

**MEDI-CAL
NOVEMBER 2012
LOCAL ASSISTANCE ESTIMATE
for
FISCAL YEARS
2012-13 and 2013-14**

**REGULAR
POLICY CHANGES**

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MEDI-CAL PROGRAM REGULAR POLICY CHANGE INDEX

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FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 1
 IMPLEMENTATION DATE: 1/1997
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$598,091,000	\$617,121,000
- STATE FUNDS	\$149,655,300	\$154,416,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$598,091,000	\$617,121,000
STATE FUNDS	\$149,655,300	\$154,416,900
FEDERAL FUNDS	\$448,435,700	\$462,704,100

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

Reason for Change from Prior Estimate:

Revised based on additional data.

Methodology:

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

FAMILY PACT PROGRAM
REGULAR POLICY CHANGE NUMBER: 1

2. The treatment of STIs and other family planning companion services are eligible for Title XIX 50/50 FFP.
3. The treatment of other medical conditions; including inpatient care for complications from family planning services are not eligible for FFP.
4. It is assumed that 13.95% of the Family PACT population are undocumented persons and are budgeted at 100% GF.

Service Category	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
Physicians	\$87,188,000	\$21,816,000	\$91,071,000	\$22,788,000
Other Medical	\$348,299,000	\$87,152,000	\$354,503,000	\$88,704,000
County Outpatient	\$4,111,000	\$1,029,000	\$4,275,000	\$1,070,000
Community Outpatient	\$4,496,000	\$1,125,000	\$4,666,000	\$1,168,000
Pharmacy	\$153,997,000	\$38,533,000	\$162,606,000	\$40,687,000
Total	\$598,091,000	\$149,655,000	\$617,121,000	\$154,417,000

Funding:

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

GF (4260-101-0001)

Title XIX 10/90 FFP (4260-101-0001/0890)

TRANSITION OF HFP TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 2
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1511

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$244,519,000	\$1,088,132,000
- STATE FUNDS	\$85,581,650	\$380,846,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$244,519,000	\$1,088,132,000
STATE FUNDS	\$85,581,650	\$380,846,200
FEDERAL FUNDS	\$158,937,350	\$707,285,800

DESCRIPTION

Purpose:

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

Authority:

AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:

CA 7 Transition of Healthy Families Children to Medi-Cal
 OA 13 Transition of HFP to Medi-Cal
 PC 64 Transition of HFP –SMH Services
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

AB 1494 shifts all HFP subscribers into the Medi-Cal program. Beginning January 2013, a nine-month transition of subscribers will take place. Children over 150% of the federal poverty level (FPL) will continue to be required to pay a premium for coverage. The administrative costs associated with this change are budgeted separately in the Transition of HFP to Medi-Cal policy changes under County Administration and Other Administration section of the Medi-Cal Estimate. In addition, postage and printing costs related to the transition are budgeted separately in the Health Care Option (HCO) section. All savings related to the Transition of HFP to Medi-Cal will be reflected in the Managed Risk Medical Insurance Board (MRMIB) budget.

Reason for Change from Prior Estimate:

The HFP caseload and phase-in structure were updated. Additionally, the scheduled transition of HFP children to Medi-Cal was delayed from October 1, 2012 to January 1, 2013.

TRANSITION OF HFP TO MEDI-CAL**REGULAR POLICY CHANGE NUMBER: 2****Methodology:**

1. Beginning January 1, 2013, 871,027 subscribers will be transferred to Medi-Cal. This does not include 3,997 AIM infants with incomes between 250-300% FPL, which will not transition to Medi-Cal. It is assumed the HFP caseload will experience 0.30% of annual growth in FY 2013-14.
2. These eligibles will be enrolled into managed care plans in those counties that have County Organized Health Systems, Geographic Managed Care, or the Two Plan Model.
3. The shift of HFP subscribers into the Medi-Cal program will occur in four separate phases. The first phase will be split into three phases transitioning January 1, 2013, March 1, 2013 and April 1, 2013, for all HFP subscribers currently enrolled in a managed care plan that also contracts directly with the Department. The second phase will transition on April 1, 2013, for all HFP subscribers currently enrolled in a managed care plan that subcontracts with a Medi-Cal managed care plan. The third phase will transition over 3-months (August 1, 2013 to October 31, 2013) for all HFP subscribers in a managed care county that were not transitioned in Phase 1 or Phase 2. The fourth phase will transition on September 1, 2013, for all remaining HFP subscribers.
4. The weighted average monthly cost of benefits for these subscribers under the Medi-Cal program is estimated to be \$87.08. This includes managed care capitation payments, FFS costs, managed care carve-outs, Federally Qualified Health Center (FQHC) wrap-around payments and dental payments (excluding California Children Services (CCS)).
5. Premiums only will be assessed for subscribers over 150% of Federal Poverty Level (FPL) at the HFP Community Provider Plan (CPP) premium level. Premiums are estimated to total \$17,926,000 in FY 2012-13 and \$66,191,000 in FY 2013-14.
6. Of the 871,027 subscribers, there are an estimated 6,406 CCS-HFP eligibles that will shift to CCS-Medi-Cal in FY 2012-13, and 23,585 in FY 2013-14. The cost for these eligibles is currently budgeted in the Family Health Estimate. CCS-HFP is funded with 65% FFP, 17.5% GF, and 17.5% county funds. It is assumed that the county share will continue under Medi-Cal. The GF reimbursement from the counties for CCS-Medi-Cal is estimated to be \$1,395,000 in FY 2012-13 and \$27,100,000 in FY 2013-14.
7. Enhanced federal funding under Title XXI is available for these subscribers enrolled in Medi-Cal.
8. This policy change includes \$7,222,000 TF (\$2,528,000 GF) in FY 2012-13 and \$14,795,000 TF (\$5,178,000 GF) in FY 2013-14 for benefit costs that were part of the Bridge to HFP policy change.

(In Thousands)	County		
FY 2012-13	TF	GF	Reimbursement*
Other Services	\$245,257	\$85,840	
CCS	\$9,966	\$2,093	\$1,395
Bridge to HFP	\$7,222	\$2,528	
Benefits Total	\$262,445	\$90,461	\$1,395
Premiums	-\$17,926	-\$6,274	
Net	\$244,519	\$84,187	\$1,395

TRANSITION OF HFP TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 2

(In Thousands) FY 2013-14	TF	GF	County Reimbursement*
Other Services	\$945,958	\$331,085	
CCS	\$193,570	\$40,650	\$27,100
Bridge to HFP	\$14,795	\$5,178	
Benefits Total	\$1,154,323	\$376,913	\$27,100
Premiums	-\$66,191	-\$23,167	
Net	\$1,088,132	\$353,746	\$27,100

Funding:

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

Reimbursement GF (4260-610-0995)*

BREAST AND CERVICAL CANCER TREATMENT

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

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$140,364,000	\$143,082,000
- STATE FUNDS	\$60,792,950	\$62,047,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$140,364,000	\$143,082,000
STATE FUNDS	\$60,792,950	\$62,047,800
FEDERAL FUNDS	\$79,571,050	\$81,034,200

DESCRIPTION

Purpose:

This policy change estimates the fee-for-service (FFS) costs of the Breast and Cervical Cancer Treatment Program (BCCTP).

Authority:

AB 430 (Chapter 171, Statutes of 2001)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

Reason for Change from Prior Estimate:

Projected expenditures increased due to a small growth in FY 2011-12 caseload data.

Methodology:

1. There were 10,550 FFS and 2,594 managed care eligibles as of August 2012 (total of 13,144). 2,649 of the FFS eligibles were eligible for State-Only services.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

2. 610 of the FFS eligibles were in Accelerated Enrollment as of August 2012.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 361 beneficiaries monthly in FY 2012-13 and FY 2013-14. Assume an average monthly premium cost per beneficiary of \$250.59.

FY 2012-13: 361 x \$250.59 x 12 months = \$1,086,000* TF (\$1,086,000 GF) *Rounded
 FY 2013-14: 361 x \$250.59 x 12 months = \$1,086,000* TF (\$1,086,000 GF) *Rounded

4. FFS costs are estimated as follows:

(Rounded)	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
Full Scope Costs	\$122,417,000	\$42,846,000	\$124,668,000	\$43,634,000
State-Only Costs				
Services	\$16,861,000	\$16,861,000	\$17,328,000	\$17,328,000
Premiums	\$1,086,000	\$1,086,000	\$1,086,000	\$1,086,000
Total	\$140,364,000	\$60,793,000	\$143,082,000	\$62,048,000

5. Managed Care costs associated with the BCCTP are budgeted in the Two-Plan, County Organized Health Systems (COHS), and Geographic Managed Care (GMC) policy changes.
6. Federal reimbursement for a portion of State-Only BCCTP costs based on the certification of public expenditures is budgeted in the policy change MH/UCD – BCCTP.

Funding:

FY 2012-13:		GF	FF	TF
General Fund	4260-101-001	\$ 17,947,000	\$0	\$ 17,947,000
Title XIX 35/65 FFP	4260-101-0001/0890	\$ 42,846,000	\$ 79,571,000	\$ 122,417,000
Total		\$ 60,793,000	\$ 79,571,000	\$ 140,364,000

FY 2013-14:		GF	FF	TF
General Fund	4260-101-001	\$18,414,000	\$0	\$18,414,000
Title XIX 35/65 FFP	4260-101-0001/0890	\$ 43,634,000	\$ 81,034,000	\$ 124,668,000
Total		\$ 62,048,000	\$ 81,034,000	\$ 143,082,000

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 8

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$13,886,000	\$14,178,000
- STATE FUNDS	\$4,860,100	\$4,962,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$13,886,000	\$14,178,000
STATE FUNDS	\$4,860,100	\$4,962,300
FEDERAL FUNDS	\$9,025,900	\$9,215,700

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

The Medi-Cal PE is captured in the Medically Indigent Children aid code, which is incorporated in the base estimate.

Effective January 2013, the HFP will cease to enroll new applicants and will be phased-out over a nine-month period. Children enrolled in the HFP will be transitioned to the Medi-Cal program, and children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal.

Reason for Change from Prior Estimate:

Updated June 2009 through August 2012 data on eligibles for aid code 8X, and change in the phase-in for the HFP transition to Medi-Cal.

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 4

Methodology:

1. Based on June 2009 through August 2012 eligible data there will be 588,445 children (35,529 HFP, 33,873 Shift of HFP to Medi-Cal, 478,283 Medi-Cal and 40,760 CHDP State-Only) in FY 2012-13 and 586,158 children (70,864 HFP, 475,921 Medi-Cal and 39,373 CHDP State-Only) in FY 2013-14 who will be screened through the Gateway.
2. Based on August 2011 through July 2012 cost data and May 2011 through April 2012 eligible data, the per member per month (PMPM) cost for HFP PE is \$200.10.
3. Based on August 2011 through July 2012 cost data and May 2011 through April 2012 eligible data, the PMPM cost for Medi-Cal PE is \$200.07.
4. The estimated FY 2011-12 and FY 2012-13 HFP and Medi-Cal PE costs are as follows:

FY 2012-13:	Avg. Mo. Eligibles	TF	GF
HFP PE*	5,922	\$ 7,109,000	\$ 2,488,000
Shift HFP to Medi-Cal PE	5,645	\$ 6,777,000	\$ 3,389,000
		\$ 13,886,000	\$ 5,877,000
Medi-Cal PE	39,857	\$ 95,692,000	\$ 47,846,000
Total		\$ 109,578,000	\$ 53,723,000

FY 2013-14	Avg. Mo. Eligibles	TF	GF
Medi-Cal PE	39,660	\$ 95,220,000	\$47,610,000
HFP PE	5,905	\$ 14,178,000	\$ 4,962,000
Total		\$109,398,000	\$52,572,000

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

Funding:

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

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

MEDI-CAL INPATIENT HOSP. COSTS - ADULT INMATES

REGULAR POLICY CHANGE NUMBER: 5
 IMPLEMENTATION DATE: 4/2012
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1569

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$9,149,000	\$14,024,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,149,000	\$14,024,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$9,149,000	\$14,024,000

DESCRIPTION

Purpose:

This policy change estimates the Federal Financial Participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR) and counties for the cost of inpatient services for inmates who are deemed eligible for Medi-Cal.

Authority:

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

Interdependent Policy Changes:

Not applicable

Background:

AB 1628 authorizes the Department, counties, and the CDCR to claim FFP for inpatient hospital services to Medi-Cal or Low Income Health Program (LIHP) eligible adult inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county.

SB 1399 authorizes the Board of Parole Hearings to grant medical parole or medical probation to permanently medically incapacitated State or county inmates. State inmates granted medical parole and county inmates granted medical probation, are potentially eligible for Medi-Cal. When a state inmate is granted medical parole, CDCR submits a Medi-Cal application to the Department to determine eligibility. When a county inmate is granted medical probation, the county processes a Medi-Cal application and notifies the Department. Previously these services were funded through CDCR or the counties with 100% General Fund or county funds.

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

MEDI-CAL INPATIENT HOSP. COSTS - ADULT INMATES

REGULAR POLICY CHANGE NUMBER: 5

Reason for Change from Prior Estimate:

Previously, this policy change only estimated inpatient costs related to adult State inmates and medical parolees. This policy change now covers inpatient costs associated with county adult inmates and individuals granted medical probation. In addition, the estimated monthly number of Medi-Cal applications is now 72 rather than 125.

Methodology:

1. Implementation of coverage for the State inmates began April 2012. Implementation of coverage for county inmates will begin January 1, 2013.
2. Applications for Medi-Cal are processed by the Department if the applicant received off-site inpatient related services. Costs for State inmates eligible for LIHP are budgeted in the LIHP Inpatient Hosp. Costs for CDCR Inmates policy change.
3. It is assumed the Department will process 375 applications per month for State inmates with verified citizenship.
4. Assume 96 percent of the monthly applicants will become eligible for Medi-Cal or LIHP.

375 monthly applications x 96% = 360 eligible State inmates

5. Of the 360 eligible State inmates, it is assumed 20% are for Medi-Cal and 80% are for LIHP. Of the Medi-Cal applications, it is assumed 75% are age 65 or older, 15% are disabled, 5% are for pregnancy events, and 5% are under 21 years of age.

Monthly Applications	FY 2012-13					FY 2013-14								
Aged	360	x	20%	x	75%	=	54	360	x	20%	x	75%	=	54
Disabled	360	x	20%	x	15%	=	11	360	x	20%	x	15%	=	11
Pregnancy Event	360	x	20%	x	5%	=	4	360	x	20%	x	5%	=	4
Under 21	360	x	20%	x	5%	=	4	360	x	20%	x	5%	=	4

6. It is assumed the Department will process 170 Medi-Cal applications per month for county inmates with verified citizenship.
7. Of the 170 eligible county inmates, it is assumed 75% are age 65 or older, 10% are disabled, 10% are for pregnancy events, and 5% are under 21 years of age

Monthly Applications	FY 2012-13				FY 2013-14					
Aged	170	x	75%	=	127	170	x	75%	=	127
Disabled	170	x	10%	=	17	170	x	10%	=	17
Pregnancy Event	170	x	10%	=	17	170	x	10%	=	17
Under 21	170	x	5%	=	9	170	x	5%	=	9

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

MEDI-CAL INPATIENT HOSP. COSTS - ADULT INMATES

REGULAR POLICY CHANGE NUMBER: 5

9. Based on fee-for-service (FFS) cost data the average per member per month (PMPM) cost for an inpatient admission is \$9,506 for aged, \$11,751 for disabled, and \$9,401 for under 21.
10. Based on FFS delivery cost data the average PMPM cost per event is \$5,931 for cesarean delivery and \$3,759 for a vaginal delivery.
11. State inmate inpatient costs are estimated to be \$8,280,000 (\$4,140,000 GF) in FY 2012-13 and FY 2013-14. County inmate inpatient costs are estimated to be \$9,373,000 (\$4,686,500 GF) in FY 2012-13 and \$18,745,000 (\$9,373,000 GF) in FY 2013-14.
12. In FY 2012-13 and FY 2013-14, it is assumed the Department will process 35 applications annually for State Medical Parolees with verified citizenship. It is assumed these eligibles will receive long term care (LTC) services.
13. Based on FFS cost data the average PMPM cost for a LTC eligible is \$7,576.

$$35 \text{ LTC eligible months} \times \$7,576 = \$265,000 \quad (\$132,500 \text{ FF})$$

14. Implementation of coverage for inmates granted Medical Probation will begin January 1, 2013.
15. In FY 2012-13 and FY 2013-14, it is assumed there will be 100 applications annually for county inmates granted Medical Probation. It is assumed these eligibles will receive LTC services.
16. Based on FFS cost data the average PMPM cost for a LTC eligible is \$7,576.

$$\begin{array}{l} \text{FY 2012-13} \\ 50 \text{ LTC eligible months} \times \$7,576 = \$379,000 \quad (\$189,500 \text{ FF}) \end{array}$$

$$\begin{array}{l} \text{FY 2013-14} \\ 100 \text{ LTC eligible months} \times \$7,576 = \$758,000 \quad (\$379,000 \text{ FF}) \end{array}$$

(Rounded)	FY 2012-13 TF	FF	FY 2013-14 TF	FF
Medical Parole	\$265,000	\$132,500	\$265,000	\$132,500
Medical Probation	\$379,000	\$189,500	\$758,000	\$379,000
CDCR Inmates	\$8,280,000	\$4,140,000	\$8,280,000	\$4,140,000
County Inmates	\$9,373,000	\$4,686,500	\$18,745,000	\$9,372,500
Total	\$18,297,000	\$9,148,500	\$28,048,000	\$14,024,000

Funding:

Title XIX FFP (4260-101-0890)

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 6
 IMPLEMENTATION DATE: 11/1998
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 5

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$7,212,000	\$0
- STATE FUNDS	\$2,524,200	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,212,000	\$0
STATE FUNDS	\$2,524,200	\$0
FEDERAL FUNDS	\$4,687,800	\$0

DESCRIPTION

Purpose:

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

Authority:

AB 2780 (Chapter 310, Statutes of 1998)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

Effective January 1, 2013, the HFP will cease to enroll new applicants and will be phased-out over a nine-month period, which will eliminate the need for the bridge from Medi-Cal to the HFP.

