 2011) removed a county's ability to retain a portion of moneys collected from the penalties to administer the EMATA and deletes the requirement that counties submit an annual report to the Department on the funds the county retained for administration costs.**

After the payment of the Department's administrative costs, 20% of the fund will be allocated to the General Fund. ~~And~~ **The remaining 80% in the EMATA fund will be matched with federal funds and** will be used to increase the payments and/or rates for medical emergency Medi-Cal air medical transportation services. ~~The Department will determine the timing and method of the payments so there will be no GF cost for the rate increases.~~

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**PROVIDER RATES: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
PR 9	(PC-81) (PC-75)		X	<u>10% Payment Reduction Restoration and Supplemental Payments</u>  Under ABX1 19 (Chapter 4, Statutes of 2011), the 10% payment reduction for AB 1629 facilities will end July 31, 2012. ABX1 19 requires the Department to: <ul style="list-style-type: none"> <li>• 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,</li> <li>• Provide a <u>an allowable</u> rate increase of up to 2.4% <u>for the 2011-12 rate year. Under ABX1 19, a rate adjustment of 0.426% was provided for the 2011-12 rate year, and a rate adjustment of 1.973% will be provided in the 2012-13 rate year.</u></li> <li>• 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.</li> </ul>

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**SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
SP 0.1 (PC-185)	X	<u>Ground EMT Payment</u>  AB 678 (Chapter 397, Statutes of 2011) provides supplemental payments to publicly owned ground emergency medical transportation (EMT) service providers. Supplemental payments combined with other reimbursements cannot exceed 100% of the costs. Governmental entities provide the federal share through CPEs. Once the SPA is approved by CMS, the supplemental reimbursement program will be retroactive to January 30, 2010.
SP 0.2 (PC-208)	X	<u>Hospital QAF Program Changes</u>  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 revenue is primarily used to match federal fund to provide supplemental payments to hospitals, increased payments to managed care plans, and direct grants to public hospitals. The Department has proposed to reduce increased payments to managed care plans and direct grants and use the fee revenue to offset GF costs for children's health coverage in the Medi-Cal program.

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
SP 1 (PC-118)	X	X	<p><u>Capital Project Debt Reimbursement</u></p> <p>SB 2665 (Chapter 1310, Statutes of 1990) and SB 1732 (Chapter 1635, Statutes of 1988) authorize Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. To qualify, a hospital must be a disproportionate share hospital, must have either a SPCP or County Organized Health Systems contract with the State of California, and must meet other specific hospital and project conditions specified in Section 14085.5 of the W&amp;I Code.</p> <p>SB 1128 (Chapter 757, Statutes of 1999) authorizes a Distinct Part (DP) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP must meet other specific hospital and project conditions specified in <del>section</del><b>Section</b>14105.26 of the W&amp;I Code Two DP facilities <del>are expected to begin</del><b><u>begin</u></b> submitting claims <b><u>and received payments</u></b> in FY 2011-12.</p>
SP 2 (PC-117)	X	X	<p><u>Hospital Outpatient Supplemental Payments</u></p> <p>AB 915 (Chapter 747, Statutes of 2002) creates a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. The supplemental amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal share used to draw down FFP will be paid exclusively with funds from the participating facilities and will not involve General Fund dollars. Interim payments are expected to be made every year in June. Interim payment adjustments are made upon receipt and review of amended claims.</p> <p>The reconciliation mandated by AB 915 against audited cost reports is scheduled to begin in FY <del>2011-12</del><b>2012-13</b>. Adjustments to interim payments, or recoupment of overpaid funds, are expected during FY <del>2011-12</del><b>2012-13</b>. Reconciliation of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.</p>
SP 3 (PC-121)	X	X	<p><u>IGTs for Non-SB 1100 Hospitals</u></p> <p>W&amp;I Code, Section 14164, provides general authority for the Department to accept IGTs from a governmental entity in the State in support of the Medi-Cal program. The IGT will be used as the non-federal share of cost in order to draw down FFP, which will then be distributed to the hospitals designated by the county or health care district.</p>
SP 4 (PC-122)	X	X	<p><u>FFP for Local Trauma Centers</u></p> <p>The Budget Act of 2003 provided authority for Los Angeles County and Alameda County to submit IGTs to the Medi-Cal program to be used as</p>

## SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

the non-federal share of costs in order to draw down federal funds. The combined funds will be used to reimburse specified hospitals for costs of trauma care provided to Medi-Cal beneficiaries.

SP 5	(PC-123)	X	X	<p><u>Certification Payments for DP-NFs</u></p> <p>AB 430 (Chapter 171, Statutes of 2001) allows Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals to claim FFP on the difference between their projected costs and the maximum DP-NF rate Medi-Cal currently pays. The acute care hospitals must be owned and operated by a public entity, such as a city, county, or health care district.</p>
SP 6	(PC-124)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient DSH</u></p> <p><del>SB 2563 appropriated \$5,000,000 General Fund to be allocated to hospitals providing a disproportionate share of outpatient services. The total appropriation each year is \$10,000,000 when combined with federal matching funds.</del> <b><u>SB 2563 (Chapter 976, Statutes of 1988) created a supplemental program for hospitals providing a disproportionate share of outpatient services.</u></b> Eligible DSH providers are reimbursed on a quarterly basis through a Payment Action Notice (PAN) to the Fiscal Intermediary (FI). The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
SP 7	(PC-125)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient Small and Rural Hospitals</u></p> <p><del>Health and Safety Code section 124870</del> <b><u>AB 2617 (Chapter 158, Statutes of 2000)</u></b> requires the Department to increase reimbursement rates for outpatient services rendered to Medi-Cal beneficiaries by small and rural hospitals (SRH). Eligible SRH providers are reimbursed on a quarterly basis through a PAN to the FI. The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
SP 8	(PC-116) (PC-126)	X	X	<p><u>Freestanding Outpatient Clinics and State Veterans' Home Supplemental Payments</u></p> <p>AB 959 (Chapter 162, Statutes of 2006) adds eligible freestanding outpatient clinics and state veterans' homes to the current Medi-Cal outpatient supplemental program. Under this program, clinics that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. State veterans' homes that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, or health care district are also eligible to receive supplemental payments.</p> <p>The non-federal match is paid from public funds of the participating facilities.</p>

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year starting August 1, 2006. Supplemental payments to freestanding outpatient clinics will be effective retroactively beginning July 1, 2006 pending an approved State Plan Amendment. The SPA is expected to be approved in FY 2011-12.

SP 9 (PC-119) X X Specialty Mental Health Services Supplemental Reimbursement

ABX4 5 (Chapter 5, Statutes of 2009) creates a provision to allow an eligible public agency receiving reimbursement for specialty mental health services provided to Medi-Cal beneficiaries to also receive supplemental Medi-Cal reimbursement up to 100% of actual allowable costs.

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

The Department submitted a SPA to CMS to obtain approval for the new supplemental payment program. The Department and CDMH are providing additional information to CMS. Upon approval, supplemental payments will be authorized retroactive to January 2009, with payments expected to be made beginning FY 2011-12.

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

SP 10 (PC-120) X X NDPH IGT Supplemental Payments

AB 113 (Chapter 20, Statutes of 2011) establishes a supplemental payment program for Non-Designated Public Hospitals (NDPHs). These payments are funded with Intergovernmental Transfers (IGTs) and are distributed to the NDPHs based upon a formula in the statute. The State retains nine percent of the IGTs to fund administrative costs and Medi-Cal children's health programs.

SP 11 (PC-115) X X Hospital QAF – Hospital Payments

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 2009 through December 2010. AB 1653 (Chapter 218, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 (Chapter 627, Statutes of 2009). AB 1653 alters the methodology, timing, and frequency of supplemental payments, increases capitation payments to Medi-Cal

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

managed health care plans, and increases payments to mental health plans.

The fee will be deposited into the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158) created by AB 188 (Chapter 645, Statutes of 2009). This fund will be used to provide supplemental payments to private, and non-designated public hospitals, grants to designated public hospitals, and increased capitation payments to managed health care and increased payments to mental health plans. Managed care capitation rates were adjusted to reflect the increased payments that are required to be made to hospitals for hospital services provided to Medi-Cal enrollees of the plan. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program. Final federal approval for the fee-for-service payments has been received. CMS has also approved the managed care contract amendments with the rate adjustments.

SP 12

SB 90 Hospital Inpatient Reimbursement

SB 90 (Chapter 19, Statutes of 2011), an urgency bill signed April 13, 2011, made a number of changes to the Medi-Cal program:

(PC-93)    X    X

MH/UCD & BTR—Private Hospital DSH Replacement

SB 90 reduced Medi-Cal DSH replacement payments to private hospitals by \$30 million GF in FY 2010-11 and \$75 million GF in FY 2011-12.

(PC-115)    X    X

Hospital QAF – Hospital Payments

SB 90 ~~created~~ **extended** a new Hospital QAF program for the period January to June 2011 based on the original Hospital QAF program enacted by AB 1383. The new program modified the amount of payments to hospitals and also increased the amount available for children's health to \$105 million per quarter during the extension from the previous \$80 million per quarter.

(PC-84)    X

Preserving Contract Hospitals

SB 90 included a provision that required a reduction in amount of any QAF supplemental payment for a contract hospital that converts to non-contract status. This reduction is equal to the amount by which the hospital's overall payment for Medi-Cal services was increased during the program period by reason of it becoming a noncontract hospital.

(PC-74)    X    X

Non-Contract Hospital Rate and Payment Changes

SB 90 repealed a number of rate and payment reductions for non-contract hospital inpatient services. These include:

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- 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 reduction of certain non-contract Small and Rural Hospital inpatient services.

SP 13

SB 335 Hospital Inpatient Reimbursement

SB 335 (Chapter 286, Statutes of 2011), an urgency bill, made a number of changes to the Medi-Cal program:

(PC-156) X X

Hospital QAF – Children’s Health Care

SB 335 creates a new Hospital ~~Quality Assurance Fee~~ **QAF** program for the period of July 1, 2011 to December 31, 2013. This new program will authorize the collection of a quality assurance fee from non-exempt hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue Fund. ~~The~~ **On an accrual basis, the** fund will also be used to pay for health care coverage for children in the amount of \$340 million for FY 2011-12, and \$387 million in FY 2012-13, **and \$193 million in FY 2013-14.**

(PC-109) X X

Low Income Health Program Out-Of-Network Fund

SB 335 creates the Low Income Health Program Out-of-Network Medi-Cal Expansion Emergency Care Services Fund (LIHP Fund) to pay for emergency care services to LIHP beneficiaries at out-of-network hospitals. Annually, \$20 million in IGTs from designated public hospitals and \$75 million from the Hospital Quality Assurance Revenue Fund will be paid to out-of-network hospitals.

(PC-93) X X

MH/UCD & BTR—Private Hospital DSH Replacement

SB 335 reduces Medi-Cal DSH replacement payments to private hospitals by \$75 million GF in FY 2011-12 and \$10.5 million GF in FY 2012-13.

(PC-94) X

MH/UCD & BTR—Private Hospital Supplemental Payment

SB 335 reduces the Private Hospital Supplemental Fund by \$17.5 GF million in FY 2012-13.

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

(PC-115)   X        X        Hospital QAF – Hospital Payments

SB 335 ~~extends~~ **created** the Hospital QAF program for the period July 2011 to December 2013. The bill will provide payments to private hospitals, designated public hospitals.

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

Applicable F/Y

C/Y    B/Y

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

Applicable F/Y

C/Y    B/Y

A 1	(PC-144) <u>Lawsuits/Claims*</u>	Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
	a. <u>Attorney Fees of \$5,000 or Less</u>		
	1. David Maxwell-Jolly	\$750	
	2. GGNSC Holdings, LLC	\$843	
	3. Nicholas Johnson	<u>\$1,000</u>	
	Total	\$2,593	
	Fund Balance \$47,407	\$50,000	\$50,000
	b. <u>Provider Settlements of \$75,000 or Less</u>		
	1. Alta Bates Summit Medical Center	\$38,418	
	2. Catholic Healthcare West Southern California	\$49,646	
	3. Columbia/HCS Western Group In.	\$364	
	4. Catholic Healthcare West	\$7,075	
	5. Daniel Freeman Memorial Hospital	\$1,680	
	6. Caritas Business Services	\$2,493	
	7. Providence Health System	\$37,924	
	8. Providence Health System	38,308	
	9. Cha Hollywood Medical Center	\$12,414	
	10. Glendale Adventist Medical Center	\$9,971	
	11. Good Samaritan Hospital	\$11,506	
	12. Catholic Healthcare West	\$3,278	
	13. Alta Hollywood Hospital Inc.	\$2,642	
	14. Alta Los Angeles Hospitals	\$1,306	
	15. Catholic Healthcare West	\$35,778	
	16. Catholic Healthcare West	\$8,671	
	17. Tri-City Regional Medical Center	\$1,750	
	18. Catholic Healthcare West	\$12,858	
	19. Daughters of Charity Health Systems	\$21,619	
	20. Alameda Hospital	\$4,021	
	21. Catholic Healthcare West	\$7,373	
	22. Central Coast Skilled Care, Inc.	\$55,304	
	23. CFHS Holdings, Inc.	\$3,947	
	24. East Los Angeles Doctors Hospital, Inc.	\$2,237	
	25. Catholic Healthcare West	\$900.34	
	26. CFHS Holdings, Inc.	\$10,391	
	27. Cedars-Sinai Medical Center	\$909	
	28. CHA Hollywood Medical Center	\$46,589	
	29. CHA Hollywood Medical Center	\$8,037	
	30. East Los Angeles Doctors Hospital, Inc.	\$1,820	
	31. Caritas Business Services	\$25,947	
	32. Caritas Business Services	\$15,464	
	33. East Los Angeles Doctors Hospital, Inc.	<u>\$1,459</u>	
	Total	\$482,103	
	Fund Balance \$1,117,897	\$1,600,000	\$1,600,000