Reason for Change from Prior Estimate:

The assumed transition of HFP into Medi-Cal was delayed from October 1, 2012 to January 1, 2013.

Methodology:

- Beginning January 1, 2013, the bridge from Medi-Cal to HFP will be eliminated. Estimated FY 2012-13 costs are based on July 1, 2012 through December 31, 2012.
- Based on current Medi-Cal data, it is estimated 64,283 children will receive the one-month bridge (aid code 7X) in FY 2012-13. The average monthly number of beneficiaries will be 10,714.

BRIDGE TO HFP
REGULAR POLICY CHANGE NUMBER: 6

3. In FY 2012-13, the FFS eligible months for aid code 7X are estimated to be 14,624, and the managed care eligible-months are estimated to be 49,659.
4. Based on FY 2011-12 cost data and eligible data from April 2011 through March 2012, the FFS PMPM cost for aid code 7X is \$49.25. The total FFS expenditures for aid code 7X will be \$720,000 in FY 2012-13.

$$\text{FY 2012-13: } \$49.25 \text{ PMPM} \times 14,624 = \$720,000$$

5. Based on FY 2011-12 cost data and eligible data from April 2011 through March 2012, the total average monthly managed care carve-out cost for aid code 7X is \$22.51. The total managed care carve-out expenditures for aid code 7X will be \$1,118,000 in FY 2012-13.

$$\text{FY 2012-13: } \$22.51 \text{ Carve-Out} \times 49,659 = \$1,118,000$$

6. The managed care capitation cost for aid code 7X will be \$5,374,000 in FY 2012-13.

$$\text{FY 2012-13: } \$108.22 \text{ managed care capitated rate} \times 49,659 = \$5,374,000$$

7. The total managed care cost for aid code 7X will be \$6,492,000 in FY 2012-13.

$$\text{FY 2012-13: } \$1,118,000 \text{ Carve-Out} + \$5,374,000 \text{ Capitation} = \$6,492,000$$

8. Total expenditures for aid code 7X are estimated to be \$7,212,000 TF in FY 2012-13.

$$\text{FY 2012-13: } \$720,000 + \$6,492,000 = \mathbf{\$7,212,000 \text{ TF } (\$2,524,000 \text{ GF})}$$

Funding:

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

REFUGEES

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

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$4,615,000	\$5,540,000
- STATE FUNDS	\$4,615,000	\$5,540,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,615,000	\$5,540,000
STATE FUNDS	\$4,615,000	\$5,540,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement #12-10028

Interdependent Policy Changes:

Not Applicable

Background:

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

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

Reason for Change from Prior Estimate:

Updated refugee eligibles from previous estimate.

Methodology:

Total refugee expenditures to be reimbursed by CDPH are estimated to be \$4,615,000 in FY 2012-13 and \$5,540,000 in FY 2013-14.

Funding:

Reimbursements (4260-610-0995)

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1755

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,451,000	\$4,901,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,451,000	\$4,901,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,451,000	\$4,901,000

DESCRIPTION

Purpose:

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

Authority:

AB 396 (Chapter 394, Statutes of 2011)

Interdependent Policy Changes:

Not applicable

Background:

AB 396 authorizes the Department, counties, and the CDCR to claim Federal Financial Participation (FFP) for inpatient hospital services to Medi-Cal eligible juvenile inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Previously these services were paid by CDCR or the county.

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

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Implementation of coverage will begin January 1, 2013.

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 8

2. Applications for Medi-Cal will be processed by the Department if the applicant received off-site inpatient or psychiatric related services.
3. It is assumed the Department will process 30 applications per month for State inmates and 88 applications per month for county inmates with verified citizenship.
4. Of the estimated 118 monthly applications, it is assumed 80% are for psychiatric services and 20% are for inpatient services.

(Rounded)	FY 2012-13				FY 2013-14			
Service Type	Total Member Months				Total Member Months			
Psychiatric Services	118	x	80%	x 6 = 566	118	x	80%	x 12 = 1,133
Inpatient Services	118	x	20%	x 6 = 142	118	x	20%	x 12 = 283

5. Based on fee-for-service (FFS) cost data the average per member per month (PMPM) cost for an general acute care inpatient admission is \$9,401 and \$6,297 for an inpatient psychiatric admission for those under 21 years old.

(Rounded)	FY 2012-13		FY 2013-14	
	TF	FF	TF	FF
CDCR				
Psych. Services	\$907,000	\$453,500	\$1,814,000	\$907,000
Inpt. Services	\$338,000	\$169,000	\$677,000	\$338,500
Subtotal	\$1,245,000	\$622,500	\$2,491,000	\$1,245,500
Counties				
Psych. Services	\$2,662,000	\$1,331,000	\$5,324,000	\$2,662,000
Inpt. Services	\$994,000	\$497,000	\$1,987,000	\$993,500
Subtotal	\$3,656,000	\$1,828,000	\$7,311,000	\$3,655,500
Total	\$4,901,000	\$2,450,500	\$9,802,000	\$4,901,000

Funding:

Title XIX FFP (4260-101-0890)

MCHA VS. DHCS AND MRMIB

REGULAR POLICY CHANGE NUMBER: 9
 IMPLEMENTATION DATE: 2/2013
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1735

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$661,000	\$511,000
- STATE FUNDS	\$330,500	\$255,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$661,000	\$511,000
STATE FUNDS	\$330,500	\$255,500
FEDERAL FUNDS	\$330,500	\$255,500

DESCRIPTION

Purpose:

This policy change estimates the benefits cost of enrolling children into Medi-Cal that were not previously identified as eligible when they were screened through the Single Point of Entry (SPE).

Authority:

Not Applicable

Interdependent Policy Changes:

CA 8 MCHA vs. DHCS and MRMIB
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

The Department uses the SPE to process joint applications that serve as an application for the Healthy Families Program (HFP) and a screening device for the Federal Poverty Level (FPL) Medi-Cal program. Maternal and Child Health Access (MCHA) contended in a lawsuit that the Department and the Managed Risk Medical Insurance Board (MRMIB) are legally required to use the joint application as an application for all Medi-Cal programs, not just the FPL program.

On December 6, 2010, the court issued its decision ruling in favor of the Department on all issues except that the State must screen for section 1931(b) Medi-Cal eligibility before enrolling children ages 6 to 18 in the HFP. On July 10, 2012, the San Francisco Superior Court issued an order enforcing writ concerning the 1931(b) screening. The Department had previously agreed to implement a screen at SPE to identify “deemed eligible” infants.

Beginning January 1, 2013, the HFP will cease to enroll new applicants and all applications submitted to the SPE will be sent to county eligibility workers for a Medi-Cal determination. Therefore, the impact of the court decision only will impact applicants who were screened by SPE prior to January 1, 2013.

MCHA VS. DHCS AND MRMIB**REGULAR POLICY CHANGE NUMBER: 9****Methodology:**

1. Assume that MRMIB will notify approximately 275,000 prior SPE applicants that they may be eligible for 1931(b) Medi-Cal coverage.
2. Assume that the responses to the MRMIB notifications will be received and processed during January, February, and March 2013.
3. Assume a 7.3% response rate will result in 20,000 responses.
4. Assume that 33% of the respondents will qualify for 2 months of accelerated enrollment at a monthly cost of \$66.45.

20,000 responses * 33% qualify for AE * 2 months * \$66.45 = \$877,000 (unlagged)

5. Assume that of the respondents, 30% will provide the necessary documentation to make a determination of Medi-Cal 1931(b) eligibility.
6. Assume that of those that receive a determination of eligibility, only 2% will be found eligible.
7. Assume that the average benefits cost per month for those found eligible is \$159.45.

20,000 responses * 30% provide documentation * 2% found eligible * \$159.45 per month * 12 months = \$230,000 (full year cost, unlagged)

8. Applying partial year phase-in adjustments and appropriate payment lags, the costs are:

	FY 2012-13	FY 2013-14
	TF	TF
Accelerated Enrollment	\$595,000	\$282,000
Ongoing Benefits	\$66,000	\$229,000
Total	\$661,000	\$511,000

Funding:

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

LANTERMAN DEVELOPMENTAL CENTER CLOSURE

REGULAR POLICY CHANGE NUMBER: 10
 IMPLEMENTATION DATE: 3/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1560

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$607,000	\$7,372,000
- STATE FUNDS	\$303,500	\$3,686,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$607,000	\$7,372,000
STATE FUNDS	\$303,500	\$3,686,000
FEDERAL FUNDS	\$303,500	\$3,686,000

DESCRIPTION

Purpose:

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

Authority:

AB 97 (Chapter 3, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

Updated caseload data

Methodology:

- Under CDDS' Plan for Closure of Lanterman Developmental Center, the individual planning process will be the basis for ensuring that each resident's needs and choices are identified and appropriately addressed in the community. Therefore, the costs of the services to be provided through the Medi-Cal program once the residents transition to the community are unknown at this time.
- Placeholder costs of \$607,000 (\$303,500 GF) for FY 2012-13 and \$7,372,000 (\$3,686,000 GF) for FY 2013-14 are included in the November 2012 Medi-Cal Estimate.

LANTERMAN DEVELOPMENTAL CENTER CLOSURE

REGULAR POLICY CHANGE NUMBER: 10

3. Assume 135 residents will transition from Lanterman Developmental Center into the community in 2012-13 and 123 residents will transition in 2013-14. As of July 1, 2012, 122 residents have moved into the community.

Funding:

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

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 11
 IMPLEMENTATION DATE: 8/2011
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1558

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,500,000	\$1,504,000
- STATE FUNDS	\$1,008,000	\$1,011,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	67.10 %	83.40 %
APPLIED TO BASE		
TOTAL FUNDS	\$493,500	\$249,700
STATE FUNDS	\$331,630	\$167,910
FEDERAL FUNDS	\$161,870	\$81,760

DESCRIPTION

Purpose:

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

Authority:

AB 1269 (Chapter 282, Statutes of 2009)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

The changes made by AB 1269 are:

1. Exemption of disability income that converts to retirement income.
2. Exemption of retained income from the resource calculation when held in a separately identifiable account and not comingled with other resources.
3. Allows beneficiaries to remain eligible for Medi-Cal up to 26 weeks while unemployed, provided premiums continue to be paid.
4. Allows the monthly premium calculation to be based on five percent of an individual's countable income.

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 11

However, under the Patient Protection and Affordable Care Act (PPACA) of 2010, Maintenance of Effort (MOE) requirements are imposed upon states until January 1, 2014. These requirements prevent states from implementing more restrictive Medicaid eligibility policies, procedures or methodologies without jeopardizing federal funding, therefore; change #4 concerning monthly premiums will not be implemented due to the MOE provisions of PPACA.

Reason for Change from Prior Estimate:

The change is due to more recent aid code 6G eligible data which showed a greater number of eligibles as well as a higher rate of increase (211 versus 70 annual growth).

Methodology:

1. The changes to the WDP were implemented August 1, 2011.
2. The provisions of the bill concerning retained income exemption and 26 weeks of eligibility while unemployed have an indeterminate impact.
3. The exemption of disability income that converts to retirement income will create an increase in the number of WDP participants resulting in additional costs to Medi-Cal.
4. Those affected by the exemption of disability income that converts to retirement income are age 65 and older.
5. Based on June 2011 through May 2012 eligible data, there are 618 average monthly eligibles in Aid Code 6G who are over 65 years of age.
6. The current growth rate of over 65 year olds in Aid Code 6G is 2.8% monthly or 18 beneficiaries per month (rounded). It is assumed there will be an additional increase of 211 eligibles per year to the WDP.
7. The full increase in eligibles will be phased-in over 12 months.
8. The fee-for-service (FFS) per member per month (PMPM) cost per eligible for aid code 6G is \$271.12 and the average monthly managed care cost is \$600.28 (\$507.35 cap rate and \$86.90 for carve-out PMPM cost). The monthly dental capitation rate is \$6.03.
9. The monthly premium for the Medicare Part B premium is \$99.90 in 2012 and 2013. The monthly premium for the Medicare Part D premium is \$102.76 in 2012, and is estimated to be \$104.46 in 2013 and \$105.60 in 2014.

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 11

FY 2012-13	TF	GF
FFS	\$ 432,000	\$ 216,000
Managed Care	\$ 537,000	\$ 268,500
Medicare Part B	\$ 263,000	\$ 263,000
Medicare Part D	\$ 253,000	\$ 253,000
Dental	\$ 15,000	\$ 7,500
Total	\$1,500,000	\$1,008,000

FY 2013-14	TF	GF
FFS	\$ 433,000	\$216,500
Managed Care	\$ 537,000	\$268,500
Medicare Part B	\$ 266,000	\$266,000
Medicare Part D	\$ 253,000	\$253,000
Dental	\$ 15,000	\$7,500
Total	\$1,504,000	\$1,011,500

Funding:

FY 2012-13:		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	\$492,000	\$492,000	\$984,000
GF	4260-101-0001	\$516,000	\$ 0	\$516,000
FY 2013-14:		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	\$492,500	\$492,500	\$985,000
GF	4260-101-0001	\$519,000	\$ 0	\$519,000

LOMELI V. SHEWRY

REGULAR POLICY CHANGE NUMBER: 12
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1583

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$504,000	\$504,000
- STATE FUNDS	\$252,000	\$252,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	82.95 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$85,900	\$0
STATE FUNDS	\$42,960	\$0
FEDERAL FUNDS	\$42,970	\$0

DESCRIPTION

Purpose:

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

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The Department has established the following assumptions based on previous lawsuit settlements.
2. The Department began receiving claims in October 2011, and costs began in December 2011.
3. Assume there are 1,000 Medi-Cal claims per month, of which 60% are eligible for retroactive coverage.

LOMELI V. SHEWRY
REGULAR POLICY CHANGE NUMBER: 12

4. Of those, assume 33% of the claims are for dental services and 67% of the claims are for medical services.
5. It is estimated that 18% of dental claims will be approved.
6. It is estimated that 28% of medical claims will be approved.
7. Assume the average cost is \$533.74 for dental claims and \$202.98 for medical claims.

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

FY 2013-14	TF	GF
Dental Costs	\$ 228,000	\$ 114,000
Medical Costs	\$ 276,000	\$ 138,000
Total Cost	\$ 504,000	\$ 252,000

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13
 IMPLEMENTATION DATE: 1/2011
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1371

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$9,127,400	-\$9,127,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$9,127,400	-\$9,127,400
FEDERAL FUNDS	\$9,127,400	\$9,127,400

DESCRIPTION

Purpose:

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

Authority:

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

The changes are due to updated expenditures for qualified children and pregnant aliens under the 5-year bar.

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

Methodology:

1. Title XXI funding of 65/35 FFP is available for 0 to 18 year olds and Title XIX funding of 50/50 FFP is available for 19 and 20 year olds and pregnant women.
2. Assume FY 2012-13 and FY 2013-14 will be unchanged from calendar year 2011.
3. Children
Based upon quarterly claiming reports for FY 2011-12, 37.57% of expenditures for NQA services are for non-emergency services.