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

Applicable F/Y  
C/Y    B/Y

c. <u>Beneficiary Settlements of \$2,000 or Less</u>			
		Fund Balance	\$15,000    \$15,000
d. <u>Small Claims Court Judgments of \$5,000 or Less</u>			
		1. Windsor Manor Rehab Center of Concord	\$5,000
		Fund Balance \$195,000	\$200,000    \$200,000
e. <u>Other Attorney Fees</u>			
		1. Emily Q.v. Diana Bonta	\$285,346
		2. Santa Clara County Health Authority	\$6,779
		3. Katie A. v. Toby Douglas	\$1,946,747
		4. CMA v. State DHCS	<u>\$50,000</u>
		Total	\$2,288,872
f. <u>Other Provider Settlements / Judgments</u>			
		1. County of Contra Costa	\$7,200,000
g. <u>Other Beneficiary Settlements</u>			
Amounts may exclude interest payments.			
A 2	(PC-64)	X    X	<u>Notices of Dispute / Administrative Appeals – Settlements</u>
Settlement agreements for disputes between the Department and the managed care plans are estimated to be \$2,000,000 for possible settlements for each fiscal year.			
A 3	(PC-146)	X	<u>Minor Consent Settlement</u>
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 within 10 days of receipt of the fully executed agreement. The balance of \$66,500,000, plus interest, will be withheld from California’s Medicaid payments over ten years, with the first “adjustment” to be made July 1, 2003.			
A 4	(OA-9)	X    X	<u>Litigation-Related Services</u>
The Department continues to experience significant and increasing litigation costs in defense of the Medi-Cal program. The number of open cases has increased, and the Department of Justice rates for litigating these cases have increased.			
Ongoing litigation filed by managed care plans against the Department regarding their capitation rates has resulted in increased work and costs for			

**OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y    B/Y

			the Department's consulting actuaries to comply with the requirements of the court rulings.
A 5 (PC-48)	X		<p><u>Litigation Settlements</u></p> <p>The Department continues to work collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks and overcharging Medicaid. Settlements are expected to be received in FY 2011-12 from Seacliff Diagnostics Medical Group; Mariner Health Care, Inc. and Sava Senior Care Administrative Services, LLC; Novartis; Eisai/Elan; Quest Diagnostics; Novo Nordisk; Serono; Merck; Lab Corp; <b>CVS; Maxim; Pfizer; UCB, Inc.; Whitefield Medical Lab</b> and Ven-A-Care of the Florida Keys (<b>Sandoz</b>).</p>
A 6 (PC-181) (Reworded)	X	X	<p><u>AB 97 Injunctions</u></p> <p>The U.S. District Court, Central District of California, issued a preliminary injunction in the following cases related to AB 97:</p> <ul style="list-style-type: none"> <li>• December 28, 2011 – <i>California Hospital Association v. Douglas, et al.</i>: The Department is prohibited from implementing reductions to hospital-based nursing facilities.</li> <li>• December 28, 2011 – <i>Managed Pharmacy Care, et al. v. Sebelius, et al.</i>: The Department is prohibited from implementing reductions for pharmacy services.</li> <li>• January 10, 2012 – <i>California Medical Transportation Association v. Douglas, et al.</i>: The Department is prohibited from implementing reductions for non-emergency medical transportation providers.</li> <li>• January 31, 2012 – <i>California Medical Association v. Douglas, et al.</i>: The Department is prohibited from implementing reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment on or after June 1, 2011.</li> </ul> <p>The Department has filed Notices of Appeals in the first three cases and will do so in the fourth case as well.</p>
A 7 (PC-194)	X	X	<p><u>Audit Settlements</u></p> <p>Payments for audit settlements with the federal government are budgeted in the Audit Settlements policy change.</p>

**OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 0.1 (PC-184)	X	X	<p><u>Siskiyou County Mental Health Plan Overpayment</u></p> <p>The Department of Mental Health (DMH) has identified overpayments to Siskiyou County Mental Health Plan (MHP) due to inappropriate Medi-Cal billing practices. The overpayment amounts were identified through the cost settlement and fiscal audits processes. The Department must return the overpaid Federal Financial Participation reimbursements to the Centers for Medicare and Medicaid Services (CMS).</p>
R 0.2 (PC-186) (OA-67)	X		<p><u>Refunds on Acts of Fraud</u></p> <p>CMS provided clarification on the FFP of Medicaid recoveries pursuant to legal action under the False Claims Act (FCA). Under the FCA, settlements are shared among the states, the federal government and the whistle-blower. The Department estimates a \$97 million recoupment from the federal government due to:</p> <ul style="list-style-type: none"> <li>• Incentive FFP for states that have enacted federally-compliant False Claims Act, and</li> <li>• Settlement payments erroneously made to the federal government from the Department.</li> </ul> <p>In addition, the Department expects \$45.9 million federal fund reimbursement in FCA relator costs.</p>
R 0.3 (OA-73)	X	X	<p><u>CalHEERS Development</u></p> <p>The ACA mandates the establishment of health insurance exchanges, in California, known as the Health Benefit Exchange (HBEX) to provide competitive health care coverage for individuals and small employers. As required by ACA, States must establish a "one-stop-shop" to accept online application and to determine an applicant's eligibility for subsidized coverage. In creating this "one-stop-shop" experience, States are also required to use a single, streamlined application to apply for all applicable health subsidy programs. The application may be filed online, in person, by mail, by telephone with an Exchange, or the Medicaid and Children's Health Insurance Program (CHIP) agency. To meet this requirement, the Department, MRMIB, and the Exchange have formed a partnership to acquire a Systems Integrator to design and implement the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) as the business solution that will allow the required one-stop-shopping, making health insurance eligibility and purchasing easier and more understandable.</p> <p>ACA also offers new enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required Exchanges.</p>

**OTHER: REIMBURSEMENTS: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
R 0.4 (OA-72)	X	<p><u>MEDS Integration into CalHEERS</u></p> <p>The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) will be programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through the Health Benefit Exchange (HBEX), Medi-Cal and the Healthy Families program. In order to provide seamless integration with the new CalHEERS system, the Department will establish and design the implementation of technology solutions for ongoing maintenance of Medi-Cal Eligibility Data System (MEDS) changes and integration with CalHEERS.</p> <p>The Department will receive the enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related systems changes needed to interface with the CalHEERS.</p>
R 0.5 (PC-196)	X	<p><u>First 5 California Funding</u></p> <p>In FY 2012-13, \$40,000,000 of First 5 California funding, will be reimbursed to Medi-Cal through an interagency agreement.</p>
R 0.6 (PC-196)	X	<p><u>Department of State Hospitals Admin. Costs</u></p> <p>The Medi-Cal budget includes the estimated cost of federal funds for Health Insurance and Portability and Accountability Act (HIPAA) for California Department of State Hospitals.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y										
		<u>C/Y</u>	<u>B/Y</u>									
R 1	(PC-NA)	X	X	<u>FMAP Changes</u>								
<p>The Federal Medical Assistance Percentage (FMAP), which determines the federal Medicaid sharing ratio for each state, was 50% for the Medi-Cal program effective for the federal fiscal year beginning October 1, 2002. Public Law 108-27, the federal Jobs and Growth Tax Relief Reconciliation Act of 2003, increased the FMAP to 54.35% from April 1, 2003, to September 30, 2003, and to 52.95% from October 1, 2003, to June 30, 2004.</p> <p>On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period.</p> <p>On August 10, 2010, the President signed the Education, Jobs and Medicaid Assistance Act of 2010 that included a six-month extension through June 2011 of Medicaid's temporary enhanced FMAP for the states. California received an 8.77% FMAP increase for January 1, 2011 through March 31, 2011 and a 6.88% FMAP increase for April 1, 2011 through June 30, 2011. 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 payment occurs, there will be some expenditures made in FY 2011-12 that receive ARRA. Expenditures may receive the applicable FMAP based on date of service, such as SNCP payments, or based on the date another department paid the initial expenditure and Medi-Cal draws the federal funds in a subsequent fiscal year.</p>												
R 2	(PC-134)	X	X	<u>Dental Contract</u>								
<p>The dental rates for the period August 1, 2009 through July 31, 2010 are:</p> <table border="0" style="margin-left: 40px;"> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">Refugees</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">All Others</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">\$9.50</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">\$6.76</td> </tr> </table> <p>Effective March 2, 2010, reimbursement rates for certain dental anesthesia procedures have been reduced. These changes are reflected in the 2010-11 capitation rates.</p>					_____	Refugees	_____	All Others	_____	\$9.50	_____	\$6.76
_____	Refugees	_____	All Others									
_____	\$9.50	_____	\$6.76									

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The dental rates are:

	Refugees	All Others
August 1, 2010 – July 31, 2011	\$7.06	\$6.70
Effective August 1, 2011	\$3.35	\$6.03

**AB 97 requires a 10% provider payment reduction. CMS approved the reduction, effective June 1, 2011.** The current rates will remain in effect until the new rates, **reflecting the reduction,** are negotiated and approved by control agencies through the change order process.

R 3	(PC-58) (PC-83)	X	X	<p><u>Dental Geographic Managed Care</u></p> <p>The Geographic Managed Care (GMC) project in Sacramento County covers dental services for eligibles with mandatory aid code sand SSI/SSP on a voluntary basis. Since April 1994, dental managed care services to beneficiaries have been delivered through several dental plans. Currently, there are five dental GMC plans.</p> <p>The five GMC contracts are in effect through December 31, 2012. The Request for Application process for a new contract, effective January 1, 2013, <del>is expected to begin</del> <b><u>began in</u></b> January 2012.</p>
R 4	(PC-58) (PC-83)	X	X	<p><u>Dental Managed Care within Medi-Cal Two-Plan Model Counties</u></p> <p>The 1997-98 Budget Act made a provision for the Department to enter into contracts with health care plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis.</p> <p>The Department has contracted with eight dental plans that are providing services as voluntary PHPs in Los Angeles County. These contracts ended June 30, 2009. Amendments have been executed extending the contracts through June 30, 2013. <del>The new contracts will be effective July 1, 2013.</del> <b><u>The Request for Application process for a new contract, effective July 1, 2013, is expected to begin in July 2012.</u></b></p>
R 5	(PC-158)		X	<p><u>FI Cost Containment Projects – Program Savings</u></p> <p>The Department has approved implementation of proposals developed by the Fiscal Intermediary to contain Medi-Cal costs. The cost containment proposals result in savings to the Medi-Cal program. The Fiscal Intermediary will share in the achieved savings for two years after implementation of each proposal.</p>
R 6	(OA-7)	X	X	<p><u>MIS/DSS Contract</u></p> <p>The Management Information System and Decision Support System (MIS/DSS) houses a variety of data and incorporates it into an</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

integrated, knowledge-based system. It is used by the Department, including the Medi-Cal Managed Care Division in its monitoring of Health Plan performance, the Third Party Liability and Recovery Division in its collection efforts, and the Audits and Investigations Division in its anti-fraud efforts.

Ongoing operation and maintenance of the MIS/DSS is accomplished through a multi-year contract with Integrus, Inc. DBA ~~Ingenix~~ **Optuminsight**, which is effective through February 14, 2014.

R 7    (PC-151)    X        X        Indian Health Services

Effective April 21, 1998, Medi-Cal implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and CMS. The agreement provided that California can be reimbursed 100% federal medical assistance percentage for payments made by the State for services rendered to Native Americans through IHS tribal facilities. Federal policy permits retroactive claiming of 100% FFP to the date of the MOA, July 11, 1996, or at whatever later date a clinic qualifies and elects to participate as an IHS facility under the MOA.

Recent changes posted in the Federal Register increased the per visit rate payable to Indian Health Clinics effective January 2011. **The per visit rate payable to Indian Health Clinics is not available until the early part of May or June in the Federal Register. However, the new rate will be retroactive to January 2012.**

R 8    (OA-57)    X        X        Kit for New Parents

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

R 9    (PC-135)    X        X        Developmental Centers/State Operated Small Facilities