FFS:

Special reports of expenditures for NQA children for 2011 services show fee-for-service (FFS) costs (including managed care carve-outs) of \$9,787,000 for 0 to 18 year olds and \$1,055,000 for 19 and 20 year olds.

Non-emergency FFS expenditures for NQA children are:

$\$9,787,000 \times 37.57\% \text{ non-emergency} = \$3,677,000$ (0 to 18 year olds)

$\$1,055,000 \times 37.57\% \text{ non-emergency} = \$396,000$ (19 and 20 year olds)

Managed Care:

Special reports of NQA children managed care eligibles for calendar 2011 show 171,628 eligible months for 0 to 18 year olds and 14,593 for 19 and 20 year olds.

The average capitation for the NQA children and pregnant women is assumed to be \$113.20 PMPM.

The non-emergency managed care expenditures for NQA children are:

$171,628 \text{ eligible months} \times \$113.20 \text{ PMPM} \times 37.57\% \text{ non-emergency} = \$7,299,000$ (0 to 18 year olds)

$14,593 \text{ eligible months} \times \$113.20 \text{ PMPM} \times 37.57\% \text{ non-emergency} = \$621,000$ (19 and 20 year olds)

4. Pregnant Women

Based on special reports of expenditures for pregnant women, 6.64% of expenditures for pregnant women are for non-pregnancy related services.

FFS:

Total FFS costs including carve-outs for pregnant women are \$34,926,000.

The non-pregnancy related FFS expenditures for pregnant women are:

$\$34,926,000 \times 6.64\% = \$2,319,000$

Managed Care:

Special reports of NQA pregnant eligibles for calendar year 2011 show 86,471 eligible months.

The average capitation for pregnant women is assumed to be \$113.20 PMPM.

Non-pregnancy services = $86,471 \text{ eligible months} \times \$113.20 \text{ PMPM} \times 6.64\% = \$650,000$

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

	<u>Title XIX</u>	<u>Title XXI</u>
Children (0-18)		
FFS		\$ 3,677,000
Managed Care		\$ 7,299,000
Children (19-20)		
FFS	\$ 396,000	
Managed Care	\$ 621,000	
Pregnant Women		
FFS	\$2,319,000	
Managed Care	\$ 650,000	
Total (rounded)	<u>\$3,986,000</u>	<u>\$10,976,000</u>
GF	\$1,993,000	\$ 3,841,600
FFP	\$1,993,000	\$ 7,134,400

5. Total FFP of \$9,127,000 offsets the General Fund cost of providing services to these eligibles.

Funding:

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

Title XXI Enhanced Healthy Families FFP (4260-113-0890)

NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 14
 IMPLEMENTATION DATE: 12/1997
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 15

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$64,317,000	\$64,317,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$64,317,000	\$64,317,000
FEDERAL FUNDS	-\$64,317,000	-\$64,317,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not applicable

Background:

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

Reason for Change from Prior Estimate:

The changes are due to updated expenditures for nonemergency services for NQAs.

Methodology:

1. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of NQAs from January 2006 through June 2012, current year and budget year costs were projected.
2. Based on the historical pattern of FFS versus managed care nonemergency service expenditures for the period of June 2010 through July 2011 (19.27%), the managed care totals for current year and budget year were projected.
3. The impact of the State Children's Health Insurance Program (SCHIP) funding for prenatal care for new qualified aliens is included in the SCHIP Funding for Prenatal Care policy change.

NEW QUALIFIED ALIENS
REGULAR POLICY CHANGE NUMBER: 14

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

(rounded)	FY 2012-13	FY 2013-14
FFS	\$ 107,848,000	\$ 107,848,000
Managed Care	\$ 20,786,000	\$ 20,786,000
Total	\$ 128,634,000	\$ 128,634,000
FFP Repayment	\$ 64,317,000	\$ 64,317,000

Funding:

Title XIX General Fund (4260-101-0001)

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 15
 IMPLEMENTATION DATE: 12/1998
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 13

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$44,850,150	-\$46,071,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$44,850,150	-\$46,071,000
FEDERAL FUNDS	\$44,850,150	\$46,071,000

DESCRIPTION

Purpose:

This policy change estimates the technical adjustment in funding for the 100% and 133% Programs expenditures to be adjusted from Title XIX 50% Federal Financial Participation (FFP) to enhanced Title XXI 65% FFP.

Authority:

SB 903 (Chapter 624, Statutes of 1997)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

Based on the provisions of SB 903 and Section 1902(l)(3) of the federal Social Security Act (42 U.S.C. Sec 1396a(l)(3)), resources will not be counted in determining the Medi-Cal eligibility for children ages one to 19 in the 100% and 133% programs. This change was implemented to help streamline the application process and to align Medi-Cal eligibility more closely with the Healthy Families Program.

Effective January 1, 2013, the Healthy Families Program will cease to enroll new applicants and will be phased-out over a nine-month period. Children enrolled in the Healthy Families Program will be transitioned to the Medi-Cal Program as targeted low-income children and resources will not be counted for children with incomes up to 250% of the Federal Poverty Level (FPL).

Reason for Change from Prior Estimate:

The changes are due to additional caseload and expenditures.

Methodology:

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

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 15

2. Average monthly fee-for-service (FFS) eligibles, which are included in the base, are estimated to be 44,953 in FY 2012-13 and 46,272 in FY 2013-14. It is assumed total FFS expenditures will be \$25,320,000 in FY 2012-13 and \$26,063,000 in FY 2013-14.
3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 180,003 in FY 2012-13 and 182,861 in FY 2013-14. It is assumed total Managed Care expenditures will be \$273,681,000 in FY 2012-13 and \$281,077,000 in FY 2013-14.
4. Enhanced federal funding under Title XXI Medicaid Children's Health Insurance Program (M-CHIP) may be claimed for children eligible under these aid codes. It is 65.00% in FY 2012-13 and FY 2013-14.

Funding:

		<u>GF</u>	<u>FF</u>	<u>TF</u>
FY 2012-13:				
Title XIX 50/50 FFP	4260-101-0001/0890	(\$149,500,000)	(\$149,501,000)	(\$299,001,000)
Title XXI 65/35 FFP	4260-113-0001/0890	\$104,650,000	\$194,351,000	\$299,001,000
Net Impact		(\$44,850,000)	\$44,850,000	\$0
		<u>GF</u>	<u>FF</u>	<u>TF</u>
FY 2013-14:				
Title XIX 50/50 FFP	4260-101-0001/0890	(\$153,570,000)	(\$153,570,000)	(\$307,140,000)
Title XXI 65/35 FFP	4260-113-0001/0890	\$107,499,000	\$199,641,000	\$307,140,000
Net Impact		(\$46,071,000)	\$46,071,000	\$0

PARIS-FEDERAL

REGULAR POLICY CHANGE NUMBER: 16
 IMPLEMENTATION DATE: 5/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1738

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$388,000	-\$665,000
- STATE FUNDS	-\$194,000	-\$332,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$388,000	-\$665,000
STATE FUNDS	-\$194,000	-\$332,500
FEDERAL FUNDS	-\$194,000	-\$332,500

DESCRIPTION

Purpose:

This policy change estimates the savings from the Public Assistance Reporting Information System (PARIS)-Federal.

Authority:

Not Applicable

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

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

Since the launch of the pilot program, Medi-Cal savings have been achieved through improved verification and identification capabilities. Currently, PARIS-Federal is implemented in 30 counties. The Department plans to expand to 40 counties in FY 2013-14.

PARIS-FEDERAL

REGULAR POLICY CHANGE NUMBER: 16

Reason for Change from Prior Estimate:

The number of beneficiaries that will be discontinued as a result of PARIS-Federal matches has increased based on recent matches. Additionally, the savings related to PARIS-Interstate matches are now captured in a separate policy change.

Methodology:

1. Savings for PARIS-Federal is assumed for both Managed Care and fee-for-service (FFS).
2. Based on quarterly reports for August 2012 through May 2013, it is estimated 344 managed care and 84 FFS beneficiaries will be discontinued from Medi-Cal in FY 2012-13.
3. Based on quarterly reports for August 2013 through May 2014, it is estimated 424 managed care and 104 FFS beneficiaries will be discontinued from Medi-Cal in FY 2013-14.
4. Total managed care savings is estimated to be \$680,000 TF in FY 2012-13, and \$1,032,000 TF in FY 2013-14. Total FFS savings is estimated to be \$2,235,000 TF in FY 2012-13 and \$3,392,000 TF in FY 2013-14.
5. In FY 2012-13, it is estimated that 86.69% of the managed care and FFS savings is captured in the base trends. In FY 2013-14, it is estimated that 84.96% of the managed care and FFS savings is captured in the base trends.

FY 2012-13	Total Savings	% in Base	Savings in Base
Managed Care Savings	(\$680,000)	86.69%	(\$589,000)
FFS Savings	(\$2,235,000)	86.69%	(\$1,937,000)
Total	(\$2,915,000)		(\$2,526,000)
FY 2013-14	Total Savings	% in Base	Savings in Base
Managed Care Savings	(\$1,032,000)	84.96%	(\$877,000)
FFS Savings	(\$3,392,000)	84.96%	(\$2,882,000)
Total	(\$4,424,000)		(\$3,759,000)

6. Total estimated savings not in the base trends:

FY 2012-13	TF	GF
Managed Care Savings	(\$91,000)	(\$45,500)
FFS Savings	(\$297,000)	(\$148,500)
Total	(\$388,000)	(\$194,000)
FY 2013-14	TF	GF
Managed Care Savings	(\$155,000)	(\$77,500)
FFS Savings	(\$510,000)	(\$255,000)
Total	(\$665,000)	(\$332,500)

Funding:

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

PARIS - VETERANS MATCH

REGULAR POLICY CHANGE NUMBER: 17
 IMPLEMENTATION DATE: 8/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1632

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,318,000	-\$1,690,000
- STATE FUNDS	-\$659,000	-\$845,000
PAYMENT LAG	0.9360	0.9476
% REFLECTED IN BASE	29.76 %	35.14 %
APPLIED TO BASE		
TOTAL FUNDS	-\$866,500	-\$1,038,700
STATE FUNDS	-\$433,260	-\$519,350
FEDERAL FUNDS	-\$433,260	-\$519,350

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code, section 14124.11

Interdependent Policy Changes:

Not applicable

Background:

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

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

Reason for Change from Prior Estimate:

The number of beneficiaries that will receive services from Veterans Affairs instead of Medi-Cal decreased from 80 to 56 per year. In addition, the average savings on a per-member-per-month basis increased from \$112.12 to \$135.96.

Methodology:

1. The Department currently is operating PARIS-Veterans in 10 counties.
2. Savings for PARIS-Veterans is for eligibles in managed care and fee-for-service (FFS).

PARIS - VETERANS MATCH
REGULAR POLICY CHANGE NUMBER: 17

3. It is estimated 56 veterans will discontinue their Medi-Cal benefits in FY 2012-13 and FY 2013-14, of which 33 will be managed care and 23 will be FFS.
4. Average savings on a per-member-per-month basis will be \$135.96.

Funding:

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

PARIS-INTERSTATE

REGULAR POLICY CHANGE NUMBER: 18
 IMPLEMENTATION DATE: 10/2009
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1357

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$3,569,000	-\$2,948,000
- STATE FUNDS	-\$1,784,500	-\$1,474,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,569,000	-\$2,948,000
STATE FUNDS	-\$1,784,500	-\$1,474,000
FEDERAL FUNDS	-\$1,784,500	-\$1,474,000

DESCRIPTION

Purpose:

This policy change estimates the savings from the Public Assistance Reporting Information System (PARIS)-Interstate.

Authority:

Not Applicable

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

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

Since the launch of the pilot program Medi-Cal savings have been achieved through improved verification and identification capabilities. Currently, PARIS-Interstate is implemented in 30 counties. The Department plans to expand to 40 counties in FY 2013-14.

PARIS-INTERSTATE

REGULAR POLICY CHANGE NUMBER: 18

Reason for Change from Prior Estimate:

The number of beneficiaries that will be discontinued as a result of PARIS-Interstate matches has been reduced based on recent matches. Additionally, all savings related to the PARIS-Federal matches are now captured in a separate policy change.

Methodology:

1. Savings for PARIS-Interstate is only for eligibles in Managed Care, since it is assumed that no expenditures exist for those in fee-for-service (FFS).
2. Based on prior quarterly reports of PARIS-Interstate matches, it is estimated that 4,783 managed care beneficiaries will be discontinued from Medi-Cal in FY 2012-13, and 6,457 in FY 2013-14.
3. Total managed care savings is estimated to be \$14,856,000 TF in FY 2012-13, and \$22,862,000 TF in FY 2013-14.
4. In FY 2012-13, it is estimated that 75.97% of the managed care savings is captured in the base trends. In FY 2013-14, it is estimated that 87.11% of the managed care savings is captured in the base trends.

FY 2012-13	<u>TF</u>	<u>% in Base</u>	<u>Savings in Base</u>
Managed Care Savings	(\$14,856,000)	75.97%	(\$11,287,000)

FY 2013-14	<u>TF</u>	<u>% in Base</u>	<u>Savings in Base</u>
Managed Care Savings	(\$22,862,000)	87.11%	(\$19,914,000)

5. Total estimated savings not in the base trends:

FY 2012-13	<u>TF</u>	<u>GF</u>
Total Savings	(\$3,569,000)	(\$1,785,000)

FY 2013-14	<u>TF</u>	<u>GF</u>
Total Savings	(\$2,948,000)	(\$1,474,000)

Funding:

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

PRIVATE DSH REPLACEMENT PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 19
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1747

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$31,982,000
- STATE FUNDS	\$0	-\$15,991,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$31,982,000
STATE FUNDS	\$0	-\$15,991,000
FEDERAL FUNDS	\$0	-\$15,991,000

DESCRIPTION

Purpose:

This policy change estimates the reductions to private Disproportionate Share Hospital (DSH) replacement payments.

Authority:

SB 1100 (Chapter 560, Statutes of 2005)
 Affordable Care Act (ACA), H.R. 3590, section 2551 and H.R. 4872, section 1203

Interdependent Policy Changes:

PC 76 MH/UCD & BTR — Private Hospital DSH Replacement

Background:

The MH/UCD and BTR made changes to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, pursuant to SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The Department determines the payments using the formulas and methodology previously in effect in FY 2004-05. These replacement payments, along with \$160.00 of the annual DSH allotment, satisfy the State's payment obligations under the Federal DSH statute. See the MH/UCD & BTR — Private Hospital DSH Replacement policy change for more information.

The ACA requires the nationwide reduction of State DSH allotments. The DSH allotment reduction begins in FY 2013-14 and the Centers for Medicare and Medicaid Services (CMS) will determine the amount of the reduction for each state.

The DSH allotment reduction affects DSH Replacement payments for private hospitals because, as required by SB 1100, the private DSH replacement payment methodology is dependent on the DSH allotment itself. Therefore, when the DSH allotment is reduced, the private DSH replacement payments will also be reduced.

The federal share of the private DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

PRIVATE DSH REPLACEMENT PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 19

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The nationwide ACA reduction of DSH allotment equates to a 4.41% of the national DSH allotment. California will apply the same percentage to its DSH allotment to estimate the reduction amount.
2. The final DSH allotment amount is applied to a formula to determine the reduction amount for the estimated FY 2013-14 aggregate DSH replacement funding. That amount is estimated to be \$34.88 million, a reduction from \$523.25 million to \$488.36 million.
3. Assume 11/12 of the FY 2013-14 ACA DSH replacement reduction (\$31.982 million) will occur in FY 2013-14.

Funding:

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

DISPROPORTIONATE SHARE HOSPITAL REDUCTION

REGULAR POLICY CHANGE NUMBER: 20
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1733

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$69,381,000
- STATE FUNDS	\$0	-\$24,013,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$69,381,000
STATE FUNDS	\$0	-\$24,013,000
FEDERAL FUNDS	\$0	-\$45,368,000

DESCRIPTION

Purpose:

This policy change estimates the reductions to Disproportionate Share Hospitals (DSHs), as required under the Affordable Care Act (ACA).

Authority:

Affordable Care Act (ACA), H.R. 3590, section 2551 and H.R. 4872, section 1203

Interdependent Policy Changes:

PC 74 MH/UCD & BTR —DSH Payment

Background:

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) and California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) made changes to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, under State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The General Fund, certified public expenditures (CPEs), or intergovernmental transfers (IGTs) funds the non-federal share of the payment. See the MH/UCD & BTR —DSH Payment policy change for more information.