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

R 10   (OA-42)    X        X        CDDS Administrative Costs

The Medi-Cal budget includes FFP for CDDS Medi-Cal-related administrative costs. Beginning in FY 2001-02, CDDS began budgeting the General Fund in its own departmental budget.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 11	(PC-130) (OA-41)	X	X	<p><u>Mental Health Services – CDMH</u></p> <p>The Medi-Cal budget includes the estimated cost of specialty mental health services provided to Medi-Cal beneficiaries through the Medi-Cal Specialty Mental Health Services waiver program administered by California Department of Mental Health (CDMH).</p> <p>On June 22, 2011, CMS granted approval of the Medi-Cal Specialty Mental Health Services waiver for the term July 1, 2011 through June 30, 2013.</p> <p>As a result of the settlement of litigation filed by a number of specialty mental health providers subcontracted to Los Angeles County, payments for certain denied or unprocessed claims under the waiver for FYs 2003-04, 2004-05 and 2005-06 will be paid in FY 2011-12.</p>
R 12	(PC-142)	X	X	<p><u>Healthy Families – CDMH</u></p> <p>Title XXI FFP will be claimed for the cost of providing additional mental health services to eligible Severely Emotionally Disturbed children who have exhausted Healthy Families mental health benefits.</p>
R 13	(PC-138) (OA-49)	X	✕	<p><u>Drug Medi-Cal – CDADP</u></p> <p>The Drug/Medi-Cal program provides substance abuse treatment services to Medi-Cal beneficiaries in an outpatient setting.</p> <p>Drug/Medi-Cal services are reimbursed on a fee-for-service (FFS) basis. These community treatment services are carved out from the regular Medi-Cal program and are administered by the CDADP.</p> <p>Title XIX FFP is claimed for Drug Medi-Cal services administered by the CDADP.</p> <p><b><u>Effective July 1, 2012, the CDADP administrative staff and associated federal funding will be shifted to the Department's state operations.</u></b></p>
R 14	(PC-150) (OA-47)	X	X	<p><u>CLPP Case Management Services</u></p> <p>The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments, which provide case management services. To the extent that local governments provide case management to Medi-Cal eligibles, federal matching funds can be claimed.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 15	(PC-152)	X	X	<p><u>Cigarette and Tobacco Products Surtax Funds</u></p> <p>Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the <i>Orthopaedic Hospital</i> settlement and Medi-Cal hospital outpatient services via the Hospital Services Account and the Unallocated Account. The amounts available to Medi-Cal vary from year to year.</p>
R 16	(OA-59)	X	X	<p><u>California Health and Human Services Agency HIPAA Funding</u></p> <p>A HIPAA office has been established at the California Health and Human Services Agency to coordinate implementation and set policy regulations for departments utilizing Title XIX programs. Title XIX FFP is available for qualifying HIPAA activities related to Medi-Cal.</p>
R 17	(OA-5)	X	X	<p><u>EPSDT Case Management</u></p> <p>Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions. <del>As more children shift from CHDP to the CHDP Gateway, costs for county administration shift from the state funded CHDP Program to the Medi-Cal and Healthy Families programs.</del></p>
R 18	(OA-3) (OA-34)	X	X	<p><u>CCS Case Management Costs</u></p> <p>Medi-Cal provides funding for the county administration of the California Children's Services (CCS) Program for those children who receive CCS services who are Medi-Cal eligible. The CMS Net automated eligibility, case management, and service authorization system is used by the CCS program to provide administrative case management for CCS clients in the CCS Medi-Cal, CCS State Only, and CCS-Healthy Families programs. The costs for CCS clients in Medi-Cal are budgeted in the Medi-Cal Estimate.</p> <p>County funds expended above the allocations on administrative activities in support of a county's CCS/Medi-Cal caseload may be used as certified public expenditures to draw down Title XIX federal financial participation.</p>
R 19	(PC-153)	X	X	<p><u>IMD Ancillary Services – CDMH</u></p> <p>Effective July 1, 1999, the cost of ancillary services for Medi-Cal eligibles, 21 years of age and older or who have not attained 65 years of age and who are residents of CDMH Institutions for Mental Diseases (IMDs), was entirely state-funded. As of 2008, this cost is now county-funded.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 20	(OA-21)	X	X	<p><u>Postage and Printing – Third Party Liability</u></p> <p>The Department uses direct mail and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payor of last resort. The number of forms/questionnaires printed and mailed and report information received correlates to the Medi-Cal caseload. Beginning July 2012 the Department will lease a Mail Creation Solution System (MCSS) to process the majority of mailings in-house.</p>
R 21	(OA-35)	X	X	<p><u>TAR Postage</u></p> <p>Postage costs related to mailing treatment authorization request-related documents are budgeted in local assistance.</p>
R 22	(PC-149)	X	X	<p><u>HIPP Premium Payouts</u></p> <p>The Department pays the premium cost of private health insurance for high-risk beneficiaries under the Health Insurance Premium Payment (HIPP) program when payment of such premiums is cost effective. On January 1, 2008, the State Plan was amended to remove HIV/AIDS as an automatic HIPP-eligible condition. Effective March 1, 2010, the Department discontinued payments for beneficiaries with HIV/AIDS whose premiums exceeded Medi-Cal cost avoidance thresholds.</p>
R 23	(PC-129)	X	X	<p><u>Medicare Part A and Part B Buy-In</u></p> <p>The Department pays CMS for Medicare Part A (inpatient services) and Part B (medical services) premiums for those Medi-Cal beneficiaries who are also eligible for Medicare.</p> <p>These premiums allow Medi-Cal beneficiaries to be covered by Medicare for their cost of services, thus saving Medi-Cal these expenditures. The premium amounts are set by CMS effective January 1st of each year.</p>
R 24	(OA-62)	X	X	<p><u>PIA Eyewear Courier Service</u></p> <p>The Prison Industries Authority (PIA) fabricates the eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an interagency agreement with PIA to reimburse them for one-half of the costs of the courier service that delivers orders between the optical providers and PIA.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 25	(OA-46)	X	X	<p><u>FFP for Department of Public Health Support Costs</u></p> <p>Title XIX federal Medicaid funding for Medi-Cal-related CDPH support costs are budgeted in the Medi-Cal local assistance budget and are shown as a reimbursement in the CDPH budget.</p>
R 26	(PC-136)	X	X	<p><u>ICF-DD Transportation and Day Care Costs - CDDS</u></p> <p>Beneficiaries that reside in Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) also receive active treatment services from providers located off-site from the ICF/DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.</p> <p>On April 15, 2011, CMS approved a SPA that allows FFP to be paid for these services retroactive back to July 1, 2007.</p>
R 27	(PC-147)	X	X	<p><u>Non-Contract Hospital Inpatient Cost Settlements</u></p> <p>All non-contract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the non-contract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.</p>
R 28	(PC-73)	X	X	<p><u>FQHC/RHC/CBRC Reconciliation Process</u></p> <p>The Medi-Cal reimbursement policy for Federally Qualified Health Centers/Rural Health Clinics and Cost-Based Reimbursement Clinics (FQHC/RHC/CBRCs) participating in the Medi-Cal PPS is applied as follows:</p> <p>Each FQHC/RHC has an individual PPS rate for its Medi-Cal clinic visits. For the FQHC/RHC visits from beneficiaries enrolled in managed care plans or dual eligible beneficiaries, an interim rate is established in order for the clinic to be reimbursed the difference between the Medi-Cal PPS rate and the payments received from managed care plans and Medicare. There is no established interim rate for CHDP visits.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

The difference between the interim rate and the payments from managed care plans and Medicare, and the difference between the PPS rate and the payments from CHDP, is reconciled by an annual reconciliation request that is filed by each FQHC/RHC within five months of the close of their fiscal period.

A tentative settlement is prepared by the Department after review of the reconciliation request. Within three years after the date of submission of the original reconciliation report, as required by W & I Code § 14170, a final audit is performed and either a final settlement or recovery invoice is prepared.

W & I Code § 14105.24 requires the Department to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. An interim rate, adjusted after each audit report is final, is paid to the clinics. The CBRCs are then required to submit an annual cost report no later than 150 days after the close of their fiscal year. The Department audits each CBRC's cost report and completes a cost settlement which results in a payment to the CBRC or a recoupment from the CBRC. The Department expects to complete audits and adjust interim rates each fiscal year to the appropriate audited levels.

R 29 (OA-26) ✕    X    HIPAA Capitation Payment Reporting Project

The Department currently pays contracted managed care health plans through a manual process which is only capable of reporting capitation amounts at the aid code level or above. HIPAA mandates that these types of payments be reported using a standard HIPAA transaction. New HIPAA transaction requirements were implemented on July 1, 2011.

The new HIPAA transaction requirements (5010) will make significant improvements to the capitation calculation process while allowing detailed reporting at the beneficiary level, which will increase the effectiveness of monthly reconciliation between Medi-Cal and the contracted managed care plans. The electronic storage of the data will also support research efforts to perform recoveries from the estates of deceased Medi-Cal beneficiaries. **Phase 1 of the new HIPAA Capitation Payment Reporting Project (CAPMAN) went into production in July 2011. The old manual system needs to be maintained for one year to process net changes.**

**Since implementation, additional unforeseen functionality is required by CAPMAN. It is anticipated that a new five year contract is required to bring additional state and vendor staff to work with the Department on CAPMAN system changes. Phase 2 will begin in FY 2012-13.**

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

R 30 (PC-143) X

ARRA – Additional FFP for DHCS

On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010 which provides an across-the-board increase to all states of 6.2 percent and an additional increase in the form of a decrease in the state share based on increased unemployment rates. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period. Among other conditions, ARRA requires that eligibility standards, methodologies, or procedures in place in the Medicaid state plan or a Section 1115 waiver program cannot be more restrictive than those in effect as of July 1, 2008. Compliance with provider prompt payment requirements, including hospitals and nursing homes, is also a condition of receiving the enhanced FMAP.

R 31 (OA-10) X  
(PC-133)  
(PC-FI)

X

ARRA HITECH Incentive Program

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of ARRA, authorizes the outlay of federal money estimated to be roughly \$45 billion over ten years between 2011 and 2021 for Medicare and Medicaid incentives to qualified health care providers who adopt and use Electronic Health Records (EHR) in accordance with the HITECH Act's requirements. **Provider payments are paid with 100% federal funds.**

**The Department received approval of the State Medicaid Health Information Technology Plan (SMHP) and Implementation Advance Planning Document (IAPD) on September 30, 2011 and was authorized to implement the EHR Incentive Program, which occurred on October 3, 2011.**

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

The Department will expand the current MMIS Health Information Exchange (HIE) for e-prescribing to ensure Medi-Cal providers are qualified for meaningful use of their electronic health records and to add automated consent features available to the Medi-Cal beneficiary community. ~~It is estimated that approximately 10,000 providers and 435 hospitals will be eligible for incentive payments over the life of the program. Provider payments are paid with 100% federal funds.~~

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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

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

**The Department is required by CMS to implement certain technical assessments and demonstration projects in order to understand the current usage of and barriers to EHR adoption and meaningful use, by providers and hospitals throughout the state. Multiple contractors are required in order to complete the projects and assessments.**

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

R 32 (PC-154) X X Reduction in IMD Ancillary Services Costs

The W&I Code requires that any state and federal Medi-Cal funds paid for the cost of ancillary services for Medi-Cal eligibles, 21 years of age and older or who have not attained 65 years of age and who are residents of Institutions for Mental Diseases (IMDs), be recovered from counties by the California Department of Mental Health (CDMH). The Department is developing processes in collaboration with CDMH to stop and to collect inappropriate billing for ancillary services.

R 33 (OA-37) X Emily Q. – Special Master

The Department is engaged in implementation of the *Emily Q.* litigation. *Emily Q.* is a class action case for children in foster care that was filed in Federal Court in Los Angeles in 1999. The case was settled in 2002 and the parties have been working towards finalizing implementation pursuant to the stipulated ~~settlement~~ **judgment.** The Department was ordered to provide individualized comprehensive home and community-based mental health benefits and services to Medicaid-eligible children

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

as required under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The court ordered the parties to collaborate on a plan for increasing “therapeutic behavior services” (TBS) utilization, and appointed a special master to assist the parties in resolving the outstanding issues.

R 34 (OA-36)    X    X    Katie A. v. Diana Bontá – Special Master

On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in *Katie A. v. Diana Bontá*, requiring the provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program “wraparound” and “therapeutic foster care” (TFC) mental health services under the Specialty Mental Health Services waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service. The court ordered the parties to engage in further meetings with the court appointed Special Master. ~~These meetings ended in November 2010; however, on July 15, 2011, the parties agreed to a settlement that is subject to court approval. It is anticipated that a new series of Special Master meetings will begin in September 2011.~~ **On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. The parties began a new series of Special Master meetings to develop a plan for, and begin, settlement implementation.** The Special Master is being funded by the Department and CDSS.

R 35 (OA-27)    X    X    Encryption of PHI Data

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

The encryption of these tapes will:

- Secure and protect Department information assets from unauthorized disclosure;
- Protect the privacy of Medi-Cal beneficiaries;
- Prevent lawsuits from citizens for privacy violations;
- Avoid costs to notify millions of people if a large breach does occur; and

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- Maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.

R 36	(PC-NA) (PC-163)	X	X	<p><u>Federal Flexibility and Stabilization - Additional Federal Reimbursement</u></p> <p>The Department received enhanced ARRA FMAP ratio for the Medicare Part D Phased-down Contribution payments, lowering state payments to the federal government. The Department requested, but did not receive, federal reimbursement for health care costs for disabled individuals who were eligible for Medicare and the recalculation of the Medicare Part D Phased-down Contribution base.</p>
R 37	(PC-145)	X	X	<p><u>ICF-DD Administrative and QA Fee Reimbursement - CDDS</u></p> <p>The Department of Developmental Services (DDS) will make supplemental payments to Medi-Cal providers that are licensed as Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), ICD-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center consumers. The services and transportation are arranged for and paid by the local Regional Centers, which will bill DDS on behalf of the ICF-DDs. A State Plan Amendment (SPA) was approved April 15, 2011. DDS will provide payment, retroactive to July 1, 2007, to the ICF-DDs for the cost of reimbursing the Regional Centers for the cost of arranging the services plus a coordination fee (administration fee and the increase in the QA fee).</p> <p>On April 8, 2011, the Department entered into an interagency agreement with DDS for the reimbursement of the increased administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.</p>
R 38	(PC-28)	X	X	<p><u>Discontinue Part B Premium for Unmet Share of Cost Beneficiaries</u></p> <p>The Budget Act of 2010 included the elimination of payment of the Medicare Part B premiums for beneficiaries with an unmet share of cost (SOC) of \$500 or less. Payment of the premiums for those with unmet SOC greater than \$500 was eliminated effective December 1, 2008.</p>
R 39	(PC-155)	X	X	<p><u>CLPP Funds</u></p> <p>Medi-Cal provides blood lead tests to children who are at risk for lead poisoning and are full-scope Medi-Cal beneficiaries or are pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program. The CHDP State-Only program provides lead screenings to Medi-Cal beneficiaries who are eligible for emergency and pregnancy related services. The lead tests are funded by the CLPP Fund which receives revenues from a fee assessed on entities formerly</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

or presently engaged in commerce involving lead products and collected by the Board of Equalization. The expenditures for the lead testing are in Medi-Cal's FFS base trends and this policy change adjusts the funding.

R 40 (PC-157)

X

Overpayments – Interest Rate Change

The Department assesses interest on 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 ~~0.48.38%~~, which is below the state's commercial borrowing rate.

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.

R 41 (PC-166)  
(PC-167)  
(PC-169)  
(PC-170)  
(PC-172)  
(PC-173)  
(PC-176)  
(PC-187)

X

Payment Deferral

Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. The Department is proposing language to delay an additional checkwrite for FY 2012-13. From then on, two checkwrites would be delayed at the end of each fiscal year.

The checkwrite normally paid on June 20, 2013 would be paid in July 2013. This delay will result in a decrease in expenditures estimated to be \$355.2 million TF in FY 2012-13.

In addition to delaying a checkwrite, the Department is also proposing to delay one month of managed care capitation rates in FY 2012-13. This delay will result in a decrease in expenditures estimated to be \$1,230.0 million TF in FY 2012-13.