The ACA requires the aggregate, nationwide reduction of State DSH allotments in the amount of \$500 million for FY 2013-14, which represents a 4.41% national reduction. Reductions increase for each fiscal year through FY 2019-20. The DSH allotment reduction begins in FY 2013-14 and the amount of the reduction for each state will be determined by the Centers for Medicare and Medicaid Services (CMS).

Reason for Change from Prior Estimate:

This is a new policy change.

DISPROPORTIONATE SHARE HOSPITAL REDUCTION

REGULAR POLICY CHANGE NUMBER: 20

Methodology:

1. California's DSH allotment for FY 2013-14 is estimated to be \$1.132 billion.
2. Assuming the national reduction percentage of 4.41 will be applied to California, the DSH allotment will be reduced by \$49 million in FY 2013-14.
3. The FY 2013-14 DSH allotment after the reduction is estimated to be \$1.083 billion.
4. Assume 11/12 of the FY 2013-14 DSH payment reduction is expected to occur in FY 2013-14.
5. The prorated FY 2013-14 DSH allotment reduction will be \$45 million on a cash basis.

The aggregate DSH payment will be reduced as follows on a cash basis:

(In Thousands)				
FY 2013-14	TF	GF**	FFP	IGT*
DSH 2013-14	(\$69,381)	(\$458)	(\$45,368)	(\$23,555)

Funding:

Demonstration DSH Fund (4260-601-7502)

MIPA Fund (4260-606-0834)*

Title XIX 50/50 GF/DSH (4260-101-0001/7502)**

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

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 21
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1742

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$73,000	-\$448,000
- STATE FUNDS	-\$36,500	-\$224,000
PAYMENT LAG	0.5960	0.8870
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$43,500	-\$397,400
STATE FUNDS	-\$21,750	-\$198,690
FEDERAL FUNDS	-\$21,750	-\$198,690

DESCRIPTION

Purpose:

This policy change estimates the savings identified by a Recovery Audit Contractor (RAC).

Authority:

Affordable Care Act (ACA) section 6411(a)
 SB 1529 (Chapter 797, Statutes of 2012)

Interdependent Policy Changes:

OA 51 Recovery Audit Contractor Costs

Background:

Section 6411(a) of the ACA requires states to contract with one or more RACs for the purpose of auditing Medicaid claims, identifying underpayments and overpayments, recouping overpayments, and educating providers. The Department awarded Health Management Systems, Inc. this contract in April 2012. The contractor will receive 12.5% of the amount identified and recovered. The recovery audit contractor costs are budgeted in the Recovery Audit Contractor Costs policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume \$500,000 in overpayment savings is identified starting in FY 2012-13.
2. Savings will be phased in over 12 months beginning January 2013.
3. Budgeted amounts are preliminary until actual data becomes available.

	<u>TF</u>	<u>GF</u>	<u>FF</u>
FY 2012-13	(\$73,000)	(\$36,500)	(\$36,500)
FY 2013-14	(\$448,000)	(\$224,000)	(\$224,000)

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 21

Funding:

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

ADDITIONAL SERVICES FOR HCBS CLIENTS

REGULAR POLICY CHANGE NUMBER: 22
 IMPLEMENTATION DATE: 2/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1476

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$533,309,000	\$305,446,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$533,309,000	\$305,446,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$533,309,000	\$305,446,000

DESCRIPTION

Purpose:

This policy change estimates the federal match to the Department of Developmental Services for participant-directed Home and Community Based Services (HCBS) for persons with developmental disabilities under a 1915(i) state plan option.

Authority:

Section 6086 of the Deficit Reduction Act (DRA) of 2005, Public Law 109-171
 Interagency Agreement (pending)

Interdependent Policy Changes:

Not Applicable

Background:

In December 2009, the Department submitted to the Centers for Medicare and Medicaid Services (CMS) a 1915(i) HCBS state plan amendment (SPA) to include certain services provided by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC consumers who have previously received or currently receive certain services will continue to be eligible for these services even though they do not meet the institutional level of care requirements for the HCBS waiver for persons with developmental disabilities. Services scheduled for coverage under this SPA include: habilitation, respite care, personal care services, homemaker services and home health aide services. It is anticipated that the SPA will be approved in FY 2012-13, with a retroactive effective date of October 1, 2009. AB3 X 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. The SPA, submitted in December 2011, proposes to restore reimbursement for the eliminated services rendered in FY 2011-12 and forward.

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

In June 2012, an additional SPA was submitted to CMS to allow participants to self-direct selected HCBS under the 1915(i) program retroactive to April 1, 2012.

ADDITIONAL SERVICES FOR HCBS CLIENTS

REGULAR POLICY CHANGE NUMBER: 22

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2009 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional Federal Financial Participation (FFP) for FY 2012-13 and FY 2013-14.

Reason for Change from Prior Estimate:

Pending federal approval has delayed implementation. Additionally, the SPA effective October 1, 2009 will be split, further delaying the implementation and claiming for some services.

Methodology:

(In Thousands)	Total Funds	CDDS GF	FFP	ARRA
FY 2012-13	\$959,459	\$426,150	\$479,730	\$53,579
FY 2013-14	\$607,263	\$301,817	\$303,633	\$1,813

Funding:

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 23
 IMPLEMENTATION DATE: 7/2000
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 25

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$138,634,000	\$140,530,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$138,634,000	\$140,530,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$138,634,000	\$140,530,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code, section 14132.06

Interdependent Policy Changes:

Not Applicable

Background:

LEAs, which consist of school districts, county offices of education, community colleges, and university campuses, may enroll as Medi-Cal providers through the LEA Medi-Cal Billing Option Program. Through the program, LEAs receive reimbursement for specific eligible health services provided to Medi-Cal eligible students to the extent federal financial participation (FFP) is available. LEAs receive interim payments based on interim reimbursement rates. A Cost and Reimbursement Comparison Schedule (CRCS) is submitted to the Department annually for the preceding fiscal year. Final payment reconciliation will be completed when the Department has audited the LEAs' cost report.

Reason for Change from Prior Estimate:

The changes are due to an increase in LEA participation and an expansion of treatment services.

Methodology:

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

LOCAL EDUCATION AGENCY (LEA) PROVIDERS

REGULAR POLICY CHANGE NUMBER: 23

some expenditures may receive the applicable FMAP based on date of services as allowed by the federal government. Therefore, some LEA payments made in FY 2012-13 will receive the enhanced ARRA FMAP.

3. The Department has completed the final reconciliation for FY 2006-07 and expects to make the final settlement of \$2,686,000 in FY 2012-13.
4. The final reconciliation for FY 2007-08 is expected to be completed in FY 2013-14 with the estimated final settlement of \$3,000,000.
5. The estimate is based on the analysis of historical claims submitted by LEAs.

(In Thousands)	Regular FFP	ARRA	Total FFP
FY 2012-13	\$135,809	\$139	\$135,948
FY 2006-07 Reconciliation	\$2,686	0	\$2,686
FY 2012-13 Total	\$138,495	\$139	\$138,634
FY 2013-14	\$137,530	0	\$137,530
FY 2007-08 Reconciliation	\$3,000	0	\$3,000
FY 2013-14 Total	\$140,530	0	\$140,530

Funding:

Title XIX FFP (4260-101-0890)

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 24
 IMPLEMENTATION DATE: 7/1984
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 28

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$40,464,000	\$40,464,000
- STATE FUNDS	\$20,232,000	\$20,232,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,464,000	\$40,464,000
STATE FUNDS	\$20,232,000	\$20,232,000
FEDERAL FUNDS	\$20,232,000	\$20,232,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 9560-9568
 SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:

PC 135 Transition of Dual Eligibles – Long Term Care
 PC 214 Transition of Dual Eligibles – Managed Care

Background:

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

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligible). Beginning September 1, 2013, the Department will mandatorily enroll dual eligibles into managed care for their Medi-Cal benefits. Those benefits include institutional LTSS, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and other HCBS. Under CCI, managed care capitation will include MSSP services.

Beginning September 1, 2013, in the counties participating in the CCI Duals Demonstration, managed care health plans will contract with existing MSSP sites for care management services. The total MSSP reimbursement (both for fee-for-service (FFS) and managed care (MC)) is budgeted in this policy change.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 24

Reason for Change from Prior Estimate:

Revised based on implementation date change on the Transition of Dual Eligibles –Long Term Care policy change.

Methodology:

FY 2013-14 (\$ in Thousands)	TF	GF	FFP	Reimburse- ment
DHCS Services	\$2,361,355	\$1,180,677	\$1,180,678	\$0
IHSS Base	\$986,662	\$463,731	\$522,931	\$0
IHSS Additional Services	\$34,986	\$16,444	\$18,542	\$0
MSSP Base	\$8,863	\$4,431	\$4,432	\$0
MSSP Additional Services	\$314	\$157	\$157	\$0
Transition of Dual Eligibles - Managed Care Payments	\$3,392,180	\$1,665,441	\$1,726,739	\$0
FFS Savings (Non IHSS, partial dual, and Medi-Cal only)	(\$1,167,686)	(\$583,843)	(\$583,843)	\$0
FFS Savings (Duals)	(\$746,668)	(\$373,334)	(\$373,334)	\$0
MSSP	(\$8,863)	(\$4,431)	(\$4,432)	\$0
Remaining HCBS (excludes IHSS)	(\$112,337)	(\$56,168)	(\$56,169)	\$0
Defer Managed Care Payment	(\$639,662)	(\$319,831)	(\$319,831)	\$0
Transition of Dual Eligibles - Long Term Care	(\$2,675,216)	(\$1,337,608)	(\$1,337,608)	\$0
Multipurpose Senior Services Program - CDA	\$8,863	\$0	\$4,432	\$4,431
Transfer of IHSS Costs to DHCS	\$0	(\$463,731)	\$0	\$463,731
Total CCI	\$725,827	(\$135,898)	\$393,563	\$468,162
Transfer of IHSS Costs to CDSS	\$1,021,648	\$0	\$0	\$1,021,648
Total of all CCI PCs including pass through	\$1,747,475	(\$135,898)	\$393,563	\$1,489,810
Delay Checkwrite	\$74,090	\$37,045	\$37,045	\$0

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

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 25
 IMPLEMENTATION DATE: 12/2008
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1228

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$45,898,000	\$50,760,000
- STATE FUNDS	\$2,191,000	\$9,127,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	22.68 %	10.74 %
APPLIED TO BASE		
TOTAL FUNDS	\$35,488,300	\$45,308,400
STATE FUNDS	\$1,694,080	\$8,146,760
FEDERAL FUNDS	\$33,794,250	\$37,161,620

DESCRIPTION

Purpose:

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

Authority:

Federal Deficit Reduction Act of 2005 6071
 Affordable Care Act (ACA)

Interdependent Policy Changes:

PC 38 California Community Transitions Savings

Background:

In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for \$130 million in federal funds. The CCT demonstration is authorized under the Federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. It is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 6,177 Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into federally-allowed HCBS. The revised award is \$104 million in federal funds.

Participants are enrolled in the demonstration for a maximum of 12 months. Enrollment began December 1, 2008. Target enrollment for the period of July 1, 2012 through June 30, 2013 is 670 individuals and 1,173 individuals for July 1, 2013 through June 30, 2014.

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD waiver beneficiaries expected to enroll into CCT is included in this policy change. Supplemental federal funding that is associated with provided CCT services to these beneficiaries is budgeted in the MFP

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 25

Funding to California Department of Developmental Services (CDDS) for CCT policy change.

Reason for Change from Prior Estimate:

There is an increase in the number of estimated enrollees into the CCT demonstration for current year and budget year.

Methodology:

1. Assume estimated costs for persons residing year-round in Nursing Facility (NF)-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be \$61,081.
2. Assume 100% of CCT participants will receive pre-transition demonstration services.
3. Assume DD beneficiaries who participate in CCT cost \$64,587 annually for pre-transition demonstration services and \$67,388 annually post-transition into CCT. Non DD beneficiaries will cost \$8,158 annually for pre-transition services and \$50,284 annually upon transitioning into CCT.
4. Assume all CCT services are reimbursed at 75% FFP and 25% GF. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.
5. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change, see MFP Funding to CDDS and CDSS for CCT for more information. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.
6. Assume CDSS will request FFP for CCT services provided to DD beneficiaries for FY 2010-11 and FY 2011-12 in FY 2012-13.
7. Costs in the budget year include phased-in and lagged payments from the current year.

	(In Thousands)			
	2012-13		2013-14	
	TF	GF	TF	GF
Lagged savings	(\$14,303)	(\$7,151)	(\$47,751)	(\$23,876)
Lagged costs	\$16,934	\$2,190	\$50,760	\$9,126
CDDS prior costs	\$28,964	\$0	\$0	\$0
Net	\$31,595	(\$4,961)	(\$3,009)	(\$14,750)

Funding:

25% General Fund (4260-101-0001)

MFP 75% Federal Grant (4260-106-0890)

MFP FUNDING TO CDDS AND CDSS FOR CCT

REGULAR POLICY CHANGE NUMBER: 26
 IMPLEMENTATION DATE: 10/2011
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1562

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$8,523,000	\$4,227,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,523,000	\$4,227,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$8,523,000	\$4,227,000

DESCRIPTION

Purpose:

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

Authority:

Federal Deficit Reduction Act of 2005 6071
 Affordable Care Act (ACA)
 Interagency Agreement 09-86345 (CDDS)
 Interagency Agreement 10-87274 (CDSS)

Interdependent Policy Changes:

Not Applicable

Background:

In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the CCT. It was extended by the ACA, and is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 6,177 Medi-Cal eligible individuals who have resided continuously in health care facilities for three months or longer to transition to federally-allowed home and community-based settings.

Reason for Change from Prior Estimate:

There is no material change.

Methodology:

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

MFP FUNDING TO CDDS AND CDSS FOR CCT

REGULAR POLICY CHANGE NUMBER: 26

2. CCT services are reimbursed at 75% FFP and 25% GF. The GF for CDDS is budgeted in the Home & Community Based Svcs.-CDDS policy change. The GF for CDSS is provided by CDSS and is budgeted in the Personal Care Services (Misc. Svcs.) policy change.
3. This policy change budgets the difference between the regular Federal Medical Assistance Percentage (FMAP) and the enhanced FMAP for eligible Medi-Cal beneficiaries participating in CCT. In FY 2010-11, the Department established an interagency agreement (IA) with CDDS and in FY 2011-12 an IA was established with CDSS. These IAs transfer the additional 25% FFP for HCBS provided to CCT participants who have developmental disabilities or are receiving IHSS services during their 365 days of participation in the CCT demonstration.
4. Assume 17% of all non-DDS enrollees utilize IHSS under CCT. Assume each case costs \$26,316 annually. The Department will provide 25% of these costs to CDSS.
5. Assume CDDS will receive 25% of the post transitional services costs for the DD population.

Estimated Costs:

	FY 2012-13	FY 2013-14
CDSS	\$1,012,000	\$1,291,000
CDDS	\$7,511,000	\$2,936,000
Total	\$8,523,000	\$4,227,000

Funding:

100% MFP Federal Grant (4260-106-0890)

DENSE BREAST NOTIFICATION SUPPLEMENTAL SCREENING

REGULAR POLICY CHANGE NUMBER: 27
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1754

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$730,000	\$7,277,000
- STATE FUNDS	\$365,000	\$3,638,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$730,000	\$7,277,000
STATE FUNDS	\$365,000	\$3,638,500
FEDERAL FUNDS	\$365,000	\$3,638,500

DESCRIPTION

Purpose:

This policy change estimates the costs due to increased utilization for breast cancer screening services as a result of notification of dense breast.

Authority:

SB 1538 (Chapter 458, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

SB 1538 would require health facilities administering mammograms to women 40 years and over to notify patients whose breasts are categorized as being heterogeneously or extremely dense and inform the patients that they may benefit from supplementary screening due to the level of dense breast tissue (DBT) seen on the mammogram. The generated notices will result in patients requesting additional screening tests, such as magnetic resonance imaging (MRIs) and ultrasounds. The provisions of this bill will become operative April 1, 2013 and sunset on January 1, 2019.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume implementation begins April 1, 2013.
2. Assume mammography exams include screening and diagnostic.

**DENSE BREAST NOTIFICATION SUPPLEMENTAL
SCREENING**
REGULAR POLICY CHANGE NUMBER: 27

3. Based on FY 2010-11 data, the average number of women who received a mammography exam is 585,739 per year for age 40 and over for fee for service.

40 – 49 years:	211,809
50 and over:	<u>373,930</u>
Total	585,739

4. According to data presented by the American Society of Breast Surgeons (ASBS) in 2009, 75% of women 40 – 49 years of age and 42% of women over 50 years of age have dense breasts.

40 – 49 years:	211,809 x 75% = 158,857
50 and over:	373,930 x 42% = <u>157,051</u>
Total	315,908

5. Assume 50% of women, who receive a notice, would request a supplementary screening test, such as ultrasound, from their physician.

40 – 49 years:	158,857 x 50% = 79,429
50 and over:	157,051 x 50% = <u>78,526</u>
Total	157,955

6. Assume the reimbursement rate per ultrasound is \$49.35.

40 – 49 years:	79,429 x \$49.35 = \$3,920,000
50 and over:	78,526 x \$49.35 = <u>\$3,875,000</u>
Total	\$7,795,000

7. Assume a lag of 0.346 for FY 2012-13 and 0.905 for FY 2013-14 for fee for service.

8. For managed care, assume expenditures to be \$223,000 annually.

FY 2012-13	TF	GF	FFP
FFS (lagged)	\$674,000	\$337,000	\$337,000
Managed Care	\$56,000	\$28,000	\$28,000
Total FY 2012-13	\$730,000	\$365,000	\$365,000
FY 2013-14	TF	GF	FFP
FFS (lagged)	\$7,054,000	\$3,527,000	\$3,527,000
Managed Care	\$223,000	\$111,500	\$111,500
Total FY 2013-14	\$7,277,000	\$3,638,500	\$3,638,500

Funding:

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 28
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1436

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$298,000	\$3,038,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$298,000	\$3,038,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$298,000	\$3,038,000

DESCRIPTION

Purpose:

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

Authority:

AB 2968 (Chapter 830, Statutes of 2006)

Interdependent Policy Changes:

Not Applicable

Background:

In the proposed new waiver, the Department is working with the San Francisco Department of Public Health to propose service delivery under a 1915(c) Home and Community Based (HCBS) Waiver. The waiver application was approved by CMS for a five year period beginning July 1, 2012 through June 30, 2017. The SF CLSB waiver assists Medi-Cal beneficiaries who are 21 years of age and older, residing in the City and County of San Francisco and who would otherwise reside in nursing facilities or be rendered homeless.

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

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 28

Reason for Change from Prior Estimate:

There is a delay in implementation due to a lack of space in approved residential facilities available to house SF CLSB participants.

Methodology:

1. The waiver has a maximum capacity of 486 over five years. These slots will be continuously enrolled by backfilling available slots. Enrollment will begin in October 2012. Target enrollment for the period of July 1, 2012 through June 30, 2013 is 163 individuals and 377 individuals for July 1, 2013 through June 30, 2014.
2. The annual total cost is estimated to be \$28,644 per participant in FY 2012-13 and \$29,475 per participant in FY 2013-14.
3. The Department will utilize Certified Public Expenditures (CPE) from the City and County of San Francisco to match the federal funds for this waiver. Assume a four-month payment lag due to the utilization of CPEs. This policy change budgets the FFP only.
4. Assume State Plan services will remain constant, but to the extent beneficiaries enroll into the waiver from skilled nursing facilities, there may be GF savings to the Medi-Cal program.

Funding:

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

QUALITY OF LIFE SURVEYS FOR MFP

REGULAR POLICY CHANGE NUMBER: 29
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1550

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$225,000	\$251,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$225,000	\$251,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$225,000	\$251,000

DESCRIPTION

Purpose:

This policy change estimates the cost of the Quality of Life (QoL) surveys administered to all California Community Transitions (CCT) enrollees.

Authority:

Section 6071 of the Deficit Reduction Act (DRA) of 2005
 Money Follows the Person (MFP) Rebalancing Demonstration (P.L. 109-171)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

Reason for Change from Prior Estimate:

The increased cost in FY 2012-13 is due to an increase in CCT caseload and delay in receiving invoices.

QUALITY OF LIFE SURVEYS FOR MFP

REGULAR POLICY CHANGE NUMBER: 29

Methodology:

1. The QoL surveys began in July 2010.
2. In FY 2010-11, 325 beneficiaries were transitioned in the CCT demonstration project and 448 additional beneficiaries transitioned into CCT in FY 2011-12. Projected enrollments are 905 in FY 2012-13 and 1,154 in FY 2013-14.
3. Assume the QoL surveys are administered to all CCT participants three times over a span of three years. Assume first follow-up QoLs are conducted 11 months after the initial transition. The second follow-up survey is conducted appropriately one year after they have been living in community settings.
4. Assume the Department reimburses \$100 per completed survey for survey administration.
5. The Department assumes the California Department of Developmental Services (CDSS), a survey administrator, will bill the Department in FY 2012-13 for 574 surveys completed in FY 2010-11 and FY 2011-12.

905 x \$100 = \$90,500 Baseline
 448 x \$100 = \$44,800 First follow up
 325 x \$100 = \$32,500 Second follow up
 574 x \$100 = \$57,400 Surveys completed by CDDS in FYs 2010-11 and 2011-12 to be paid in FY 2012-13.

FY 2012-13 Estimated Costs: \$225,000 TF (rounded)

1,154 x \$100 = \$115,400 Baseline
 905 x \$100 = \$90,500 First follow up
 448 x \$100 = \$44,800 Second follow up

FY 2013-14 Estimated Costs: \$251,000 TF (rounded)

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
Baseline	\$90,500	\$115,500
First follow up	\$45,000	\$90,500
Second follow up	\$32,500	\$45,000
Prior year surveys	\$57,000	-
Total	\$225,000	\$251,000

Funding:

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

FAMILY PACT RETROACTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 30
 IMPLEMENTATION DATE: 2/2013
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1744

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$3,000	\$3,000
- STATE FUNDS	\$300	\$300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,000	\$3,000
STATE FUNDS	\$300	\$300
FEDERAL FUNDS	\$2,700	\$2,700

DESCRIPTION

Purpose:

This policy change estimates the costs of family planning services provided retroactively for newly-enrolled Family Planning, Access, Care and Treatment (Family PACT) program clients.

Authority:

State Plan Amendment (SPA)

Interdependent Policy Changes:

Not Applicable

Background:

A 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 April 1, 2011, retroactive eligibility is available for qualifying clients for up to three months prior to the first day of the month of application to the Family PACT program. The Family PACT program implemented a retroactive eligibility certification procedure and claim process for newly-enrolled qualified Family PACT clients.

The Department has implemented procedures to ensure Family PACT clients, entitled to reimbursement for covered services obtained during the retroactivity period, are reimbursed.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume the reimbursement to beneficiaries will begin in February 2013.

FAMILY PACT RETROACTIVE ELIGIBILITY

REGULAR POLICY CHANGE NUMBER: 30

2. Based on claims volume and reimbursements from April 2011 through August 2012, costs are estimated to be:

	<u>TF</u>	<u>GF</u>	<u>FFP</u>
FY 2012-13	\$3,000	\$300	\$2,700
FY 2013-14	\$3,000	\$300	\$2,700

Funding:

Title XIX 10/90 FFP (4260-101-0001/0890)

INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER: 31
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1557

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$14,302,800	-\$4,767,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$14,302,800	-\$4,767,600
FEDERAL FUNDS	\$14,302,800	\$4,767,600

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14132(aa)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

The Fiscal Intermediary backlog has delayed the implementation of the new FPACT reimbursement rates. As a result, savings for FY 2010-11 and FY 2011-12 were shifted to FY 2012-13.

Methodology:

1. Assume a retroactive SPA implementation date of July 1, 2010.
2. Costs for eligible family planning services and supplies which were previously paid with 100% GF will now be claimed at 90%, and costs for family planning-related services at 50% FFP.

INCREASED FEDERAL MATCHING FUNDS FOR FPACT

REGULAR POLICY CHANGE NUMBER: 31

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

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

4. With enhanced funding, costs for these services and supplies will be \$4,767,000 FFP and \$1,592,000 GF for a GF savings of \$4,767,000 annually.
5. FY 2010-11 and FY 2011-12 savings of \$9,534,000 have been shifted to FY 2012-13. As a result, total GF savings for FY 2012-13 are \$14,301,000.

FY 2012-13	GF
FY 2010-11	<u>(\$4,767,000)</u>
FY 2011-12	<u>(\$4,767,000)</u>
FY 2012-13	<u>(\$4,767,000)</u>
FY 2012-13 Savings	(\$14,301,000)
FY 2013-14 Savings	(\$4,767,000)

Funding:

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

ADHC TRANSITION-BENEFITS

REGULAR POLICY CHANGE NUMBER: 32
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1594

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$21,945,000	-\$60,286,000
- STATE FUNDS	-\$10,972,500	-\$30,143,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$21,945,000	-\$60,286,000
STATE FUNDS	-\$10,972,500	-\$30,143,000
FEDERAL FUNDS	-\$10,972,500	-\$30,143,000

DESCRIPTION

Purpose:

This policy change estimates the costs of Community-Based Adult Services (CBAS) in managed care plans and the resulting savings in fee-for-service (FFS) expenditures.

Authority:

AB 97 (Chapter 3, Statutes of 2011)
Esther Darling, et al. v. Toby Douglas, et al. settlement agreement

Interdependent Policy Changes:

Not Applicable

Background:

AB 97 eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program effective July 1, 2011. A class action lawsuit, *Esther Darling, et al. v. Toby Douglas, et al.*, sought to challenge the elimination of ADHC services. A settlement of the lawsuit was reached that establishes the new CBAS program. The fiscal intermediary cost of the transition is included in the fiscal intermediary section of the Estimate. The ADHC Transition – Administration policy change includes other administration costs of the transition to CBAS.

Reason for Change from Prior Estimate:

1. The extension of ADHC services pursuant to the settlement agreement is no longer reflected in this policy change. (\$-21.3 million TF)
2. This policy change includes the impact of the managed care payment deferral and the 5,100 former CBAS users in managed care counties that are electing to stay in FFS. Neither of these were included in the May 2012 policy change. (\$-63.2 million TF)
3. In the May 2012 policy change, the cost of CBAS services had to be added to the Estimate. The FFS base estimate now includes the cost of CBAS in FFS. This policy change shifts the CBAS costs in the FFS base to the managed care plans instead of adding the total cost to the Estimate. (\$-222.5 million TF)

ADHC TRANSITION-BENEFITS

REGULAR POLICY CHANGE NUMBER: 32

Methodology:

Transition costs include:

CBAS—Effective April 1, 2012, this new, smaller, and more targeted program was created for those former ADHC clients who are most in need of medical and social services. For those eligible for enrollment in Medi-Cal managed care plans, these services will be covered only through the plans. All County Organized Health System (COHS) plans except Ventura began covering CBAS July 1, 2012. All other managed care plans began covering CBAS October 1, 2012. The estimated CBAS average monthly managed care caseload is 22,400. In addition, approximately 5,100 former CBAS users in managed care counties are expected to stay in FFS and no longer receive services.

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

FFS Assessment and Care Coordination—For those ADHC clients in counties without managed care or when the client chooses FFS rather than managed care, the Department has contracted with APS, Inc., to provide health risk assessment, care coordination, and case management. These costs are in the ADHC-Transition – Administration policy and are shown here for information only.

(In Thousands)	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
FFS CBAS Savings	(\$222,465)	(\$111,233)	(\$274,489)	(\$137,245)
Payment Lags	0.8145	0.8145	0.9992	0.9992
Lagged FFS CBAS Savings	(\$181,198)	(\$90,599)	(\$274,269)	(\$137,135)
Managed Care CBAS Costs	\$222,465	\$111,232	\$274,489	\$137,245
Managed Care Payment Deferral	(\$22,874)	(\$11,437)	\$0	\$0
CBAS Users Electing FFS	(\$40,338)	(\$20,169)	(\$60,506)	(\$30,253)
Net CBAS Benefits Cost	(\$21,945)	(\$10,973)	(\$60,286)	(\$30,143)
HCO (included in FI Estimate)	\$432	\$216	\$0	\$0
Other Administration Cost				
FFS Assessment & Care Coordination	\$1,741	\$871	\$564	\$282
Total All Costs	(\$19,772)	(\$9,886)	(\$59,722)	(\$29,861)

Funding:

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

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 33
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1007

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$84,620,900	-\$87,932,650
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$84,620,900	-\$87,932,650
FEDERAL FUNDS	\$84,620,900	\$87,932,650

DESCRIPTION

Purpose:

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

Authority:

AB 131 (Chapter 80, Statutes of 2005)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

The changes are due to updated data and projections for undocumented women and legal immigrants.

Methodology:

- The cost of prenatal care for undocumented women is estimated to be \$123,671,000 in FY 2012-13 and \$128,622,000 in FY 2013-14.
- Based on the estimated costs and 65% SCHIP FFP, the following amounts are budgeted for FY 2012-13 and FY 2013-14:

FY 2012-13:	$\$123,671,000 \times .65 =$	\$80,386,000 FFP
FY 2013-14:	$\$128,622,000 \times .65 =$	\$83,604,000 FFP

SCHIP FUNDING FOR PRENATAL CARE

REGULAR POLICY CHANGE NUMBER: 33

3. The estimated prenatal care cost for legal immigrants, who have been in the country for less than five years, is \$6,515,000 for FY 2012-13 and \$6,659,000 for FY 2013-14.

FY 2012-13:	\$6,515,000 x .65 SCHIP FFP =	\$4,235,000 FFP
FY 2013-14:	\$6,659,000 x .65 SCHIP FFP =	\$4,329,000 FFP

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

FY 2012-13 Savings:	\$80,386,000 + \$4,235,000 =	\$84,621,000
FY 2013-14 Savings:	\$83,604,000 + \$4,329,000 =	\$87,933,000

Funding:

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

HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 34
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1515

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$795,000	-\$795,000
- STATE FUNDS	-\$397,500	-\$397,500
PAYMENT LAG	0.9331	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$741,800	-\$795,000
STATE FUNDS	-\$370,910	-\$397,500
FEDERAL FUNDS	-\$370,910	-\$397,500

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

Reason for Change from Prior Estimate:

Implementation date was changed from May 1, 2012 to July 1, 2012 because of delay in establishing the Department cap policies and controls through the Treatment Authorization Request (TAR) adjudication process.

Methodology:

1. Assume savings will begin July 1, 2012.
2. Actual annual hearing aid expenditures for FY 2009-10 were \$20,186,000 for 24,762 unduplicated users.
3. Of the annual hearing aid expenditures amount, \$1,547,000 were associated with beneficiaries

HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 34

residing in long-term care and pregnant women, and \$2,015,000 were associated with beneficiaries under 21 years of age.

$$\$1,547,000 + \$2,015,000 = \$3,562,000$$

4. Expenditures subject to cap are: \$20,186,000 - \$3,562,000 = \$16,624,000
5. Based on paid claims for hearing aids for dates of service between July 1, 2009 and June 30, 2010, total FFS hearing aids expenditures below the \$1,510 cap were \$8,643,000 for 14,201 beneficiaries.
6. Based on paid claims for hearing aids for dates of service between July 1, 2009 and June 30, 2010, an average of \$1,580 is spent annually per beneficiary at and above the \$1,510 expenditure cap.
7. There are 5,051 adult users above the \$1,510 Cap. The allowable costs for these users is \$7,627,000.

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

(In Thousands)	<u>TF</u>	<u>GF</u>	<u>FFP</u>
Annual FFS Expenditures	\$20,186	\$10,093	\$10,093
LTC, children, & pregnant women	(\$3,562)	(\$1,781)	(\$1,781)
Expenditures Subject to Cap	\$16,624	\$8,312	\$8,312
FFS Expenditures < \$1,510 cap	(\$8,642)	(\$4,321)	(\$4,321)
FFS Expenditures > \$1,510 cap	\$7,982	\$3,991	\$3,991
Allowable costs for > the \$1,510 cap	(\$7,627)	(\$3,814)	(\$3,814)
Annual FFS savings due to cap	\$355	\$177	\$178
Annual Managed Care savings due to cap	\$440	\$220	\$220
Total Annual Savings	\$795	\$397	\$398
<u>FY 2012-13</u>			
FFS	\$355	\$177	\$178
Managed Care	\$440	\$220	\$220
Total FY 2012-13	\$795	\$397	\$398
<u>FY 2013-14</u>			
FFS	\$355	\$177	\$178
Managed Care	\$440	\$220	\$220
Total FY 2013-14	\$795	\$397	\$398

HEARING AID CAP
REGULAR POLICY CHANGE NUMBER: 34

Funding:

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

ELIMINATION OF OTC COUGH AND COLD PRODUCTS

REGULAR POLICY CHANGE NUMBER: 35
 IMPLEMENTATION DATE: 3/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1575

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,421,000	-\$4,432,000
- STATE FUNDS	-\$2,210,500	-\$2,216,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	56.40 %	69.36 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,927,600	-\$1,358,000
STATE FUNDS	-\$963,780	-\$678,980
FEDERAL FUNDS	-\$963,780	-\$678,980

DESCRIPTION

Purpose:

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

Authority:

AB 97 (Chapter 33, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable.