**OTHER: RECOVERIES: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**OTHER: RECOVERIES: OLD ASSUMPTIONS**

		Applicable F/Y		
		C/Y	B/Y	
RC 1	(PC-164)	X	X	<p><u>Base Recoveries</u></p> <p><del>Budget Act Language</del> Medi-Cal allows all <b>Medi-Cal</b> recoveries to be <del>are</del> credited to the Health Care Deposit Fund and to be used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, lawsuit settlements, providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances. <del>Gross Third Party Liability collections</del> <b>Recoveries</b> are based on trends in actual collections.</p>
RC 2	(PC-161)	X	X	<p><u>Anti-Fraud Initiative</u></p> <p>Effective July 1, 2010, the Department expanded its anti-fraud activities for physician services <b>using preventative, front-end claims analyses tools</b>.</p>
RC 3	(PC-160)	X	✕	<p><u>FQHC/RHC Audit Staffing</u></p> <p>The Department received three <b>limited-term</b> positions to perform audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines. In the past five years, the number of FQHC/RHC providers has increased from 460 to <del>907</del> <b>1,000</b>, while the number of audit staff has remained the same. <del>It is anticipated that the new positions will generate increased cost savings.</del> <b>The positions were filled in December 2011, but will expire on June 30, 2012. Due to the expiration of the positions, only limited savings is anticipated.</b></p>
RC 4	(OA-11)	X	X	<p><u>Medi-Cal Recovery Contract</u></p> <p>The Department contracts with vendors to identify third party health insurance and workers compensation insurance. When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries.</p>
RC 5	(PC-159)	X	X	<p><u>Anti-Fraud Activities for Pharmacy and Physicians</u></p> <p>In FY 2011-12, the Department <del>will expand</del> <b>expanded</b> its anti-fraud activities. The activities <del>will</del> focus on pharmacy <del>services</del> and physician services.</p>
RC 6	(PC-162) (OA-20)	X	X	<p><u>Medicare Buy-In Quality Review Project</u></p> <p>On October 1, 2010, the Department entered into a three-year contract with the University of Massachusetts (UMASS) to identify potential overpayments to CMS or Medicare providers related to the buy-in process for Medicare/Medi-Cal dual eligibles. UMASS will assist the Department in auditing the invoices received from CMS to pay the</p>

**OTHER: RECOVERIES: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

Medicare premiums. The Department anticipates it will begin realizing savings in FY 2011-12. Payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers.

**FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

FI 0.1 (PC-FI)        X        Cost Reasonableness Contractor

In accordance with the ACS Contract, the Department plans to procure a Cost Reasonableness contractor. The contractor evaluates the reasonableness and accuracy of any Systems Development Notice, Change Order, or Enhancement cost estimates submitted by the FI Contractor. Procurement is anticipated to be completed in October 2012.

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 1	(PC-FI) (PC-158)	X	X	<p><u>Cost Containment Proposals – Savings Sharing</u></p> <p>The Department continues to review and approve the Fiscal Intermediary-initiated cost containment proposals, implementing as appropriate to contain Medi-Cal costs. Savings are achieved, with the Fiscal Intermediary continuing to receive a share of the savings.</p> <p>Additionally, the Contractor continues the process of identifying fraudulent claims activity in two areas – outpatient (physician, DME, lab, pharmacy, etc.) and prepayment review. As other areas are identified, they will be further developed. The savings methodology is linked to actual cost avoidance and/or realized recovery of fraudulent payments to providers. The Contractor has developed a program to formalize the identification of fraudulent claims activity, facilitate appropriate intervention with various audit organizations, recommend system or policy modifications, if appropriate, and support regulation development, if necessary, to support efforts by the Department to expeditiously stop illegal and inappropriate payment activity. The staffing is provided by the Contractor.</p>
FI 2	(PC-FI)	X	✕	<p><u>HIPAA – Provider Relations</u></p> <p>Provider relations are an essential component of the activities relating to HIPAA. Additional Fiscal Intermediary (<b>FI</b>) staffing will be necessary to obtain appropriate provider feedback on proposed HIPAA changes and to provide technical assistance specific to the many CA-MMIS and claims processing changes resulting from these projects. Clear and accurate communication is vital and will be supplemented by provider bulletins, seminars, <del>and</del> interactive workshops, and other notices via mail and the Internet. This activity is in addition to <del>these</del> <b>the</b> provider relation activities already funded in the FI fixed price contract. The costs <del>associated with this</del> <b>for the</b> additional activity were authorized through the change order process.</p> <p><del>Fiscal Intermediary</del> <b>FI</b> staff will be utilized to accommodate increased suspense rates and provider appeals with each code conversion, claim transaction and unique identifier implementation while providers become accustomed to the changes.</p> <p>Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation was in September 2003. The remaining transactions and code conversions will continue to be phased-in. <del>The Fiscal Intermediary also</del> <b>FI</b> continues <del>work</del> <b>working</b> on implementing the National Provider Identifier. <b><u>Under the ACS Contract, HIPAA Provider relations are covered under the fixed price beginning October 3, 2011.</u></b></p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/YFI 3    (PC-FI)    X        X        HIPAA UPN Exception Request

Implementation of the original scope of the Universal Product Number (UPN) pilot project was cancelled in March of 2006 because it was determined that the modifications to the current California Medicaid Management Information System (CA-MMIS) infrastructure would be too costly and could not be implemented in an efficient manner. Further analysis determined that in order to implement the use of the UPN into a claims processing environment, it would be necessary to bring forth new technology in order to allow for the system to be flexible, cost effective and easily modified for future requirements.

The Department received 90% funding approval from CMS to revise the scope of the UPN pilot in order to reduce costs and to leverage system changes needed to comply with the Federal Deficit Reduction Act of 2005 which mandates the collection of rebates for physician administered drugs using the National Drug Code (NDC). ~~Changes were implemented on April 1, 2009; however, medical supply providers were given an additional 90-day grace period in order to make the changes to their systems. Effective July 1, 2009, all medical supplies were billed with a national HCPCS code along with a UPN for products that have been contracted with the Department. CMS is requiring a two-year evaluation of the project to substantiate the possible adoption of the UPN as a HIPAA standard. The two-year UPN evaluation period extends through FY 2010-11 and FY 2011-12. During this time, State and contract staff will continue to administer research tools, collect and analyze data and develop evaluation reports on the study findings.~~ **The Department completed the two-year evaluation of the UPN and submitted findings to CMS in September 2011. Additional work will be required in FY 2012-13 to ensure Medi-Cal continues using the UPN on medical supply claims and assist in activities necessary to adopt the UPN as a HIPAA standard.**

FI 4    (PC-FI)    X        X        HIPAA – CA-MMIS

HIPAA requires uniform national health data standards, unique identifiers and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff is required to provide for remediation/implementation of HIPAA changes to the CA-MMIS and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, and high level work on other rules. APDUs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- ~~Privacy (April 14, 2003 compliance deadline)~~
- Transactions and Codes (October 16, 2003 compliance deadline)
- ~~Unique Employer Identifier (July 30, 2004, compliance deadline)~~
- Security (April 21, 2005, compliance deadline)
- ~~National Provider Identifier (May 23, 2008 compliance deadline)~~
- Electronic Signature (Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM)
- Enforcement (March 16, 2006 effective date)
- National Health Plan Identifier (NPRM pending)
- Claims Attachments (Final Rule pending)
- First Report of Injury (NPRM pending)
- Transactions and Code Sets Revisions(Final Rules published January 16, 2009)

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation began in October 2003 and the remaining transactions and code conversions will continue to be phased-in and implemented. The January 16, 2009 published HIPAA rules will require MMIS changes in order to incorporate updated transactions for Medi-Cal and prescription drug claims by the federal compliance date of January 1, 2012. The final rules also require the implementation of a new diagnosis and inpatient hospital procedure coding standard, ICD-10, by October 1, 2013.

FI 5    (PC-FI)    X        **X**

Extension of the HP Contract

The Department contracts with HP up to June 30, 2012 to allow for the completion of all post operation activities.

FI 6    (OA-32)    X        X

Medicaid Information Technology Architecture

The CMS is requiring the Department to create frameworks and technical specifications for the Medicaid Management Information Systems (MMIS) of the future. CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through Medicaid Information Technology Architecture(MITA) the Department will develop the ability to streamline the process to access information from various systems. CMS will not approve APDs or provide federal funding to the Department without adherence to MITA.

The Department completed the CMS-required MITA State Self-Assessment (SS-A) of business processes to determine the current and long-term business requirements. The Department must now complete a MITA Transition and Implementation plan by ~~December 31, 2011~~ **July 1,**

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

**2012**, to retain the enhanced funding for the SS-A. The Department is currently developing Enterprise Architecture (EA) at the Agency level to address MITA EA activities.

FI 7	(OA-12)	X	X	<p><u>CA-MMIS Takeover and Replacement Oversight</u></p> <p>CA-MMIS is the claims processing system used for Medi-Cal. This system has changed considerably over the past 30 years to incorporate technological advances as well as address new business and legislative requirements and, as a result, is extremely complex, difficult to maintain, and nearing the end of its useful life cycle. CA-MMIS is a mission critical system that must assure timely and accurate claims processing for Medi-Cal providers. Given the business critical nature of CA-MMIS, a detailed assessment was completed by a specialty vendor which recommends that modernization of CA-MMIS begin immediately. The Department contracts with various vendors to assist with FI oversight activities, documentation of business rules, project management, change management and IV&amp;V services during transition and replacement of the CA-MMIS.</p>
FI 8	(PC-FI)	X	✕	<p><u>Medi-Cal Fiscal Intermediary Contract Turnover</u></p> <p>The Turnover period is to ensure an orderly transfer of the Medi-Cal Fiscal Intermediary contract from the current contractor to the successor contractor at the end of the contract. The Department extended the term of the current contract up to June 30, 2012 to continue uninterrupted support of ongoing operations <del>until a successful AOO by the new FI contractor.</del> Turnover activities began January 1, 2008 <b><u>and will end March 2012.</u></b></p>
FI 9	(PC-FI)	X	✕	<p><u>CA-MMIS Takeover by New FI Contractor</u></p> <p>CA-MMIS is the claims processing system used for Medi-Cal, and is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal providers. The Department extended the term of the current contract up to June 30, 2012 to continue uninterrupted support of ongoing operations until a successful AOO by the new FI contractor. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published on December 8, 2009. The Takeover activities of the new FI contractor began on May 3, 2010. In the Takeover Phase, the new FI is required to complete contractually required activities necessary for the AOO from the current contractor. These activities include the following expansion items:</p> <ul style="list-style-type: none"> <li>• On-line and Computer-Based Interactive Training,</li> <li>• Post-Service Prepayment Audit,</li> <li>• Contingency Payments,</li> </ul>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

- Caller Satisfaction Evaluation Tool,
- Encounter Data Processing,
- Geographic Mapping,
- Contract Management,
- CA-MMIS Enterprise Project Management Office,
- Project and Portfolio Management,
- Additional Software Licenses,
- Additional Office Space,
- Security for Data "At Rest",
- Additional 32-Bit Processors,
- Payment Methodology Modification,
- Sensitive Information Redaction.

**Takeover plans are expected to be completed in FY 2011-12.**

FI 10	(OA-15)	X	<u>X</u>	<u>CA-MMIS Takeover/Replacement Other State Transition Costs</u>  <p>CA-MMIS is the claims processing system used for Medi-Cal. The current FI contract was scheduled to end on June 30, 2011. The Department extended the term of the current contract up to June 30, 2012 through a contract amendment utilizing a non-competitive bid justification. Additional costs will be incurred for CA-MMIS Takeover <b><u>and Replacement</u></b> activities which include interfacing with other Departmental mission critical systems such as MEDS, EMBER, SCO, MIS/DSS and PCES applications that will require coordination and resources with other Department Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system and parallel), support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these new environments in support of transition activities during the Takeover <b><u>phase and Replacement phases</u></b>. <del>The CA-MMIS is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during Takeover</del> <b><u>both phases. The Takeover activities are expected to be completed in FY 2011-12, and Replacement activities are underway. Consultative contractors and other resources are required to continue the CA-MMIS replacement phase.</u></b></p>
FI 11	(PC-FI)	X	X	<u>Business Rules Extraction Enhancement</u>  <p>The objective of the Business Rules Extraction (BRE) Enhancement is to define a new rules base for the legacy MMIS and store the rules, once confirmed, in a requirements traceability tool for tracking future testing management and updating. The existing business rules for CA-MMIS are not well documented and may not fully represent current Medi-Cal</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

policy. It is the Department's intent to implement the Replacement System with the current business rules and program policy, to support validation of the Replacement System functionality, and then update the system through policy directives to the Contractor, based on the Contractor's report of the BRE. The Confirmed Legacy System business rules will also be incorporated into the Replacement System design. The Contractor will develop this policy base through analysis of business rules embedded in the legacy CA-MMIS and compare the policy base with published Department policy manuals. The Contractor will identify discrepancies between the system embedded rules and current Department policy and recommend a course of action. The Department will determine the appropriate course of action and direct the Contractor on this course. The Department will verify and validate the business rules only after the Contractor has completed its detailed analysis. **The Department plans alternative approaches to BRE that streamline the resources and time required for BRE. This results in an adjustment of BRE estimates. BRE may occur as part of the CA-MMIS replacement efforts, as opposed to a separate one time effort through system Enhancement. Costs related to BRE activities are not expected until FY 2012-13.**

FI 12	(PC-FI)	X	X	<u>CA-MMIS Re-Procurement – HIPAA ICD-10 Legacy Enhancement</u>
				<p>As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding. Medi-Cal currently uses ICD-9 coding, as does the majority of the national health care industry, as critical data for claims processing, prior authorization, fraud investigation, and other program operations. The Final Rule for ICD-10 indicates an expectation that efforts to begin addressing these requirements begin no later than January 2011; the compliance deadline is October 1, 2013.</p> <p>The new contract for the CA-MMIS was awarded to Affiliated Computer Services (ACS), and includes an enhancement of the existing system to address ICD-10 requirements. Planning, analysis, development and implementation of the CA-MMIS ICD-10 enhancement is in process.</p>
FI 13	(PC-FI)	X	X	<u>CA-MMIS Re-Procurement – 5010/D.0 Legacy Enhancement</u>
				<p>As part of the HIPAA, the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt new versions of the standards for electronically exchanging critical administrative health care transactions, including health care claims, eligibility information, prior authorizations, and</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

payment information. These changes will impact the vast majority of Medi-Cal providers and managed care plans. These new versions are maintained by two national standards organizations; X12 and the National Council for Prescription Drug Programs (NCPDP). X12's transactions are part of standard called "5010," while NCPDP's standard is called "D.0". The compliance deadline is January 1, 2012.