Background:

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

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The legislation was enacted on March 24, 2011, and savings began in March 2012.
2. Fee-for-service expenditures for nonprescription cough and cold products for adults and children are estimated to be \$3,762,000 annually.
3. Managed care savings are estimated to be \$670,000 annually.

ELIMINATION OF OTC COUGH AND COLD PRODUCTS

REGULAR POLICY CHANGE NUMBER: 35

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

FY 2012-13 Savings:	TF	GF
FFS (Lagged)	\$3,751,000	\$1,875,500
Managed Care	\$ 670,000	\$ 335,000
Total	\$4,421,000	\$2,210,500
FY 2013-14 Savings:	TF	GF
FFS (Lagged)	\$3,762,000	\$1,881,000
Managed Care	\$ 670,000	\$ 335,000
Total	\$4,432,000	\$2,216,000

Funding:

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

CERVICAL CANCER SCREENING

REGULAR POLICY CHANGE NUMBER: 36
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1751

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$6,108,000	-\$12,215,000
- STATE FUNDS	-\$3,054,000	-\$6,107,500
PAYMENT LAG	0.6710	0.9870
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,098,500	-\$12,056,200
STATE FUNDS	-\$2,049,230	-\$6,028,100
FEDERAL FUNDS	-\$2,049,230	-\$6,028,100

DESCRIPTION

Purpose:

This policy change estimates the change in cervical cancer screening due to new guidelines.

Authority:

Health & Safety Code 104150

Interdependent Policy Changes:

Not Applicable

Background:

Current policy allows women of all ages to receive a Papanicolaou (Pap) test every year for cervical cancer screening. If the Pap test is abnormal, additional tests may be allowed. The Department pays for Pap tests without restriction. The frequency of the Pap test is at the discretion of the clinician and is based on the woman's risks and the need to follow-up abnormal results. The United States Preventive Services Task Force (USPSTF) guidelines for cervical cancer screenings was revised on March 2012.

The recommendations for cervical cancer screening are the following, except for women with prior high grade precancerous lesions and those who are immunocompromised:

Before Age 21: No Pap test

Age 21 – 29: Pap test every three years

Age 30 – 65: Pap test every three years or Pap test and HPV test every five years

After Age 65: No Pap test

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Effective January 1, 2013, the Department will implement the new guidelines for cervical cancer screening.

CERVICAL CANCER SCREENING

REGULAR POLICY CHANGE NUMBER: 36

2. Based on a CPT and HCPCS 2011 data, the average number of beneficiaries receiving cervical cancer screenings is 339,896 per year.
3. Based on the current population, assume 20% will continue receiving annual cervical cancer screenings due to abnormalities.
4. Assume 80% of the under 21 years of age and over 65 years of age will no longer receive cervical cancer screenings.
5. Assume 80% of the beneficiaries between the ages of 21-65 will receive one cervical cancer screening exam every three to five years.
6. Of the beneficiaries between the ages of 21-65, assume 90% will receive a Pap test every three years and 10% of the women will receive a Pap test and HPV test every five years.
7. Based on calendar year 2011 data, \$76,867,000 was reimbursed to providers for Pap tests, lab tests, and follow-up visits due to outcomes of the Pap test.
8. Assume savings from eliminating Pap test for women that do not have abnormal conditions before 21 years of age and after 65 years of age.
9. For women that do not have abnormal conditions, ages 21-65, assume savings from implementing a Pap test every three to five years.
10. Assume a savings of \$6,108,000 in FY 2012-13 and \$12,215,000 in FY 2013-14.

Funding:

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

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 37
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1519

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$11,466,000	-\$22,933,000
- STATE FUNDS	-\$5,733,000	-\$11,466,500
PAYMENT LAG	0.7016	0.9844
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$8,044,500	-\$22,575,200
STATE FUNDS	-\$4,022,270	-\$11,287,620
FEDERAL FUNDS	-\$4,022,270	-\$11,287,620

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

AB 97 caps the number of physician visits and clinic visits, including Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs), allowed per Medi-Cal beneficiary at seven per year. The cap on the number of physician and clinic visits is for adults 21 years of age or older that do not meet the statutory exemptions or exceptions criteria. The Department concluded that any changes in the managed care utilization would be minimal and any savings from a utilization decrease would be offset by increased administrative costs for the plans and providers. Consequently, the cap applies only to fee-for-service (FFS) settings.

Reason for Change from Prior Estimate:

- Implementation date changed from July 1, 2012 to January 1, 2013 because of delay in expected federal approval and implementing necessary system changes, and
- The percent of eliminated visits above the cap reduced to 10% from 15%. The percent of eliminated visits above the cap reduced to 10% from 15%. According to a recent Department comprehensive study, the number of beneficiaries remaining in Fee for Services is lower than previously estimated and many of these individuals have medical conditions likely to exempt them from the visit CAP.

Methodology:

1. Savings will begin on January 1, 2013.

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 37

2. The annual physician visit cap is set at seven visits per beneficiary. All visits above the seven allowed will require a physician's certification to be paid by Medi-Cal.
3. In CY 2009, the average cost per visit is \$114.66.
4. Assume that 90% of the visits above the cap will meet the physicians' certification requirement, and the remaining 10% will be eliminated.
5. Assume 200,000 visits will be eliminated annually due to 7 visit cap rule.
6. FFS annual savings are estimated to be:
200,000 eliminated visits x \$114.66 average cost per visit = \$22,933,000 TF (\$11,466,500 GF)

Annual Savings:	TF	GF
FFS	<u>(\$22,933,000)</u>	<u>(\$11,465,500)</u>
 FY 2012-13 Savings:	 TF	 GF
FFS	<u>(\$11,466,000)</u>	<u>(\$5,733,000)</u>
 FY 2013-14 Savings:	 TF	 GF
FFS	<u>(\$22,933,000)</u>	<u>(\$11,465,500)</u>

Funding:

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

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 12/2008
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1222

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$14,303,000	-\$47,751,000
- STATE FUNDS	-\$7,151,500	-\$23,875,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	22.68 %	10.74 %
APPLIED TO BASE		
TOTAL FUNDS	-\$11,059,100	-\$42,622,500
STATE FUNDS	-\$5,529,540	-\$21,311,270
FEDERAL FUNDS	-\$5,529,540	-\$21,311,270

DESCRIPTION

Purpose:

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

Authority:

Federal Deficit Reduction Act of 2005 6071
 Affordable Care Act (ACA)

Interdependent Policy Changes:

PC 25 California Community Transitions Costs

Background:

In January 2007, the Centers for Medicare and Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant for \$130 million in federal funds. The CCT demonstration is authorized under the Federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. It is effective from January 1, 2007, through September 30, 2016. The grant was amended to require the Department to develop and implement strategies to assist 6,177 Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into federally-allowed HCBS. The revised award is \$104 million in federal funds.

Participants are enrolled in the demonstration for a maximum of 12 months. Enrollment began December 1, 2008. Target enrollment for the period of July 1, 2012 through June 30, 2013 is 670 individuals and 1,173 individuals for July 1, 2013 through June 30, 2014.

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 38

CCT participants who have developmental disabilities are provided services through the Developmentally Disabled (DD) waiver and partially funded by MFP. The number of DD waiver beneficiaries expected to enroll into CCT is included in this policy change. Supplemental federal funding that is associated with provided CCT services to these beneficiaries is budgeted in the MFP Funding to California Department of Developmental Services (CDDS) for CCT policy change.

Reason for Change from Prior Estimate:

There is an increase in the number of estimated enrollees into the CCT demonstration for current year and budget year based on Department projections.

Methodology:

1. Assume estimated costs for persons residing year-round in Nursing Facility (NF)-Bs, pre-waiver costs for waiver impacted services for persons residing in NF-Bs would be \$61,081.
2. Assume 100% of CCT participants will receive pre-transition demonstration services.
3. Assume DD beneficiaries who participate in CCT cost \$64,587 annually for pre-transition demonstration services and \$67,388 annually post-transition into CCT. Non DD beneficiaries will cost \$8,158 annually for pre-transition services and \$50,284 annually upon transitioning into CCT.
4. Assume all CCT services are reimbursed at 75% FFP and 25% GF. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.
5. Enhanced FFP will be provided to CDDS and is budgeted in a separate policy change, see MFP Funding to CDDS and CDSS for CCT for more information. The enhanced FFP is for CCT participants who have developmental disabilities and receive HCBS through CDDS.
6. Assume CDSS will request FFP for CCT services provided to DD beneficiaries for FY 2010-11 and FY 2011-12 in FY 2012-13.
7. Costs in the budget year include phased-in and lagged payments from the current year.

	(In Thousands)			
	2012-13		2013-14	
	TF	GF	TF	GF
Lagged savings	(\$14,303)	(\$7,151)	(\$47,751)	(\$23,876)
Lagged costs	\$16,934	\$2,190	\$50,760	\$9,126
CDDS prior costs	\$28,964	\$0	\$0	\$0
Net	\$31,595	(\$4,961)	(\$3,009)	(\$14,750)

Funding:

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

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 39
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1524

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$16,854,000	-\$33,707,000
- STATE FUNDS	-\$8,427,000	-\$16,853,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$16,854,000	-\$33,707,000
STATE FUNDS	-\$8,427,000	-\$16,853,500
FEDERAL FUNDS	-\$8,427,000	-\$16,853,500

DESCRIPTION

Purpose:

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

Authority:

AB 97 (Chapter 3, Statutes of 2011)
 Welfare & Institutions Code 14134(c)(1)

Interdependent Policy Changes:

Not Applicable

Background:

AB 97 implemented a mandatory copayment of up to \$50 for non-emergency use of the emergency room. After discussion with the Centers for Medicare & Medicaid Services (CMS), the Department will implement a \$15 copayment for non-emergency medical care provided in an emergency room.

The Department has submitted an amendment to the 1115 Demonstration Project Waiver and is awaiting CMS approval to implement a two-year demonstration project in select managed care settings. The copayment proposal will not apply to children in Aid to Families with Dependent Children (AFDC)-Foster Care, American Indian/Alaskan Natives, and beneficiaries who are dual eligible for both Medicare and Medi-Cal. The provider will collect the \$15 copayment from the beneficiaries after receipt of non-emergency medical care in the emergency room.

Reason for Change from Prior Estimate:

The change from the prior estimate is due to updated data.

Methodology:

1. It is assumed that the copayment will be implemented January 1, 2013.
2. The managed care savings are estimated to be \$16,854,000 TF (\$8,427,000 GF) in FY 2012-13 and \$33,707,000 TF (\$16,853,500 GF) annually.

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 39

Funding:

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

FEDERAL DRUG REBATE CHANGE

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

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$145,000,000	\$0
- STATE FUNDS	\$145,000,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$145,000,000	\$0
STATE FUNDS	\$145,000,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

Affordable Care Act (ACA), H.R. 3590

Interdependent Policy Changes:

Not Applicable

Background:

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

The Department is required to pay back the GF share of the differential to CMS. CMS agreed to collect 25% of the amount owed for the first quarter, 50% of the amount owed for the next three quarters, and 100% thereafter until reconciliation for these time periods is completed. Once the reconciliation is completed, the Department will be required to pay any outstanding amount owed. The Department is required to complete the reconciliation process by December 31, 2012.

Reason for Change from Prior Estimate:

Payments were not made according to the previous schedule as a result of system development delays.

FEDERAL DRUG REBATE CHANGE

REGULAR POLICY CHANGE NUMBER: 41

Methodology:

1. CMS will send the Department an estimated quarterly rebate offset amount (EQROA) to be remitted to the federal government. The EQROA will be reconciled with the total quarterly rebate offset amount (QROA) when the Department receives the unit offset amount from CMS.
2. In October 2010, CMS began collecting the additional federal financial participation (FFP) for the rebates collected by the Department retroactive to January 1, 2010.
3. The Department estimates that the rebate increase differential owed to CMS would be \$76 million per quarter. Currently, the Department pays CMS back at the current FMAP of that total.
4. Assume that, beginning with the October 2011 payment, CMS has collected 100% of the estimated additional amount due.
5. The Department paid \$38 million for the August 2012 payment, \$37 million for the September payment and \$70 million to CMS for the final reconciliation of prior payments that included a discount factor.
6. Beginning July 2012, the ongoing additional FFP that CMS collects for federal drug rebates is fully reflected in the Federal Drug Rebate Program policy change.

August 2012 payment	$\$38,000,000 \times 100\% = \$ 38,000,000$
September 2012 payment	$\$37,000,000 \times 100\% = \$ 37,000,000$
Reconciliation payment	<u>\$ 70,000,000</u>
	\$145,000,000

Funding:

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

KALYDECO FOR TREATMENT OF CYSTIC FIBROSIS

REGULAR POLICY CHANGE NUMBER: 42
 IMPLEMENTATION DATE: 2/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1669

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$4,800,000	\$4,800,000
- STATE FUNDS	\$2,400,000	\$2,400,000
PAYMENT LAG	0.9980	1.0000
% REFLECTED IN BASE	74.96 %	95.43 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,199,500	\$219,400
STATE FUNDS	\$599,760	\$109,680
FEDERAL FUNDS	\$599,760	\$109,680

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

There is no change.

Methodology:

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

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

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

KALYDECO FOR TREATMENT OF CYSTIC FIBROSIS

REGULAR POLICY CHANGE NUMBER: 42

Fiscal Year	TF	GF
2012-13	\$4,800,000	\$2,400,000
2013-14	\$4,800,000	\$2,400,000

Funding:

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

NON FFP DRUGS

REGULAR POLICY CHANGE NUMBER: 43
 IMPLEMENTATION DATE: 3/2007
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 108

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$1,672,000	\$1,683,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$1,672,000	\$1,683,000
FEDERAL FUNDS	-\$1,672,000	-\$1,683,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes

Not Applicable

Background:

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

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

Reason for Change from Prior Estimate:

The collection projections were revised based on additional actual data.

Methodology:

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

(In Thousands)

	<u>Non-FFP Drug Exp.</u>	<u>Est. FFP Repayment</u>
FY 2012-13	\$3,344	\$1,672
FY 2013-14	\$3,366	\$1,683

NON FFP DRUGS
REGULAR POLICY CHANGE NUMBER: 43

Funding:

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

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 44
 IMPLEMENTATION DATE: 1/2010
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1433

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$15,000,000	-\$15,000,000
- STATE FUNDS	-\$5,250,000	-\$5,250,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$15,000,000	-\$15,000,000
STATE FUNDS	-\$5,250,000	-\$5,250,000
FEDERAL FUNDS	-\$9,750,000	-\$9,750,000

DESCRIPTION

Purpose:

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

Authority:

Welfare and Institutions Code, section 14105.33(b)(4)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

Projections were revised based on an upward trend in actual data.

Methodology:

1. Payments began in January 2010.
2. Rebates are invoiced quarterly.
3. The average quarterly rebate for October 1, 2011 through March 31, 2012 was \$3,999,046.
4. Previously, the average quarterly rebate was slightly less. It is unknown if the increase for October 1, 2011 through March 31, 2012 is a new trend or an anomaly. Consequently, this estimate assumes an average quarterly rebate of \$3,750,000.

BCCTP DRUG REBATES
REGULAR POLICY CHANGE NUMBER: 44

Funding:

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

MEDICAL SUPPLY REBATES

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

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$22,722,000	-\$19,476,000
- STATE FUNDS	-\$11,361,000	-\$9,738,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$22,722,000	-\$19,476,000
STATE FUNDS	-\$11,361,000	-\$9,738,000
FEDERAL FUNDS	-\$11,361,000	-\$9,738,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The Department negotiates Maximum Acquisition Cost (MAC) and rebates for diabetic testing supplies with manufacturers to provide savings to the Department. The product reimbursement rates for diabetic testing products are based on the contracted MAC.

Due to system limitations in the Rebate Accounting Information System (RAIS), manually created invoices are being sent to manufacturers for the contracted rebate percentage of the MAC.

Reason for Change from Prior Estimate:

Based on updated actual rebate data for the past three quarters, the average quarterly collection is \$6,492,000 instead of \$7,114,000.

Methodology:

1. Assume the current medical supply diabetic testing products contract will be renegotiated and the new contract will be effective January 1, 2013.
2. Based on actual rebate data for the last three quarters, the average quarterly collection is \$6,492,000.
3. Based on the renegotiation of the new contract, assume expenditures will decrease by 25%, resulting in lower rebates received beginning in the third quarter of FY 2012-13.

MEDICAL SUPPLY REBATES
REGULAR POLICY CHANGE NUMBER: 45

FY 2012-13:

(\$6,492,000 x 2 qtrs. = \$ 12,984,000) + (\$4,869,000 x 2 qtrs. = \$9,738,000) = **\$22,722,000**

FY 2013-14:

\$4,869,000 x 4 qtrs. = **\$19,476,000**

CASH BASIS	Medical Supply Rebates
FY 2010-11	\$ 33,314,000
FY 2011-12	\$ 29,575,000
Est. FY 2012-13	\$ 22,722,000
Est. FY 2013-14	\$ 19,476,000

Funding:

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

PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 46
 IMPLEMENTATION DATE: 10/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1434

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$42,750,000	-\$57,000,000
- STATE FUNDS	-\$21,375,000	-\$28,500,000
PAYMENT LAG	0.9250	0.9990
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$39,543,800	-\$56,943,000
STATE FUNDS	-\$19,771,880	-\$28,471,500
FEDERAL FUNDS	-\$19,771,880	-\$28,471,500

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The previous rate of reimbursement for physician-administered drugs was the Average Wholesale Price (AWP) minus 5%. SB 853 established a new reimbursement rate methodology for physician-administered drugs to be reimbursed consistent with Medi-Cal rates of payment for non-physician-administered pharmaceuticals beginning in January 2011.

In June 2012, a State Plan Amendment, approved by the Centers for Medicare and Medicaid Services (CMS), approved a methodology to establish a rate of reimbursement for physician-administered drugs at the Medicare rate if available, or pharmacy rate if the Medicare rate is not available. The new methodology is expected to generate savings beginning October 2012 for claims from September 2011 and ongoing.

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

Reason for Change from Prior Estimate:

The Department received approval from CMS in June 2012 instead of April 2012.

PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 46

Methodology:

1. Savings will begin in October 2012.
2. Assume implementation will be retroactive to September 2011.
3. Annual savings are estimated to be \$57,000,000 TF (\$28,500,000 GF).
4. Assume there will be no effect on claims for services from September 2011 to September 2012 when this change is initially implemented in October 2012.
5. The timing and amount for the retroactive recoupment for services from September 2011 to September 2012 is undetermined at this time.
6. Savings are estimated to be:

FY 2012-13: $\$57,000,000 \div 12 \text{ mos.} \times 9 \text{ mos.} = \$42,750,000 \text{ TF } (\$21,375,000 \text{ GF})$

FY 2013-14: $\$57,000,000 \text{ TF } (\$28,500,000 \text{ GF})$

Funding:

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

FAMILY PACT DRUG REBATES

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

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$70,090,000	-\$76,370,000
- STATE FUNDS	-\$9,170,600	-\$9,992,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$70,090,000	-\$76,370,000
STATE FUNDS	-\$9,170,600	-\$9,992,200
FEDERAL FUNDS	-\$60,919,400	-\$66,377,800

DESCRIPTION

Purpose:

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

Authority:

Welfare and Institutions Code, section 14105.33 (b)(4)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

Reason for Change from Prior Estimate:

The collection projections were revised based on additional actual data.

Methodology:

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 47

CASH BASIS
(In Thousands)

<u>Fiscal Year</u>	<u>FPACT Drug Expenditures</u>	<u>FPACT Rebate</u>	
FY 2011-12	\$148,583	(\$72,666)	
Est. FY 2012-13		(\$70,090)	
Est. FY 2013-14		(\$76,370)	
	<u>TF</u>	<u>50% FFP</u>	<u>90% FFP</u>
FY 2012-13	(\$70,090)	(\$5,404)	(\$64,686)
FY 2013-14	(\$76,370)	(\$5,888)	(\$70,482)

Funding:

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

Title XIX 10/90 FFP (4260-101-0001/0890)

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 48
 IMPLEMENTATION DATE: 4/2004
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1182

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$75,000,000	-\$75,000,000
- STATE FUNDS	-\$37,433,600	-\$37,433,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$75,000,000	-\$75,000,000
STATE FUNDS	-\$37,433,600	-\$37,433,600
FEDERAL FUNDS	-\$37,566,400	-\$37,566,400

DESCRIPTION

Purpose:

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

Authority:

Welfare and Institutions Code, Section 14105.33

Interdependent Policy Changes:

PC-49 State Supplemental Drug Rebates
 PC-52 Federal Drug Rebate Program

Background:

Aged Rebates

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

Disputed Rebates

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

Reason for Change from Prior Estimate:

The Department's ability to recover an increased number of aged and disputed drug rebate payments has increased the estimated savings.

Methodology:

Not Applicable

AGED AND DISPUTED DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 48

Funding:

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

Title XIX 10/90 FFP (4260-101-0001/0890)

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49
 IMPLEMENTATION DATE: 1/1991
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 54

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$106,853,000	-\$112,709,000
- STATE FUNDS	-\$53,332,100	-\$56,254,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$106,853,000	-\$112,709,000
STATE FUNDS	-\$53,332,100	-\$56,254,900
FEDERAL FUNDS	-\$53,520,900	-\$56,454,100

DESCRIPTION

Purpose:

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

Authority:

Welfare and Institutions Code, section 14105.33

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

The collection projections were revised based on additional actual data.

Methodology:

1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.
2. In FY 2011-12, actual FFS drug expenditures were \$2,519,943,400, of that amount, 5% were collected in State supplemental rebates.
3. In FY 2012-13 and FY 2013-14, it is assumed that 5% of projected FFS base drug expenditures will be collected as State supplemental rebates.
4. Family planning drugs account for 0.221% of rebates and are funded with 90% federal funds and 10% General Fund.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49

	<u>TF</u>	<u>50% FFP</u>	<u>90% FFP</u>
FY 2012-13	(\$106,853)	(\$53,308)	(\$213)
FY 2013-14	(\$112,709)	(\$56,230)	(\$224)

Funding:

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

Title XIX 10/90 FFP (4260-101-0001/0890)

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 50
 IMPLEMENTATION DATE: 8/2009
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1449

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	-\$220,307,000	\$0
- STATE FUNDS	-\$220,307,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$220,307,000	\$0
STATE FUNDS	-\$220,307,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the settlement amounts expected to be received by the Department from pharmaceutical and other companies due to overcharges.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

Additional settlement agreements.

LITIGATION SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 50

Methodology:

The following settlements are expected to be received in FY 2012-13:

	FY 2012-13
	Settlement Payments
A-Med Pharmacy	\$ 73,000
Amgen	\$ 1,154,000
Bio-Med	\$ 2,261,000
Bioscrip	\$ 122,000
Boehringer Ingelheim Pharmaceuticals, Inc.	\$ 809,000
Dava Pharmaceuticals, Inc	\$ 72,000
GlaxoSmithKline, LLC	\$ 21,349,000
KV Pharmaceuticals, Inc.	\$ 61,000
Maxim	\$ 4,225,000
McKesson	\$ 17,689,000
Merck (Vioxx)	\$ 19,124,000
Pacific Health Corporation	\$ 674,000
Seacliff Diagnostics	\$ 124,000
Senior Care Action Network	\$ 152,288,000
Serono	\$ 268,000
Walgreen's Pharmacy	\$ 14,000
Total GF Savings	\$ 220,307,000

Funding:

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

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 51
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1585

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$222,289,000	-\$547,807,000
- STATE FUNDS	-\$111,144,500	-\$273,903,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$222,289,000	-\$547,807,000
STATE FUNDS	-\$111,144,500	-\$273,903,500
FEDERAL FUNDS	-\$111,144,500	-\$273,903,500

DESCRIPTION

Purpose:

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

Authority:

Social Security Act Section 1927(b) as amended by Section 2501(c) of the Affordable Care Act (ACA).

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

California Medicaid Management Information System (CA-MISS) system updates were not implemented in 2011-12; as a result, invoicing for managed care drugs did not commence. Consequently, the initial collection rate of 40% has been decreased to 30%.

Based on updated historical data, the Department anticipates invoicing \$80.4 million quarterly through December 2012 and \$89.8 million thereafter. Previously, ongoing rebates were estimated to be \$70 million.

Methodology:

1. Rebates are invoiced quarterly and payments occur four months after the conclusion of each quarter.
2. Assume the overall collection rate will be 70+% of invoiced amounts beginning in FY 2013-14.

MANAGED CARE DRUG REBATES**REGULAR POLICY CHANGE NUMBER: 51**

3. Assume rebates will be collected beginning in April 2013.
4. Assume the Department will invoice \$580,144,600 TF in retroactive rebates and \$80,409,400 TF ongoing for each quarter through December 2012 and \$89,793,500 thereafter.
5. Assume the first invoices will be for the retroactive period of March 23, 2010 to June 30, 2012 and the current period of July 2012 to March 2013. These rebates assume an initial collection rate of 30%; however, the Department anticipates collecting the remaining 40% in FY 2013-14. Due to the lag in collection, the rebates invoiced for the period of January 2013 to March 2013 will be collected in FY 2013-14.
6. Assume the Department will collect 70% of the amounts invoiced for the period of April 2013 to December 2013 in FY 2013-14. The rebates invoiced for the period of January 2014 to March 2014 will be collected in FY 2014-15.

Retroactive Rebates:	$\$580,144,600 \times 30\% =$	\$174,043,000
July 2012 – December 2012:	$2 \times \$80,409,400 \times 30\% =$	\$ 48,246,000
FY 2012-13		<u>\$222,289,000</u>

Retroactive Rebates:	$\$580,144,600 \times 40\% =$	\$232,058,000
July 2012 – December 2012:	$2 \times \$80,409,400 \times 40\% =$	\$ 64,328,000
January 2013 – March 2013:	$\$89,793,500 \times 70\% =$	\$ 62,855,000
April 2013 – December 2013:	$3 \times \$89,793,500 \times 70\% =$	\$188,566,000
FY 2013-14		<u>\$547,807,000</u>

Funding:

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

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 52
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 55

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,097,274,000	-\$1,157,416,000
- STATE FUNDS	-\$491,667,000	-\$521,684,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,097,274,000	-\$1,157,416,000
STATE FUNDS	-\$491,667,000	-\$521,684,800
FEDERAL FUNDS	-\$605,607,000	-\$635,731,200

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The State Medi-Cal Drug Discount Program and OBRA 1990 allow the Department to obtain price discounts for drugs.

Reason for Change from Prior Estimate:

The collection projections were revised based on additional actual data.

Methodology:

1. Rebates are estimated by using actual fee-for-service (FFS) trend data for drug expenditures, and applying a historical percentage of actual amounts collected to the trend projection.
2. In FY 2011-12, actual FFS drug expenditures were \$2,519,943,400, of that amount, 55% were collected in Federal rebates.
3. FFS drug expenditures are declining because of the shift of Medi-Cal beneficiaries into managed care.
4. In FY 2012-13 and FY 2013-14, it is assumed that 55% of projected FFS base drug expenditures will be collected as rebates.

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 52

5. Family planning drugs account for 0.221% of rebates and are funded with 90% federal funds and 10% General Fund.
6. Beginning July 2012, the ongoing additional federal financial participation (FFP) of \$112,000,000, claimed by the Centers for Medicare and Medicaid Services (CMS), is fully reflected in this policy change.

	<u>TF</u>	<u>50% FFP</u>	<u>90% FFP</u>	<u>100% FFP</u>
FY 2012-13	(\$1,097,274)	(\$491,424)	(\$2,182)	(\$112,000)
FY 2013-14	(\$1,157,416)	(\$521,429)	(\$2,302)	(\$112,000)

Funding:

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

Title XIX 10/90 FFP (4260-101-0001/0890)

Title XIX FFP (4260-101-0890)

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1724

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$1,723,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,723,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	-\$1,723,000

DESCRIPTION

Purpose:

This policy change budgets for the annual rate adjustment to the Drug Medi-Cal (DMC) rates.

Authority:

Welfare & Institutions Code 14021.5, 14021.6, 14021.9, and 14105

Interdependent Policy Changes:

Not Applicable

Background:

Annually, the Department adjusts the DMC rates based on the growth of the cumulative implicit price (CIP) deflator for the costs of goods and services to governmental agencies. The proposed DMC rates are based either on the developed rates for use in FY 2013-14 or the FY 2009-10 Budget Act rates adjusted for the CIP deflator, whichever is lower.

The following DMC rates are adjusted each year:

- Narcotic Treatment Program (NTP) – Dosing
- NTP - Individual Counseling
- NTP - Group Counseling
- Day Care Rehabilitative (DCR)
- Naltrexone
- Perinatal Residential (PR)
- Outpatient Drug Free (ODF) - Individual Counseling
- ODF- Group Counseling

Reason for Change from Prior Estimate:

This is a new policy change.

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

Methodology:

1. The CIP deflator used in calculating the FY 2013-14 DMC rate is 8.6%.

Regular-Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2013-14 Rates *	FY 2013-14 Developed Rates	FY 2013-14 Required Rates
NTP-Dosing	\$11.34	8.6%	\$12.32	\$11.49	\$11.49
NTP-Individual	\$13.30	8.6%	\$14.44	\$15.42	\$14.44
NTP- Group	\$3.14	8.6%	\$3.41	\$3.27	\$3.27
DCR	\$61.05	8.6%	\$66.30	\$62.15	\$62.15
Naltrexone	\$19.07	8.6%	\$20.71	\$19.07	\$19.07
ODF-Individual	\$66.53	8.6%	\$72.25	\$77.10	\$72.25
ODF-Group	\$28.27	8.6%	\$30.70	\$29.39	\$29.39

Perinatal- Services	FY 2009-10 UOS Rate	CIP Deflator	FY 2013-14 Rates *	FY 2013-14 Developed Rates	FY 2013-14 Required Rates
NTP-Dosing	\$12.21	8.6%	\$13.26	\$12.57	\$12.57
NTP-Individual	\$19.04	8.6%	\$20.68	\$24.08	\$20.68
NTP- Group	\$6.36	8.6%	\$6.91	\$7.41	\$6.91
DCR	\$73.04	8.6%	\$79.32	\$85.32	\$79.32
PR	\$89.90	8.6%	\$97.63	\$110.29	\$97.63
ODF-Individual	\$95.23	8.6%	\$103.42	\$120.38	\$103.42
ODF-Group	\$57.26	8.6%	\$62.18	\$66.65	\$62.18

*Rate calculation is based on FY 2009-10 rates adjusted by the CIP deflator.

2. The incremental difference between FY 2012-13 required rates and FY 2013-14 required rates are:

Regular-Services	FY 2012-13 Required Rates	FY 2013-14 Required Rates	Incremental Difference
NTP-Dosing	\$11.97	\$11.49	(\$0.48)
NTP-Individual	\$14.24	\$14.44	\$0.20
NTP- Group	\$3.36	\$3.27	(\$0.09)
DCR	\$65.38	\$62.15	(\$3.23)
Naltrexone	\$19.07	\$19.07	\$0.00
ODF-Individual	\$71.25	\$72.25	\$1.00
ODF-Group	\$30.28	\$29.39	(\$0.89)

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

Perinatal-Services	FY 2012-13 Required Rates	FY 2013-14 Required Rates	Incremental Difference
NTP-Dosing	\$13.05	\$12.57	(\$0.48)
NTP-Individual	\$20.39	\$20.68	\$0.29
NTP- Group	\$6.81	\$6.91	\$0.10
DCR	\$78.23	\$79.32	\$1.09
PR	\$96.28	\$97.63	\$1.35
ODF-Individual	\$101.99	\$103.42	\$1.43
ODF-Group	\$61.33	\$62.18	(\$0.85)

3. The cost estimate is developed by the following:

Caseload x Units of Service (UOS) x Rates:

4. The incremental rate change on an accrual basis will result in an annual savings of \$4,960,000 TF:

Regular-Services	(In Thousands)		
	TF	FFP	County
NTP	(\$2,716)	(\$1,357)	(\$1,359)
DCR	(\$877)	(\$439)	(\$438)
Naltrexone	\$0	\$0	\$0
ODF	(\$1,391)	(\$515)	(\$876)
Perinatal-Services	TF	FFP	County
NTP	(\$7)	(\$3)	(\$4)
DCR	\$8	\$4	\$4
PR	\$5	\$3	\$2
ODF	\$18	\$9	\$9
Total FY 2013-14	(\$4,960)	(\$2,298)	(\$2,662)

5. Based on historical claims received, assume 75% of each fiscal year claims will be paid/recovered in the year the services occurred. The remaining will be paid/recovered in the following year.