The new contract for the CA-MMIS was awarded to ACS, and includes an enhancement of the existing system to address the 5010/D.0 transaction requirements. ~~Planning~~ **The planning, analysis, and development and implementation of the CA-MMIS 5010/D.0 enhancement are in process has been completed. Implementation into CA-MMIS is scheduled for July 1, 2012.**

FI 14 (PC-FI)    ✕    X    TAR/SAR System Replacement

The Department will replace the existing Treatment Authorization Request (TAR) System, establish two TAR Processing Centers and consolidate existing ~~Medi-Cal Field Office~~, Field Office Automation Group (FOAG) activities. The CMS-Net and Service Authorization Request (SAR) functionality, including the help desk, will also be replaced by the new TAR system. TAR/SAR replacement DD&I ~~will~~ **is scheduled to begin January in February** 2012, and implementation of the system will begin within two years of assumption of operations by the new FI.

FI 15 (PC-FI)    ✕    X    Pharmacy Claims/DUR/Rebate Accounting Replacement

The Department will implement a new pharmacy claims system that will include three major components: real-time Point-of-Service (POS) and batch claims processing; the rebate collection and tracking system; and drug utilization review (both prospective and retrospective). Work on the system ~~will begin~~ **began** in January 2012, and implementation of the system will begin within two years of assumption of operations by the new FI.

FI 16 (PC-FI)    ✕    **X**    Rebate Accounting and Information System Hardware and Software Refresh

The Rebate Accounting and Information System (RAIS) supports invoicing of pharmaceutical drugs, physician-administered drugs, and medical supply rebates.

RAIS is built upon technology that is client server oriented. Since the hardware technology is constantly changing and expanding, the hardware has a limited life span. In order to avoid memory storage reaching maximum capacity and hardware components failing due to the age of the equipment, the FI Contractor is required to evaluate RAIS hardware and software every five years. The last refresh of the RAIS platforms was completed in 2005. The FI Contractor's review of RAIS

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

determined that the RAIS hardware has reached its end of life. The refresh is expected to take place in FY ~~2011-12~~ **2012-13**.

FI 17	(PC-FI)	✗	X	<p><u>Provider Enrollment Automation Project</u></p> <p>Beginning in FY <del>2011-12</del> <b>2012-13</b>, the Department will implement an Optional Contractual Service (OCS) under the FI contractor to enhance the current CA-MMIS Health Enterprise Provider Enrollment functionality. This will provide Medi-Cal providers with web-based, high-speed access to fully automated e-forms; imaging; communications; and workflow management, as well as reporting features to support timely, accurate, and efficient receipt and processing of provider enrollment and re-enrollment applications.</p>
FI 18	(PC-FI)	X	X	<p><u>Point of Service Refresh</u></p> <p>Medi-Cal providers are currently able to use the Point of Service (POS) devices to verify Medi-Cal recipients' eligibility, and perform claims-related transactions including: decrement Share of Cost (SOC), submit pharmacy transactions for immediate on-line adjudication, access the Child Health and Disability Prevention Gateway, and submit Family Planning, Access, Care and Treatment transactions.</p> <p>The devices that support the POS network are out-of-date and need to be replaced to comply with the new HIPAA transactions standards. Implementation of the POS refresh is scheduled to be completed in <del>August 2011</del> <b>June 2013</b>.</p>
FI 19	(PC-FI)	X	X	<p><u>FI Assumption of Operations Delay Reimbursement</u></p> <p>In May 2010, the Department awarded the medical fiscal intermediary contract to Affiliated Computer Services (ACS) to assume the responsibilities for Medi-Cal claims processing functions as well as to replace the current California Medicaid Management Information System (CA-MMIS). The Assumption of Operations (AOO) by ACS was scheduled for February 1, 2011, but delayed to June 13, 2011. ACS has agreed to reimburse the Department for costs related to this delay.</p> <p>In January 2011, ACS delayed the AOO from June 13, 2011 to September 30, 2011. The Department and ACS are in the process of determining ACS' liability due to the second AOO delay.</p>
FI 20	(PC-FI)	X	X	<p><u>Additional Resources to Support CSU Operations</u></p> <p>Additional funding is required to support operations of the Correspondence Specialist Unit (CSU) due to the implementation of SDN 09041 Optional Benefits Exclusions (OBE) Phase Three. A post payment audit of OBE claims generated by the implementation of SDN 09041 will be performed on a sample basis.</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 21	(PC-FI)	X	X	<p><u>Family PACT Retroactive Eligibility Claim Process</u></p> <p>Effective April 1, 2011, the Department implemented a manual retroactive eligibility process for newly-enrolled qualified Family PACT beneficiaries <b>clients</b>. The manual process <del>will include</del> <b>includes</b> procedures to allow qualifying Family PACT clients to be reimbursed for qualifying out of pocket expenses for the prior three months before eligibility determination, <del>requiring HP</del> <b>and requires the FI</b> to update all affected systems necessary to ensure proper payment of these Family PACT claims. This function <del>will continue</del> <b>continues</b> under <b>the new FI contract with</b> ACS <del>upon a successful Assumption of Operations as of the AOO on October 3, 2011.</del></p>
FI 22	(PC-FI)	X	✗	<p><u>Additional Costs Associated with Delay in AOO</u></p> <p>Due to the delay in AOO by ACS, there will be additional anticipated costs associated with HP for the following:</p> <ul style="list-style-type: none"> <li>• Incremental turnover support beyond the contract required 12 months,</li> <li>• Increases in short term lease payment for buildings,</li> <li>• Increases in short term hardware and software maintenance agreements,</li> <li>• Potential increases in leases to replace failing equipment.</li> </ul> <p><b><u>Payments are expected to be completed in FY 2011-12.</u></b></p>
FI 23	(OA-28)	X	X	<p><u>MIS/DSS Contract Reprocurement Services</u></p> <p>The contract for ongoing development, maintenance, and operation of the Management Information System and Decision Support System (MIS/DSS) is scheduled to end on February 14, 2014. The Department will contract with a vendor to provide assistance with the reassessment of the scope of services to be included in the reprocurement of the MIS/DSS contract beginning in FY 2011-12. Resources are needed to develop the required project approval documents (FSR/APD) to achieve required state and federal level approvals.</p>
FI 24	(PC-FI)	X		<p><u>Clarity Software</u></p> <p>The federal health reform initiatives require the Department to effectively and efficiently initiate, manage, monitor and report human and cost resources.</p> <p>Clarity is a portfolio management tool designed for prioritization, efficiency, and analysis. This tool will help the Department manage the various technology undertakings that are required to make improvements to the Medi-Cal fiscal intermediary process and for implementing the new</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

California Medicaid Management Information System (CA-MMIS), which will bring additional efficiencies and functionality to support the Medi-Cal program.

FI 25 (PC-FI)    X    X

Additional CA-MMIS Office Space

The Department has decided to locate all CA-MMIS staff in one facility and has directed ACS to provide additional office space within the new Medi-Cal Operations Center (MOC) facility in West Sacramento, CA. This office space exceeds the FI's contractual office space requirements. The build out of additional office space is expected to be completed by FY 2011-12.

FI 26 (PC-FI)    X

Termination of Convenience

Fiscal Intermediary (FI) HP Enterprise Services (HP) Contract 02-25999 was amended via Amendment 09 to provide an extension of the termination date from 30 to 90 days to retain HP as the FI due to ACS' delay in the Assumptions of Operations (AOO). Since ACS could not assure the Department of an AOO completion date until August 31, 2011, the Department could only provide HP with a 30-day notification rather than the 90-day notification requested by HP and contained in Amendment 09. As a result, the Department has agreed to reimburse HP for all reasonable and supported expenses related to this late notification.

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

Applicable F/Y  
C/Y    B/Y

HO 0.1 (PC-FI)    X

Updates to Existing HCO Informing Materials

All existing HCO informing materials will be reviewed and revised to reflect changes associated with the current health care environment. This includes, but is not limited to:

- Current managed care requirements,
- New program needs and modifications,
  - Shifts from voluntary to mandatory eligibility requirements
  - Changes in plan or provider eligibility
- Compliance with Federal Health Care Reform law.

All informing materials used by the Department in the Medi-Cal Managed Care HCO program will be updated. The updates will generate costs for production, printing, and threshold language translations.

HO 0.2 (PC-FI)

X

Health Plan of San Joaquin Replacing Anthem Blue Cross as LI in Stanislaus County

Stanislaus County currently designates Anthem Blue Cross as the Local Initiative (LI) health plan. Through a request for proposal, the County selected Health Plan San Joaquin (HPSJ) as the new designated LI. Notices and packets will be mailed to all beneficiaries to coincide with a January 1, 2013 start date for HPSJ. The first notice will be mailed in September 2012.

## FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
HO 1 (PC-FI)	X	X	<p><u>Personalized Provider Directories</u></p> <p>HCO currently prints and mails health plan Provider Directories that provide information for every Medi-Cal managed care provider in the beneficiary's county of residence. AB 203 (Chapter 188, Statutes of 2007) authorized the implementation of a Personalized Provider Directory (PPD) as a pilot project in one Two-Plan Model county (Los Angeles) and one GMC county (Sacramento). The content and format of the Personalized Provider Directories were determined in consultation with health plans and stakeholders. The pilot project began on February 27, 2009 and continued for a period of two years. At the end of the pilot project period (March 2011), the Department, in consultation with health plans and stakeholders, performed an assessment to determine if Personalized Provider Directories provide more accurate, up-to-date provider information to Medi-Cal managed care beneficiaries, in a smaller, standardized, and user-friendly format that results in a reduction of default assignments, and if they should be implemented statewide in all managed care counties. This determination will be based on the outcomes set forth in the evaluation provided to the Legislature. If necessary, the pilot project will continue beyond the initial two year period until this determination is made.</p>
HO 2 (PC-FI)	X	✗	<p><u>Additional Contractual Service – Initial Health Screen Questionnaire</u></p> <p>The HCO contract includes an Additional Contractual Service. The Department implemented the Initial Health Screen Questionnaire Additional Contractual Service in March 2011. This questionnaire helps ensure that applicants and beneficiaries with existing disabilities or chronic conditions identify themselves so as to receive immediate access to care. The questionnaire is currently being mailed within the HCO informing packet. This Additional Contractual Service is consistent with the Department's continued commitment to serve this population.</p>
HO 3 (PC-FI)	X	X	<p><u>SPD Mandatory Enrollment into Managed Care HCO Costs</u></p> <p>Effective June 1, 2011, it is mandatory for all Medi-Cal Only Seniors and Persons with Disabilities (SPDs) residing in managed care counties to enroll in a managed care plan. As a result, MAXIMUS, the HCO enrollment broker, is sending informing materials to each SPD beneficiary upon transitioning to a mandatory status for enrollment.</p> <p>To meet the Department's outreach and education goals, MAXIMUS hired additional staff to aid the beneficiaries in this transition and to handle ongoing outreach and education.</p>

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 4 (OA-23)	X	X	<u>Health Care Options Consultant Costs</u>

The Department will contract with a health care consultant to identify the best practices used in other states with enrollment broker contracts, determine the impact of Health Care Reform on the HCO program, and assist in evaluating all options regarding enrollment.

Operations for the current enrollment broker contracts ends on September 30, 2012, with three one-year extension options.

**FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS**

Applicable F/Y

C/Y    B/Y

DD 0.1 (PC-FI)                    X    Implementation of New Federal Rules (Federal Register Vol. 76, No. 22)

Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal Dental Program. The new rules establish requirements for the enrollment and screening of Medicare, Medicaid, and Children's Health Insurance Program providers at the federal and state levels.

To stay in compliance, the Department plans to hire additional FI staff to complete the increased workload. The Department plans to incur costs once all control agencies negotiate and approve a change order in the first quarter of FY 2012-13.

## FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
DD 1 (PC-FI)	X	X	<u>HIPAA – CD-MMIS</u>

HIPAA requires uniform national health data standards, unique identifiers, and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff are required to provide for remediation/implementation of HIPAA changes to the California Dental Medicaid Management Information System (CD-MMIS) and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, and high-level work on other rules. APDUs will continue to be submitted as new rules are published to continue to secure enhanced funding.

The work necessary is associated with the following HIPAA regulations:

- ~~Privacy (April 14, 2003 compliance deadline)~~
- ~~Transaction and Code Sets (October 16, 2003 compliance deadline)~~
- ~~Unique Employer Identifier (July 30, 2004 compliance deadline)~~
- ~~Security (April 21, 2005 compliance deadline)~~
- ~~National Provider Identifier (NPI) (May 23, 2007 compliance date)~~
- Electronic Signature (Notice of Proposed Rule Making (NPRM) pending, originally part of Security NPRM)
- Enforcement (March 16, 2006 effective date)
- National Health Plan Identifier Standard (NPRM pending)
- Claims Attachments (Final rule pending)
- First Report of Injury (NPRM pending)
- Transactions and Code Sets Revisions (Final Rules published January 16, 2009)
- **Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claims Transactions (Interim Final Rule published July 8, 2011)**

Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased in approach to implement the most critical transactions (in terms of provider impact) and code sets first, without interrupting payments to providers or services to beneficiaries. The January 16, 2009 published HIPAA rules require CA-MMIS changes in order to incorporate updated **ASC X12 5010** transactions for dental claims by the federal compliance date of January 1, 2012. **The July 8, 2011 published HIPAA rules require changes to the Claim Status Companion Guides and have a compliance date of January 1, 2013.**

## FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
DD 2 (PC-FI)	X	X	<p><u>Medi-Cal Dental FI Contract Turnover</u></p> <p>The Turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, in addition to supporting the Department's procurement effort by ensuring that all required data and documentation was included in the Office of Medi-Cal Procurement's data library. Turnover support services and all activities in accordance with the contract requirements commenced on January 4, 2010 and will continue through June 30, 2012.</p>
DD 3 (PC-FI)	X	X	<p><u>CD-MMIS Takeover by New Dental FI Contractor</u></p> <p>The CD-MMIS is the Medi-Cal dental claims processing system operated by the dental FI. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published in August 2011. The takeover activities for the new dental FI contractor <del>are expected to begin on October 1, 2011</del> <b>began in February 2012</b>. In the Takeover Phase, the new FI is required to complete contractually required activities necessary to ensure a timely and accurate takeover of the existing MMIS.</p>
DD 4 (PC-FI)	X	X	<p><u>CD-MMIS Business Rules Extraction Enhancement</u></p> <p>The Business Rules Extraction (BRE) Enhancement will identify and extract the business rules in the current legacy CD-MMIS and store the rules in a requirements traceability tool for tracking, future testing, managing and updating.</p> <p>The Department will hire a contractor to develop a traceability matrix of forward and backward contextual links between the various requirements and the work products developed for implementation, as well as to verify the completeness and accuracy of the requirements. All requirements will be captured including: business, user, functional and test requirements for the entire system.</p>
DD 5 (PC-FI)	X	X	<p><u>Dental Managed Care Encounter Data Enhancement</u></p> <p>The federal government is requiring that HIPAA-covered entities adopt new versions of the transaction requirements (5010) for electronically exchanging critical administrative health care data. The Medical Fiscal Intermediary (FI), ACS is enhancing CA-MMIS to address the 5010 requirement. The Dental Managed Care Plans will submit encounter data to the Medical FI in the new standard transaction formats. The Medical FI will pass the encounter data to the Dental FI, consequently CD-MMIS must be enhanced to accept the new format from CA-MMIS.</p>

**FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

DD 6 (PC-FI)                      X    Medi-Cal Dental FI Contract - Runout

The Medi-Cal Dental FI contract ends on June 30, 2012. The Runout period for TARs and claims will begin July 1, 2012. The contractor is required to process TARs and claims with dates of service prior to July 1, 2012 and will continue to do so for fifteen months, ending in September 2013. The new Medi-Cal Dental FI contractor will process TARs and claims beginning July 1, 2012.

**INFORMATION ONLY:****GENERAL FUND REVENUES****1. General Fund Revenues**

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

FY 2010-11:	\$ 23,168,000		ICF-DD Quality Assurance Fee
	\$ 304,432,000		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 126,165,000		Additional Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 198,315,000		Gross Premium Tax (AB 1422)
	\$1,921,992,000		Hospital Quality Assurance Revenue Fund (Item 4260-601-3158)
	<b>\$ 3,233,000</b>		<b>Emergency Medical Air Transportation (EMATA) Fund</b>
	<b><u>\$2,577,305,000</u></b>		<b>Total</b>
FY 2011-12:	\$ <del>24,596,000</del> <b>\$22,221,000</b>		ICF-DD Quality Assurance Fee
	\$ 469,014,000		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 28,640,000		(The revenues for this is now included in the revenues for AB 1629.)
	\$ 7,244,000 <b>\$2,246,000</b>		ICF-DD Transportation/Day Care Quality Assurance Fee
	\$ 234,151,000 <b>\$265,213,000</b>		Freestanding Pediatric Subacute Quality Assurance Fee
	\$2,637,323,000 <b>\$2,621,059,000</b>		Gross Premium Tax (AB 1422)
	<b>\$ 7,151,000</b>		Hospital Quality Assurance Revenue Fund (4260-610-3158)
	<b><u>\$3,415,544,000</u></b>		<b>Emergency Medical Air Transportation (EMATA) Fund</b>
			<b>Total</b>
FY 2012-13:	\$ <del>25,175,000</del> <b>\$22,710,000</b>		ICF-DD Quality Assurance Fee
	\$ <del>539,647,000</del> <b>\$552,818,000</b>		Skilled Nursing Facility Quality Assurance Fee (AB 1629)
	\$ 6,620,000		ICF-DD Transportation/Day Care Quality Assurance Fee
	\$ 7,911,000 <b>\$4,585,000</b>		Freestanding Pediatric Subacute Quality Assurance Fee
	\$ 352,430,000 <b>\$435,505,000</b>		Gross Premium Tax
	\$2,942,270,000 <b>\$2,848,303,000</b>		Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
	<b>\$ 7,151,000</b>		<b>Emergency Medical Air Transportation (EMATA) Fund</b>
	<b><u>\$3,877,692,000</u></b>		<b>Total</b>

Effective August 1, 2009, the Department expanded the amount of revenue upon which the quality assurance fee is assessed, to include Medicare for AB 1629 facilities.

The FY 2011-12 ICF/DD Transportation/Day Care QA fee includes a one-time retroactive collection of \$22.5 million in QA fees for FY 2007-08 through FY 2010-11. In addition to the retroactive QA fees, the QA fee includes an estimated \$6.1 million for FY 2011-12. The ICF/DD Transportation/Day Care QA fee is expected to remain consistent in future years.

**INFORMATION ONLY:**

Effective ~~August 1, 2011~~ **January 1, 2012**, pursuant to ABX1 19 (Chapter 4, Statutes of 2011), the Department ~~began collecting~~ **will implement** a QA fee from Freestanding Pediatric Subacute Care facilities, **pending CMS approval**.

AB 1422 (Chapter 157, Statutes of 2009) has imposed an additional tax on the total operating revenue of all Medi-Cal managed care plans. The provision pertaining to this tax will be effective retroactive to January 1, 2009 until June 30, ~~2011~~ **2012**. The Department is proposing legislation that will ~~extend the tax~~ **eliminate the gross premium tax sunset date on the total operating revenue of Medi-Cal managed care plans**. The amount for FY 09-10 includes revenue retroactive to January 1, 2009. This new **The permanent extension of the** tax will generate additional General Fund revenue.

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

~~Legislation is being proposed to create a new~~ **SB 335 (Chapter 286, Statutes of 2011) authorizes the implementation of a new** Hospital Quality Assurance Fee (QAF) program for the period of July 1, 2011 to December 31, 2013. This new program will authorize the collection of a quality assurance fee from non-exempt hospitals. The fee will be deposited into the Hospital Quality Assurance Revenue and will be used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, increased capitation payments to managed health care plans, and increased payments to mental health plans. The fund will also be used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the reductions allowed the QA fee amounts collected from the freestanding NF-Bs and ICF/DDs (including Habilitative and Nursing) to increase by an equal amount. Currently, the QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. For FY 2011-12, CDPH increased L&C fees which will result in a reduction in the collection of the QA fee by an equal amount to the L&C fee increase for free-standing NF-Bs, Freestanding Pediatric Subacute Facilities and ICF/DDs (including Habilitative and Nursing).

**Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations. Upon CMS approval, the Department will provide two supplemental payments in April and September 2012 for FFS Medi-Cal air medical transportation services. Effective July 1, 2012 and for each FY thereafter until January 1, 2018, the Department will augment air medical transportation rates.**

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

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

**INFORMATION ONLY:****ELIGIBILITY**1. Qualifying Individual Program

The Balanced Budget Act of 1997 provided 100% federal funding, effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The current sunset date has been extended to ~~December 31, 2011 by the Medicare and Medicaid Extenders Act of 2010, Public Law No: 111-309~~ **February 29, 2012 by HR 3765, the Temporary Payroll Tax Cut Continuation Act of 2011.**

2. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings and/or hours from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. The current sunset date has been extended to ~~December 31, 2011 by the Medicare and Medicaid Extenders Act of 2010, Public Law No: 111-309~~ **February 29, 2012 by HR 3765, the Temporary Payroll Tax Cut Continuation Act of 2011.**

3. Lomeli, et al., v. Shewry

On January 20, 2011, the Department finalized a settlement of the *Lomeli, et al., v. Shewry* lawsuit. The petitioners in *Lomeli* alleged that the Department does not properly inform SSI applicants of the availability of retroactive Medi-Cal coverage and demanded the Department to provide those applicants a meaningful opportunity to apply for retroactive Medi-Cal coverage. The settlement requires the Department to send notices to all new SSI applicants who have not had Medi-Cal eligibility in three consecutive months before applying for SSI. The Department will also send notices to new SSI beneficiaries informing them of the availability of retroactive coverage.

The Department ~~anticipates implementation to begin~~ **implemented the changes** in August 2011. The petitioners claim that the Department is required to pay for their attorney fees in excess of \$168,000. ~~The Department is reviewing the claim.~~ **The Department, through the Attorney General's Office, is in negotiations with the petitioners.**

4. Impact of SB 708 on Long-Term Care for Aliens

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the current state-only long-term care program is available to eligible new applicants and does not include the expenditure limit, the Department is taking steps to bring the current program into conformance with SB 708. This will require the Department to rescind outdated regulations, and implement new regulations to define the spending limit and to clarify other implementation requirements. Because the number of undocumented immigrants receiving State-only long-term care has not increased

**INFORMATION ONLY:**

above the number in the 1999-00 base year, no fiscal impact is expected in FY 2011-12 and FY 2012-13 due to the spending limit.

**5. Limitation of IHSS Services**

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

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

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

**6. Reduction of IHSS Hours**

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

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

**7. Ledezma v. Shewry Lawsuit**

The Department is currently negotiating a settlement of the *Ledezma v. Shewry* lawsuit. The suit resulted from a system programming error that discontinued Qualified Medicare Beneficiaries (QMB) at annual re-determination. Eligibility for Medicare Part A has been restored and affected beneficiaries have been reimbursed for the cost of their premiums. The Department remains responsible for the cost of reimbursing out-of-pocket medical expenses for qualified claims. Settlement costs are not expected to be significant. The parties have tentatively agreed to a process determining the scope of possible Department liability by contacting beneficiaries who may have incurred out-of-pocket expenses. Beneficiary reimbursements and costs associated with the beneficiary reimbursement process are not eligible for federal matching funds.

**8. Electronic Asset Verification Program**

**Due to the requirements imposed by H.R. 2642 of 2008, the Department is required to implement electronic verification of assets for all Aged, Blind or Disabled (ABD) applicants/beneficiaries through electronic requests to financial institutions. The Department will enter into a contract with a financial vendor that will enable the counties to receive asset information for the ABD population. The financial vendor will provide counties with data from financial institutions that could indicate assets and property not reported by the applicant or beneficiary. The counties will have the responsibility to require the applicant or beneficiary to provide additional supporting documentation before an eligibility determination is made. There will be undetermined costs for a third party contract as well as reimbursements to financial institutions. Although savings from asset and eligibility verification are currently indeterminate, savings/cost avoidance will be achieved when supplemental data increases the accuracy of eligibility determinations for the ABD population. The implementation date of this program is currently unknown.**

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**INFORMATION ONLY:****BENEFITS**1. State-Only Anti-Rejection Medicine Benefit Extension

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

2. CDSS IHSS Share-of-Cost Buyout

The CDSS and the Department implemented a process that enabled Medi-Cal IHSS recipients who had a Medi-Cal SOC higher than their IHSS SOC to pay the IHSS SOC. Without the payment from CDSS each IHSS recipient with a Medi-Cal SOC that exceeded his/her IHSS SOC was required to meet the Medi-Cal SOC obligation to establish Medi-Cal eligibility.

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

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

3. California Children's Services (CCS) Program Pilots

The Department will develop and implement four organized health care delivery models to serve CCS eligible children in at least four geographical locations within the State. This effort is a major component of the BTR with CMS and will secure additional federal financial participation for the five year life of the Waiver. The four organized health care delivery systems to be tested during the course of the Waiver are: an enhanced primary care case management model; an accountable care organization model; an existing Medi-Cal managed care organization; and a specialty health care plan. In the pilot counties, administrative work traditionally performed by counties for these children will be performed by the pilot contractor. Implementation of the pilots will begin January 2012.

**HOME & COMMUNITY BASED-SERVICES**1. AB 398—Traumatic Brain Injury

The Traumatic Brain Injury Pilot Project was authorized by AB 1410 (Chapter 676, Statutes of 2007). AB 1410 was updated and replaced by AB 398 (Chapter 439, Statutes of 2009) which directed the Department to work in conjunction with the Department of Rehabilitation to develop a waiver or SPA that would allow the Department to provide HCBS to at least 100 persons with Traumatic Brain Injury. The legislation contained language stating the project would only be operable upon appropriation of funds. There is currently no appropriation to initiate and sustain this pilot project.

**INFORMATION ONLY:**2. Self-Directed Services Waiver - CDDS

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

3. Assisted Living Waiver Expansion

AB 499 (Chapter 557, Statutes of 2000) required the Department to develop a waiver program to test the efficacy of providing assisted living as a Medi-Cal benefit for elderly and disabled persons in Residential Care Facilities for the Elderly (RCFEs), and Publicly Subsidized Housing (PSH). In June 2005, CMS approved the Assisted Living Waiver (**ALW**) Pilot Project and in March 2009 approved the renewal of the waiver for a five-year period. This increased the waiver capacity beginning in FY 2011-12 ~~by 390 slots or 56 slots per county.~~ Vacant slots are continually backfilled.

The waiver currently serves ~~1,450 persons~~ **participants** in the pilot counties of Los Angeles, Sacramento and San Joaquin and the expansion counties of Fresno, Riverside, and San Bernardino. It is anticipated that enrollment in Sonoma County will begin in 2012.

The expansion is expected to be cost-neutral based on a cost analysis of ALW enrollees.

4. Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver Expansion

AB 359 (Chapter 845, Statutes of 1999) required the Department to establish a pilot program to provide continuous 24-hour nursing care to medically fragile infants, children and adults with developmental disabilities in home-like community settings. The Department obtained a 1915 (b) freedom of choice waiver which CMS approved for the period of August 16, 2001 through September 30, 2009.

The Department converted this waiver into a 1915(c) HCBS waiver, effective October 1, 2009 through September 30, 2012. DD/CNC waiver participants must be Regional Center consumers, require 24-hour continuous skilled nursing care, and be free of clinically active communicable diseases. Nursing care services are currently available in seven regional center catchment areas. The Department will expand to two additional areas as adding 12 slots beginning in FY 2012-13. The expansion is expected to be cost-neutral based on a cost analysis of DD/CNC waiver enrollees.

5. IHSS Provider Tax

AB 1612 (Chapter 725, Statutes of 2010) mandates that IHSS providers be taxed at the State sales tax rate. In exchange, the providers will receive a supplementary payment through CDSS equal to the amount of the tax, plus the federal income, Social Security and Medicare tax liabilities on that supplementary payment. DHCS will provide the Title XIX federal funds for the supplementary payments for services provided to Medi-Cal beneficiaries, retroactive to October 1, 2010, and upon approval of a SPA that was submitted to CMS in December 2010.

**FAMILY PACT****BREAST AND CERVICAL CANCER TREATMENT**

**INFORMATION ONLY:****PHARMACY**1. Average Acquisitions Cost as the New Drug Reimbursement Benchmark

Average Wholesale Price (AWP) is currently the pricing benchmark used to reimburse drug claims to Medi-Cal FFS pharmacy providers. First Databank, the Department's primary drug price reference source, ~~has stated that it will cease to provide~~ **ceased publishing** AWP as of September 2011. AB 102 (Chapter 29, Statutes of 2011) gave the Department the authority to establish and implement a new methodology for Medi-Cal drug reimbursement that is based on average acquisition cost (AAC). If CMS provides guidelines for an alternative national benchmark, such a benchmark could be used under the new statute. To ensure the benchmark is in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.

2. Federal Upper Limit

The Deficit Reduction Act (DRA) of 2005 requires CMS to use 250% of the Average Manufacturer Price (AMP) to establish the federal upper limit (FUL) on generic drugs. CMS had estimated that the new FULs would be implemented on January 30, 2008. However, an injunction preventing CMS from implementing these changes and sharing pricing information with the states put the AMP and FUL changes on hold. The Affordable Care Act (ACA) modified federal statute to establish the FUL to be no less than 175% of the weighted average (based on utilization) of the AMP and redefined how AMP is calculated. These changes will result in an indeterminate change in the amount the Department reimburses for generic drugs. On May 23, 2011, CMS reported that a notice of proposed rulemaking (NPRM) implementing the changes to AMP had been drafted and was under review. The Department plans to implement the ~~FUL~~ **FULs**, after federal regulations have been published **and/or final FULs are provided by CMS**.

**1115 WAIVER—MH/UCD & BTR**1. South LA Preservation Fund – Deferral

The Department made payments from the South Los Angeles Medical Services Preservation Fund (SLAMSP) to LA County. The payments were consistent with the Special Terms and Conditions for the MH/UCD, which require SNCP funds be claimed based on the certified public expenditures of designated public hospitals, or the governmental entities with which they are affiliated, or based on certain designated State program expenditures.

CMS had raised questions and deferred \$255.2 million related to the costs incurred by LA County as contract payment for nonhospital services rendered to the uninsured by private providers. The deferral is due to the lack of a specific protocol in the Special Terms and Conditions for the Demonstration related to the use of the SNCP funding allotment for the SLAMSP.

The Department responded on May 2, 2011 discussing the rationale for concluding that claiming for the contract payments counties have with private providers is appropriate under the 1115 Waiver. ~~The Department continues to work with CMS to resolve the deferral issue.~~ **In January 2012, CMS approved the contract payments with private providers issue. The Department expects LA County to claim the remaining SLAMSP in FY 2011-12.**

**INFORMATION ONLY:****MANAGED CARE**1. ARRA – Payments for Services Provided by Certain Indian Health Care Providers

Under ARRA, non-Indian Medicaid managed care plans are required to make payments to participating and non-participating Indian health care providers, for services provided to Indian enrollees, at a rate equal to the rate negotiated between the managed care plan and the Indian health care provider. To the extent such a rate has not been negotiated, payment would be at a rate no less than what would have otherwise been paid to a participating provider who is not an Indian health care provider.

Additionally, for payments made by the Medicaid managed care plan, for services to Indian enrollees that are provided by Indian health care service providers that are FQHCs, but are not participating providers, payment would be the amount that the Medicaid managed care plan would pay a FQHC that is a participating provider but not a Indian health care provider.

Also, for Indian enrollees who receive services from Indian health care providers that are not FQHCs, whether they are participating or non-participating providers, to the extent the managed care payments to these providers are less than what would otherwise be required under the State Plan for that provider, the Medicaid managed care plan shall pay the amount required by the State Plan for that provider. California managed care contracts already require managed care plans, for services provided to Indian enrollees by non-FQHCs, to pay the State Plan rate for that facility.

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

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

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

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

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

2. Hospital Inpatient Rate Freeze

The hospital inpatient rate freeze imposed by SB 853, the Health Trailer Bill of 2010, was annulled by SB 90. Any payment reductions because of the rate freeze will be refunded to hospitals.

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

1. *Mission Hospital Regional Medical Center et al. v. Shewry*  
*Kaiser Foundation Hospitals et al. v. Shewry*

The plaintiffs in the *Mission Hospital Regional Medical Center* and *Kaiser Foundation Hospital* lawsuits are over 100 non-contract hospitals that challenge the validity of Medi-Cal reimbursement for hospital inpatient services provided during the FY 2004-05 in accordance with Section 32(b) of Senate Bill 1103 (Health Trailer Bill of 2004). The statute limits the final reimbursement to a non-contract hospital for services provided during that state fiscal year to a hospital's audited allowable costs for its fiscal period ending during calendar year 2003. Plaintiffs contend that this has reduced the reimbursement they would have otherwise been entitled to by over \$50 million. The two lawsuits were consolidated and on December 19, 2006, the Sacramento Superior Court issued a judgment in favor of the Department on all issues, with one exception. The court ruled in the plaintiffs' favor on their claim that applying section 32(b) to services provided from July 1, 2004 through August 15, 2004 (prior to August 16, 2004 when the statute was enacted) violated the contract clause of the Constitution. On January 29, 2007, all but 5 of the over 100 plaintiffs filed an appeal. The Department appealed the one issue it lost. On November 20, 2008, the Court of Appeal, Third Appellate District issued a decision in which it held that the State had violated title 42 United States Code section 1396a (a)(13) in implementing section 32 (b). On June 19, 2009, the trial court issued an order with respect to the plaintiff hospitals that would have required the Department to (1) cease applying the SB 1103 reimbursement limit when conducting audits and issuing final cost settlements, (2) cease collection of any overpayments that resulted from applying the SB 1103 limit, (3) recalculate and reissue final cost settlements without applying the SB 1103 limit, and (4) refund any overpayments resulting from the SB 1103 limit that was previously recouped. The Department appealed the order on August 14, 2009. On May 25, 2011, the Court of Appeal issued an unpublished decision in which it reversed the trial court's June 19, 2009 order. On July 5, 2011, the plaintiff hospitals filed a petition for review with the California Supreme Court.

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

Plaintiffs/Petitioners, an association of home health care providers, a home health care provider, and a disability rights advocacy group filed this lawsuit on April 27, 2004, and sought reimbursement, injunctive, and declaratory relief premised upon the Department's alleged violation of the Medicaid Act's "reasonable promptness" requirement; the Medicaid Act's "access" and efficiency, economy, and quality of care ("EEQ") provisions; federal regulation (42 C.F.R. § 447.204) and the State Plan. In March 2007, following an appeal of a trial court decision, the Court of Appeal issued a published decision holding that 1) the Department was required to review reimbursement rates for home health services annually for years 2001 through 2005 to ensure that they comply with the former State Plan provision incorporating 42 United States Code 1396a(a)(30)(A), and 2) the Department was not obligated to set new rates - i.e., for years after 2005.

The Department completed a rate review and concluded that rates were consistent with section 1396a(a)(30)(A). After the rate review was filed with the court, petitioners objected. On September 25, 2009 the trial court held that the Department did not perform a proper rate review in light of the standard set forth in *Orthopaedic Hospital v. Belshe*. The court ordered the Department to perform a further rate review. The Department has appealed the trial court's ruling. A hearing on the Department's appeal has not yet been scheduled.

3. *California Hospital Association v. Shewry*

The California Hospital Association is a trade association that represents nursing facilities that are a distinct part of a hospital (DP/NF). The plaintiff filed a lawsuit in San Francisco Superior Court challenging

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the validity of Medi-Cal reimbursement policy for DP/NFs for rate years 2001-02 to the present. The plaintiff contends that the rates paid to DP/NFs violate Title 42, United States Code section 1396a(a)(30)(A). The plaintiff seeks a court order that would require the Department to recalculate rates paid to DP/NFs for rate year 2001-02 through the present and then pay DP/NFs the additional amount owed based on the recalculated rates. On November 14, 2008, the trial court denied the plaintiff's motion for injunctive relief that would have invalidated the current rate methodology and required the Department to recalculate rates for the rate years 2001-02 to present. The plaintiff appealed. On August 20, 2010, the Court of Appeal issued a decision reversing the trial court judgment for the Department. It held that the Department had not complied with section 1396a(a)(30)(A) in establishing the rates paid to DP/NFs. The California Supreme Court denied the Department's petition for review. The Department then filed a petition for certiorari with the United States Supreme Court. It is anticipated that the Supreme Court will decide whether to grant certiorari by fall 2011.

4. *Santa Rosa Memorial Hospital, et al. v. Sandra Shewry, Director of the Department of Health Care Services*

On December 9, 2008, 17 hospitals filed a lawsuit contending that the 10% reduction in Medi-Cal reimbursement for non-contract hospital inpatient services, which was enacted by ABX3 5, violated various federal Medicaid laws, including 42 United States Code sections 1396a(a)(8) and 1396a(a)(30), the Supremacy clause and Equal Protection clause of the United States Constitution, the State Plan, and State law. On November 18, 2009, the district court issued a preliminary injunction with respect to the 10% reduction for the 17 hospitals. The Department appealed, and on May 27, 2010 the United States Court of Appeals affirmed the preliminary injunction. On January 18, 2011, the United States Supreme Court granted the Department's petition for certiorari (request to the court to accept a discretionary appeal). A hearing on the merits of the Department's petition is scheduled for October 3, 2011 in the United States Supreme Court.

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

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

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

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

The Department filed a petition for certiorari, which is a request for a discretionary appeal, with the United States Supreme Court in March 2010. On January 18, 2011, the United States Supreme Court granted the

**INFORMATION ONLY:**

Department's petition for certiorari. A hearing on the merits of the Department's petition is scheduled for October 3, 2011 in the United States Supreme Court.

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

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

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

This ruling would have impacted the Department's implementation of temporary withholds to protect the Medi-Cal Program against fraud and abuse. The Department appealed the decision and the appellate court reversed it, holding that the law does not require payment of interest based on the temporary withholding of payments. The plaintiff then filed an amended complaint. Over the Department's objection, on July 8, 2011, the trial court certified this legal issue for immediate appellate review. The Department will seek immediate appellate review of the trial court's ruling.

7. AB 1183 Litigation

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

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

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

8. CHA v. David Maxwell-Jolly

On February 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for Distinct Part Nursing Facilities (DP/NF) Level B and DP/NF adult and pediatric subacute providers. The court also enjoined the

**INFORMATION ONLY:**

Department from continuing the 10% reduction for some non-contract small and rural hospitals. The injunctions are effective as of February 24, 2010. The Department appealed. The Court of Appeals has stayed appellate proceedings pending a decision by the United States Supreme Court on the Department's petition for certiorari (request to the court to accept a discretionary appeal) in the case of *Independent Living Center of Southern California v. Maxwell-Jolly*.

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

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

On October 18, 2010, the United States District Court issued an injunction ordering the Department to provide the reimbursement of adult dental, chiropractic, and podiatry services as Medi-Cal covered benefits when provided in an RHC/FQHC setting. The Court ruling states that the optional benefits exclusion cannot be implemented until the Department receives federal approval. The Department appealed the court order. The plaintiffs appealed the portion of the court's decision that held that federal law does not require states to cover these services when rendered by RHCs and FQHCs. On May 23, 2011, the federal government approved a SPA eliminating Medi-Cal coverage of these optional services when provided by RHC and FQHC providers. The plaintiffs are continuing their appeal of the district court's decision that federal law does not require states to cover these services. If the plaintiffs are successful in their appeal, the fiscal impact for the Medi-Cal program is indeterminate but could be significant.

10. Managed Care Potential Legal Damages***Santa Clara Family Health Authority dba Santa Clara Family Health v. DHCS******Health Net of California, Inc. v. DHCS******Blue Cross of California, Inc., dba Anthem Blue Cross and Blue Cross of California Partnership Plan, Inc., v. DHCS******Molina Healthcare of California, Inc., v. DHCS***

Four health plans (~~Santa Clara County Health Authority, Health Net, Blue Cross and Molina Healthcare~~) filed lawsuits against the Department challenging the Medi-Cal managed care rate setting methodology for the rate years from 2002 through 2005. On April 20, 2011, the trial court issued a judgment in favor of the plaintiff in the Santa Clara County Health Authority case and on June 13, 2011, judgment was issued in favor of the plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. The Department **is in appellate mediation on damages and interest for each of these cases, but mediation has not been completed.** The possible fiscal impact if the Department loses the appeals is unknown but could be significant.

***Molina Healthcare of California v. Toby Douglas***

**Antelope Valley Hospital sued Molina Healthcare for failure to pay the interim rate for emergency services (rather than the CMAC rate). Molina then cross-complained against Health Net as well as the Department, and is now seeking compensation from Health Net and the Department in Superior Court. Health Net has now filed an administrative appeal seeking indemnification from the Department.**

**INFORMATION ONLY:****AIDS Healthcare dba Positive Healthcare**

**AIDS Healthcare Centers has submitted a settlement proposal to consolidate four appeals pending with the Office of Administrative Hearings and Appeals (OAHA). The matters relate to 2009 and 2010 capitation rates and 2007 and 2008 savings sharing. There have not been formal hearings in these cases.**

11. **Maternal and Child Health Access (MCHA) vs. DHCS and the Managed Risk Medical Insurance Board (MRMIB)**

MCHA alleged in their petition to the San Francisco Superior Court that because the Healthy Families (HF) and Medi-Cal joint application used at Single Point of Entry (SPE) was a Medi-Cal application, due process required the State to send out a Notice of Action (NOA) if the screen did not indicate eligibility for the children's Medi-Cal federal poverty level program (FPL). Further, the petitioners alleged that the SPE should screen for "deemed eligible" infants for Medi-Cal and "AIM-linked" infants for the HF Program, and that the SPE should screen for the 1931(b) Medi-Cal program for all children rather than or in addition to the FPL Medi-Cal Program.

In December 2010, the San Francisco Superior Court denied the petitioner's allegations regarding requirements to issue NOAs and screen for deemed eligibility for infants; however, the Court ordered that SPE screen children ages 6 up to age 19 for the no-cost Medi-Cal 1931 (b) program before the child can be enrolled in the HF program. ~~In response to the court order, the Department and MRMIB have developed an implementation timeline that was presented to the court in May 2010. The timeline projects the completion of SPE systems modifications, Health-E-App and application form revisions, translations and printing by January 2013.~~ **On May 5, 2011, the Department filed a status report with the court indicating, in part, that implementation of the 1931(b) screen would be completed by January 2013. MCHA objected to the January 2013 implementation date and requested an interim solution be implemented immediately. The Department and MRMIB are negotiating an agreement for a final settlement with the petitioner using the current application and Health-E-App formats and minimizing SPE systems modification. MCHA has submitted a demand that the Department pay attorneys' fees in connection with this litigation.**

12. **Darling et al. v. Toby Douglas**

A lawsuit had been filed seeking to enjoin the elimination of Medi-Cal coverage of adult day health care (ADHC) services, as required by Assembly Bill 97 (Chapter 3, Statutes of 2011). The plaintiffs contended that elimination of Medi-Cal covered ADHC services would violate various federal laws, including the Americans with Disabilities Act. A settlement agreement between the parties has been reached and will be heard by the court on January 2012. The settlement ends ADHC services effective February 29, 2012, and establishes Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective March 1, 2012.

13. **California Association of Health Facilities, et al. v. Toby Douglas**

A lawsuit has been filed seeking to enjoin a freeze in the Medi-Cal reimbursement rates paid to intermediate care facilities for the developmentally disabled (ICF/DDs), ICF/DD-Ns (Nursing), ICF/DD-Hs (Habilitative), and freestanding pediatric subacute care providers. The rate freeze was mandated by California Welfare and Institutions Code section 14105.191 and became effective August 1, 2009. The plaintiffs contend the rate freeze violates various federal Medicaid laws. On May 6, 2011, the federal district court issued a preliminary injunction against the rate freeze that would apply to services rendered on or after that date. The Department has filed an appeal, which is now pending at the United States Court of Appeals for the Ninth Circuit. The Court of Appeals has stayed the preliminary injunction pending a decision on the Department's appeal. Appellate briefing is now occurring and oral argument is

**INFORMATION ONLY:**

scheduled for October 2011. On November 30, 2011, the Court of Appeals issued a decision reversing the preliminary injunction. Also the federal government recently approved a state plan amendment providing for the rate freeze. Thus, the Department is continuing to implement the rate freeze for these providers.

**14. California Pharmacists Association v. David Maxwell-Jolly**

On May 5, 2010, in the case of the *California Pharmacists Association v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the Upper Billing Limitation (UBL), which required pharmacy providers to bill Medi-Cal at a rate that is no higher than the lower of the lowest price reimbursed to pharmacies by other third party payers (excluding Medi-Cal managed care plans and Medicare Part D drug plans) or the lowest price routinely offered to any segment of the general public. The UBL had been implemented in October 2009.

The court also enjoined the Department from implementing the Maximum Allowable Ingredient Cost (MAIC), which is an upper payment limit established by the Department that creates a maximum reimbursement for generically equivalent drugs. Implementation of the MAIC was to begin July 1, 2010.

**OTHER: REIMBURSEMENTS****1. Federal Upper Payment Limit**

The Upper Payment Limit (UPL) is computed in the aggregate by hospital category, as defined in federal regulations. The federal UPL limits the total amount paid to each category of facilities to not exceed a reasonable estimate of the amount that would be paid for the services furnished by the category of facilities under Medicare payment principles. Payments cannot exceed the UPL for each of the three hospital categories.

The UPL only applies to private hospitals and non-designated public hospitals that are part of the category of "non-state government-owned hospitals". The UPL for designated public hospitals consists of audited costs.

**2. Selective Provider Contracting Program Waiver Renewal**

The 1915(b) waiver that authorized the SPCP allowed California to negotiate contracts with hospitals for inpatient services on a competitive basis expired on August 31, 2005. However, the Department was allowed to continue the SPCP under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver which ended on October 31, 2010. The BTR Waiver was approved November 1, 2010 for five years and includes continuation of the SPCP.

**On July 1, 2013, the Department will implement a new payment system, which will replace the SPCP and existing non-contract payment system currently utilized with a system based on diagnosis related groups (DRG). The DRG payment system will pay for inpatient fee for service hospital stays at all hospital except for Designated Public Hospitals. Rehabilitation and psychiatric stays will not be reimbursed by the DRG payment system. The implementation of the DRG payment system is expected to generate ongoing general fund savings compared to what would have occurred under the existing methodology due to the ability of the Department to eliminate the annual increases that currently occur under the contract rate and non-contract cost methodologies.**

**INFORMATION ONLY:****3. Accrual Costs Under Generally Accepted Accounting Principles**

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to accrual. For the most recently completed fiscal year (FY 2010-11), the June 30, 2011 Medi-Cal accrual amounts were estimated to be \$1.33 billion state General Fund and \$5.43 billion federal funds, for a total of \$6.76 billion.

**4. Freestanding Clinic – Former Agnews State Hospital**

The 2003-04 Governor's Budget directed the California Department of Developmental Services (CDDS) to develop a plan to close Agnews Developmental Center (Agnews) by July 2005. The facility is now officially closed and all of the former residents have been placed in community settings or other alternate locations.

As part of the closure plan, Agnews agreed to continue to operate a freestanding clinic at the former Agnews location in order to continue to cover services that were previously provided as part of the general acute care hospital. The clinic services include health, dental and behavioral services which are offered to former Agnews residents as well as referrals from the various developmental centers in the area. The freestanding clinic became operational on April 1, 2009, and will remain open until CDDS is no longer responsible for the Agnews property.

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

The Department will enter into an Interagency Agreement with CDDS to reimburse the FFP for Medi-Cal clients served at the clinic.

**OTHER: RECOVERIES****FISCAL INTERMEDIARY: MEDICAL****1. CA-MMIS Replacement – TPL and ACMS**

**The Department will replace the existing Third Party Liability (TPL) legacy system, comprised of the TPL subsystem and the Automated Collection Management System (ACMS).**

**The replaced system will result in an automated tracking and case management system for TPL and estate recovery cases. Case tracking will allow the Department to more actively manage debts owed by liable third parties through automated updates as opposed to manual updates to the current legacy system. The new system will also allow for conformance with HIPAA compliant processes intended to streamline coordination of benefits (COB) between other insurance companies and other payers by utilizing standardized electronic methods of sharing healthcare claim information. This replacement component is planned for implementation within 36 months of AOO. Payments for these costs are expected to be made after FY 2012-13.**

**INFORMATION ONLY:**

**2. CA-MMIS Replacement – Claims and All Other Remaining Operations**

**The Department will replace core California Medicaid Management Information Systems (CA-MMIS) functionality, including hardware and software components, during the final phase of the CA-MMIS Replacement Design, Development and Implementation (DD&I). This replacement component is planned for implementation within 54 months of AOO. Payments for these costs are expected to be made after FY 2012-13.**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**

**1. Medi-Cal Dental FI Contract – Optional Contractual Services**

The CD-MMIS is the Medi-Cal dental claims processing system operated by the dental FI. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published in August 2011. The Medi-Cal Dental RFP allows proposers to submit up to three Optional Contractual Services (OCS) that relate to claims processing or other services required by the RFP. The Department has the option to purchase any OCS submitted by any proposer.

**2. CMS' Determination That Dental Contract is Not Valid MMIS**

**The Department completed the procurement for the CD-MMIS Fiscal Intermediary and published the Notice of Intent in August 2011. CMS reviewed the dental contract and determined that the contract no longer meets the regulatory criteria and conditions as a MMIS acquisition. The Department will submit an Advanced Planning Document (APD) to demonstrate that the dental contract meets requirements for funding at the enhanced FFP rate. If CMS approves the new APD, the program will continue to receive enhanced funding at the rate of 75%. If CMS rejects the submission of the new APD, FFP for system operations will be reduced from 75% to 50% of expenditures.**

**DISCONTINUED ASSUMPTIONS**

**Fully Incorporated Into Base Data/Ongoing**

**ELIGIBILITY**

**BENEFITS**

**HOME & COMMUNITY-BASED SERVICES**

**FAMILY PACT**

**BREAST AND CERVICAL CANCER**

**PHARMACY**

**1115 WAIVER—MH/UCD & BTR**

**MANAGED CARE**

1. Trigger Cuts to Other Managed Care Plans

The Budget Act of 2011 established trigger cuts that would go into effect if revenues are forecasted up to \$2 billion less than budgeted. For Medi-Cal, the budget shortfall triggered the extension of certain program reductions to the Program of All-Inclusive Care for the Elderly (PACE), Senior Care Action Network (SCAN), and AIDS Healthcare Centers (AHF) managed care plans.

2. Mandatory SPD Enrollment into Managed Care

Effective June 1, 2011, it is mandatory for all Medi-Cal Seniors and Persons with Disabilities (SPDs) residing in managed care counties, and not dually eligible for Medicare, to enroll in a managed care plan. Previously, only SPDs in County Organized Health System counties were required to enroll in managed care.

**PROVIDER RATES**

**SUPPLEMENTAL PAYMENTS**

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**

## DISCONTINUED ASSUMPTIONS

### Time Limited/No Longer Applicable

#### ELIGIBILITY

#### BENEFITS

#### HOME & COMMUNITY-BASED SERVICES

#### FAMILY PACT

#### BREAST AND CERVICAL CANCER

#### PHARMACY

#### 1115 WAIVER—MH/UCD & BTR

#### MANAGED CARE

#### PROVIDER RATES

#### SUPPLEMENTAL PAYMENTS

#### OTHER: AUDITS AND LAWSUITS

#### OTHER: REIMBURSEMENTS

##### 1. ARRA – Additional FFP for DHCS

On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010 which provides an across-the-board increase to all states of 6.2 percent and an additional increase in the form of a decrease in the state share based on increased unemployment rates. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period. Among other conditions, ARRA requires that eligibility standards, methodologies, or procedures in place in the Medicaid state plan or a Section 1115 waiver program cannot be more restrictive than those in effect as of July 1, 2008. Compliance with provider prompt payment requirements, including hospitals and nursing homes, is also a condition of receiving the enhanced FMAP.

#### OTHER: RECOVERIES

#### FISCAL INTERMEDIARY: MEDICAL

##### 1. Field Office Automation Group Staffing

HP Hired 13 additional pharmacy consultants after the FI procurement was initiated. The Department has concluded these staff are needed by the new contractor, ACS, and will amend the ACS contract accordingly.

#### FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

**DISCONTINUED ASSUMPTIONS**

**Time Limited/No Longer Applicable**

FISCAL INTERMEDIARY: DENTAL

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**DISCONTINUED ASSUMPTIONS****Withdrawn****ELIGIBILITY****BENEFITS**1. Copayments for Dental Services

AB 97 (Chapter 3, Statutes of 2011) requires all Medi-Cal beneficiaries to pay a \$5 copayment for each dentist visit at the point of service. Pending CMS approval the dental FI will reimburse providers at the appropriate Medi-Cal reimbursement rate less the \$5 copayment.

2. Copayments for Emergency ER Visits

AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of \$50 for emergency use of the emergency rooms at the point of service. This copayment will be implemented without exemptions and in both the fee-for-service and managed care settings. The hospital will collect the \$50 copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$50 copayment.

3. Copayments for Physician/FQHC/RHC Office Visits

AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of \$5 for physician and Federally Qualified Health Center/Rural Health Clinic (FQHC/RHC) office visits at the point of service. This copayment does not apply to FPACT beneficiaries. The copayment will be implemented in both the fee-for-service and managed care settings. The providers will collect the \$5 copayment from the beneficiaries at the time of service, and the providers will be reimbursed the appropriate Medi-Cal reimbursement rate minus the \$5 copayment.

4. Copayments for Hospital Inpatient Days

AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of \$100 per hospital inpatient day up to a maximum of \$200 per admission. This copayment will be implemented without exemptions and in both the fee-for-service and managed care settings. The hospitals will request the copayment from the beneficiaries in accordance with the hospital's collection policy for all copayment clients. The hospitals will be reimbursed the appropriate Medi-Cal reimbursement rate minus the copayment.

**HOME & COMMUNITY-BASED SERVICES****FAMILY PACT****BREAST AND CERVICAL CANCER****PHARMACY****1115 WAIVER—MH/UCD & BTR****MANAGED CARE****PROVIDER RATES**

**DISCONTINUED ASSUMPTIONS**

**Withdrawn**

**SUPPLEMENTAL PAYMENTS**

**OTHER: AUDITS AND LAWSUITS**

**OTHER: REIMBURSEMENTS**

**OTHER: RECOVERIES**

**FISCAL INTERMEDIARY: MEDICAL**

1. ACS Beneficiary Call Center

The Centers for Medicare & Medicaid Services (CMS) requires the Department to monitor beneficiary access to care as a condition of reducing reimbursement levels to Medi-Cal providers authorized under AB 97 (Chapter 3, Statutes of 2011). The Department, as part of a monitoring plan, will establish a beneficiary call center at the Affiliated Computer Systems (ACS) fiscal intermediary in FY 2011-12 in order to monitor fee-for-service beneficiary access to care through beneficiary calls for assistance.

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**