Regular-Services	(In Thousands)		
	TF	FFP	County
NTP	(\$2,037)	(\$1,018)	(\$1,019)
DCR	(\$658)	(\$329)	(\$329)
Naltrexone	\$0	\$0	\$0
ODF	(\$1,043)	(\$386)	(\$657)
Total	(\$3,738)	(\$1,733)	(\$2,005)

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

<u>Perinatal-Services</u>	<u>TF</u>	<u>FFP</u>	<u>County</u>
NTP	(\$5)	(\$2)	(\$3)
DCR	\$6	\$3	\$3
PR	\$4	\$2	\$2
ODF	\$14	\$7	\$7
Total	\$18	\$10	\$8
Total FY 2013-14	(\$3,720)	(\$1,723)	(\$1,997)

Funding:

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

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 59
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1723

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$7,017,000	-\$3,508,000
- STATE FUNDS	-\$2,827,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$7,017,000	-\$3,508,000
STATE FUNDS	-\$2,827,000	\$0
FEDERAL FUNDS	-\$4,190,000	-\$3,508,000

DESCRIPTION

Purpose:

This policy change budgets the federal funds for cost settlements to counties and contracted providers for payments related to the Drug Medi-Cal program's alcohol and drug treatment services.

Authority:

Health & Safety Code 11758.46 (i)(2)

Interdependent Policy Changes:

Not Applicable

Background:

The Drug Medi-Cal (DMC) program initially pays a claim for alcohol and drug treatment at a provisional rate, not to exceed the State's maximum allowance. At the end of each fiscal year, non-Narcotic Treatment Program providers must submit actual cost information. The DMC program completes a final settlement after receipt and review of the provider's cost report. The cost settlement is based on the county's certified public expenditures (CPE).

Reimbursement for non-narcotic treatment services is limited to the lowest of the following costs:

- Provider's usual and customary charges to the general public for the same or similar services,
- Provider's allowable costs, or
- DMC statewide maximum allowance for each service modality.

Reimbursement to Narcotic Treatment Program providers is limited to the lowest of the following costs:

- Provider's usual and customary charges to the general public for the same or similar services, or
- DMC statewide maximum allowance for the service.

Narcotic treatment programs that do not receive General Fund or federal Substance Abuse Prevention and Treatment block grant funds are not required to submit cost data.

DRUG MEDI-CAL PROGRAM COST SETTLEMENT**REGULAR POLICY CHANGE NUMBER: 59**

Effective July 1, 2012, perinatal services funding was budgeted in the Department of Alcohol and Drug Program's (DADP) perinatal appropriation 4200-102-0001 and 4200-101-0890 and the non-perinatal services funding was budgeted in the DADP's Drug Medi-Cal (DMC) services appropriation 4200-103-0001 and 4200-101-0890. Effective July 1, 2012, the federal funds for these services are budgeted in the Department's appropriation 4260-101-0890.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The interim cost settlement is based on a reconciliation of the provider's cost report against the actual expenditures paid by the Department.
2. Final cost settlements are based on comparing actual expenditures against audited cost reports. If an audit is not conducted within three years of the interim cost settlement, the interim cost settlement becomes the final cost settlement.
3. Savings were calculated by averaging FY 2007-08, FY 2008-09, and FY 2009-10 actual cost settlements.

REGULAR EXPENDITURES	FY 2007-08	FY 2008-09	FY 2009-10
Actual Expenditures	\$83,313,000	\$67,699,341	\$76,986,000
Cost Settlement	\$74,471,389	\$67,696,589	\$65,804,685
Difference	\$8,841,611	\$2,752	\$11,181,315

PERINATAL EXPENDITURES	FY 2007-08	FY 2008-09	FY 2009-10
Actual Expenditures	\$3,323,988	\$1,946,945	\$2,278,000
Cost Settlement	\$3,156,546	\$1,913,686	\$1,452,385
Difference	\$167,442	\$33,259	\$825,615

	Difference (Regular)	Difference (Perinatal)
	\$8,841,611	\$167,442
	\$2,752	\$33,259
	\$11,181,315	\$825,615
	\$20,025,677	\$1,026,315
Divide by the # of FYs	3	3
	\$6,675,226	\$342,105

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 59

4. Savings are estimated to total \$7,017,000 for FY 2012-13 and FY 2013-14. In the FY 2011-12, the General Funds (GF) were replaced by a County Funds.

FY 2010-11 Settlements	(In Thousands)			
	<u>TF</u>	<u>GF</u>	<u>FFP-Regular</u>	<u>FFP-ARRA</u>
Regular (Item 103)	(\$6,675)	(\$2,690)	(\$3,338)	(\$648)
Perinatal (Item 102)	(\$342)	(\$137)	(\$171)	(\$33)
Total for FY 2012-13	\$7,017	(\$2,827)	(\$3,509)	(\$681)

FY 2011-12 Settlements	(In Thousands)		
	<u>TF</u>	<u>FFP</u>	<u>County</u>
Regular (Item 103)	(\$6,675)	(\$3,337)	(\$3,338)
Perinatal (Item 102)	(\$342)	(\$171)	(\$171)
Total for FY 2013-14	\$7,017	(\$3,508)	(\$3,509)

Funding:

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

State Only General Fund (4260-101-0001)

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 61
 IMPLEMENTATION DATE: 11/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1458

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$64,187,000	\$232,861,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$64,187,000	\$232,861,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$64,187,000	\$232,861,000

DESCRIPTION

Purpose:

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

Authority:

ABX4 5 (Chapter 5, Statutes of 2009)
 Welfare & Institution Code 14723

Interdependent Policy Changes:

Not Applicable

Background:

State law 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 for what would otherwise be uncompensated costs for services provided to Medi-Cal beneficiaries.

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

The Supplemental Payment Program is pending approval from the Centers for Medicare and Medicaid Services.

Reason for Change from Prior Estimate:

Estimate has been revised based on additional data.

**SPECIALTY MENTAL HEALTH SVCS SUPP
REIMBURSEMENT
REGULAR POLICY CHANGE NUMBER: 61**

Methodology:

1. The FY 2008-09 estimates were developed using the final filed cost reports received from each county mental health plan.
2. The unreimbursed costs for county-operated providers was calculated based on the difference between the county operated provider's gross allowable cost and the gross schedule of statewide maximum allowance (SMA).
3. The amount of unreimbursed costs was increased by the ratio of county costs to total mental health plan costs to account for unreimbursed costs for contract providers.
4. The FY 2009-10 estimates were developed using the final filed cost reports received from each county and are still under Department review.
5. Assumes the FY 2010-11 supplemental payment will increase by 10% from the payment for FY 2009-10.

	In Thousands		
FY 2012-13	FFP - REGULAR	FFP - ARRA	TOTAL FFP
FY 2008-09 FFP	\$52,108	\$12,079	\$64,187
FY 2013-14	FFP - REGULAR	FFP - ARRA	TOTAL FFP
FY 2009-10 FFP	\$90,019	\$20,867	\$110,886
FY 2010-11 FFP	\$99,022	\$22,953	\$121,975
Total	\$189,041	\$43,820	\$232,861

Funding:

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

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 62
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1712

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$21,215,000	\$20,417,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$21,215,000	\$20,417,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$21,215,000	\$20,417,000

DESCRIPTION**Purpose:**

This policy change estimates the healthy families enrollees who are Seriously Emotionally Disturbed (SED).

Authority:

California Insurance Code 12693.61 and 12694.1

Interdependent Policy Changes:

Not Applicable

Background:

The Healthy Families Program (HFP) provides low cost insurance for eligible children under the age of 19 whose families:

- Do not have insurance,
- Do not qualify for zero share of cost Medi-Cal,
- Income is at or below 250 percent of the federal poverty level.

Mental health services for the HFP subscribers who are SED are “carved-out” of the HFP health plans’ array of covered services and are provided by county mental health departments. County mental health departments are responsible for the provision and payment of all treatment of SED conditions, with the exception of the first thirty days of psychiatric inpatient services per benefit year, which remain the responsibility of the HFP health plan. This covered benefit is referred to as the “HFP SED benefit.”

When a mental health department assumes responsibility for the treatment of the HFP subscriber’s SED condition, it can submit claims to obtain federal reimbursement for the services. County mental health departments pay for services provided to HFP subscribers using realignment dollars or other local funds and can submit claims to receive 65% federal reimbursement.

Effective January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 62

transition into Medi-Cal through a phase-in methodology. Children enrolled in the HFP will be transitioned to the Medi-Cal Program as targeted low-income children.

Reason for Change from Prior Estimate:

There is no material change.

Methodology:

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) approved claims data from August 2006 through May 2012, excluding disallowed claims.
2. Due to the lag in reporting of claims data, the most recent six months of data must be weighted (Lag Weights) based on observed claiming trends to create projected final claims and clients data.
3. Applying more weight to recent data necessitates the need to ensure that lag weight adjusted claims data (a process by which months of partial data reporting is extrapolated to create estimates of final monthly claims) is as complete and accurate as possible. The development and application of lag weights is based upon historical reporting trends of the counties.
4. Medi-Cal Specialty Mental Health programs costs are shared between federal funds (FFP) and a county match. M-CHIP claims are eligible for federal reimbursement of 65%.
5. The forecast is based on a service year of costs. This accrual cost is below:

Accrual Estimate	(In Thousands)		
	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2010-11	\$27,493	\$17,870	\$9,623
FY 2011-12	\$30,260	\$19,669	\$10,591
FY 2012-13	\$30,750	\$19,987	\$10,763
FY 2013-14	\$31,240	\$20,306	\$10,934

6. On a cash basis for FY 2012-13, the Department will be paying 1% of FY 2010-11 claims, 33% of FY 2011-12 claims, and 73% of FY 2012-13 claims.

Cash Estimate	(In Thousands)		
	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2010-11	\$275	\$179	\$96
FY 2011-12	\$9,869	\$6,415	\$3,454
FY 2012-13	\$22,495	\$14,621	\$7,874
TOTAL FY 2012-13	\$32,639	\$21,215	\$11,424

7. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 27% of FY 2012-13 claims, and 73% of FY 2013-14 claims.

HEALTHY FAMILIES - SED
REGULAR POLICY CHANGE NUMBER: 62

Cash Estimate	(In Thousands)		County
	TF	FFP	
FY 2011-12	\$303	\$197	\$106
FY 2012-13	\$8,255	\$5,366	\$2,889
FY 2013-14	\$22,853	\$14,854	\$7,999
TOTAL FY 2013-14	\$31,411	\$20,417	\$10,994

Funding:

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

KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER: 63
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1718

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$9,785,000	\$23,161,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$9,785,000	\$23,161,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$9,785,000	\$23,161,000

DESCRIPTION**Purpose:**

This policy change estimates the increase in costs due to the *Katie A v. Diana Bonta* lawsuit.

Authority:

Katie A v. Diana Bonta

Interdependent Policy Changes:

Not Applicable

Background:

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 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 effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. 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. Since October 13, 2011, the parties have met with the Special Master to develop a plan for settlement implementation. As a result of the lawsuit, beneficiaries meeting medical necessity criteria may receive an increase in existing services that will be provided in a more intensive and effective manner. These additional services are court ordered to begin by January 1, 2013.

Reason for Change from Prior Estimate:

This is a new policy change.

KATIE A. V. DIANA BONTA
REGULAR POLICY CHANGE NUMBER: 63

Methodology:

1. The Katie A. cost estimate is based on two factors:
 - An increase in the penetration rate of children receiving specialty mental health services within the Katie A. subclass of clients; and
 - An increase in the cost of services per client for existing clients due to the availability of more intensive services.
2. The estimated annual cost for new clients is \$38,830,000 and the estimated annual increase in cost for existing clients is \$14,672,000, giving a total annual cost of \$53,502,000.

Accrual Estimate	(In Thousands)		Total
Annual	New	Existing	
	\$38,380	\$14,672	\$53,502

3. Assume the additional services will begin January 1, 2013.
4. In FY 2012-13 assume the accrual estimate is half of the full year costs.

$$\$53,502,000 \div 12 \text{ months} \times 6 \text{ months} = \$26,751,000$$

5. Based on historical claims received, assume 73% of the each fiscal year claims will be paid in the year the services occur. The remaining 27% is paid in the following year.

Cash Estimate	(In Thousands)		County
FY 2012-13	TF	FFP	
	\$19,570	\$9,785	\$9,785
FY 2012-13	\$7,182	\$3,591	\$3,591
FY 2013-14	\$39,139	\$19,570	\$19,569
FY 2013-14	\$46,321	\$23,161	\$23,160

Funding:

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

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 64
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1719

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$8,297,000	\$33,500,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,297,000	\$33,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$8,297,000	\$33,500,000

DESCRIPTION

Purpose:

This policy change estimates the federal reimbursement for specialty mental health benefits associated with transitioning the Healthy Families Program (HFP) subscribers into the Medi-Cal program.

Authority:

AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:

PC-2 Transition of HFP to Medi-Cal

Background:

AB 1494 transitions all HFP subscribers into the Medi-Cal program using a phased-in approach beginning January 2013. Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) enrollees are carved out and provided by county mental health plans. The Medi-Cal program does not have an "SED carve-out," but it does not carve out from Medi-Cal managed care plans any mental health services beyond what a primary care physician can provide under their scope of practice; this includes Medi-Cal specialty mental health services. Children transitioning from the HFP to Medi-Cal will have access to the carved-out Medi-Cal specialty mental health services through county mental health plans if they meet medical necessity criteria for those services. County mental health plans are eligible to claim FFP through the CPE process.

HFP subscribers that transition to the Medi-Cal program will be considered EPSDT eligible and can receive the full array of Medi-Cal specialty mental health services based on medical necessity and their mental health needs.

Reason for Change from Prior Estimate:

Revision based on the updates to HFP caseload and phase-in.

Methodology:

1. Beginning January 1, 2013, HFP subscribers will transition to Medi-Cal.

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 64

2. The majority of mental health services provided to current SED enrollees will continue under the Medi-Cal specialty mental health services. As such, the current SED expenditures will shift from the HFP Families – SED policy change to the Children, Adult, and FFS Psychiatric Inpatient policy change.
3. Additional EPSDT clients may be served by the mental health plans as a result of changing from SED criteria to Medi-Cal medical necessity criteria, which will increase utilization of outpatient services.
4. Additional psychiatric inpatient services will be provided by the mental health plans that were previously covered by the HFP managed care plans.

	(In Thousands)		
	TF	FFP	County
SED Services	\$16,143	\$10,493	\$5,650
Outpatient	\$9,618	\$6,252	\$3,366
Inpatient	\$3,146	\$2,045	\$1,101
FY 2012-13	\$28,907	\$18,790	\$10,117

	(In Thousands)		
	TF	FFP	County
SED Services	\$24,875	\$16,169	\$8,706
Outpatient	\$38,836	\$25,243	\$13,593
Inpatient	\$12,703	\$8,257	\$4,446
FY 2013-14	\$76,414	\$49,669	\$26,745

Funding:

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

SOLANO COUNTY

REGULAR POLICY CHANGE NUMBER: 65
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1716

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,769,000	\$2,769,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,769,000	\$2,769,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,769,000	\$2,769,000

DESCRIPTION

Purpose:

This policy change estimates Solano County exercising their right to assume responsibility for providing or arranging for Medi-Cal specialty mental health services.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Prior to FY 2012-13, the Medi-Cal managed care program, Partnership Health Plan, "carved in" specialty mental health services for Solano County.

Under the 2011 Realignment, Solano County decided to exercise its right to "take back" specialty mental health services from the Medi-Cal Managed Care Plan, effective July 1, 2012.

The Medi-Cal Managed Care contract will be reduced for the mental health services component and the mental health managed care funding to Solano County will increase by the same amount.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

- Partnership Health Plan has identified that it pays out approximately \$4.5 million TF to Solano County Mental Health Plan and \$1 million TF to Kaiser Permanente in capitation payments per year for specialty mental health services.

SOLANO COUNTY
REGULAR POLICY CHANGE NUMBER: 65

	(In Thousands)		
	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2012-13	\$5,538	\$2,769	\$2,769
FY 2013-14	\$5,538	\$2,769	\$2,769

Funding:

Title XIX FFP (4260-101-0890)

OVER ONE-YEAR CLAIMS

REGULAR POLICY CHANGE NUMBER: 66
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1717

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$2,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,000,000	\$2,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,000,000	\$2,000,000

DESCRIPTION

Purpose:

This policy change estimates the claims that are submitted by county mental health plans for late eligibility determinations.

Authority:

Title 22, California Code of Regulations 50746 and 51008.5
 Welfare & Institutions Code 14680-14685.1
 Specialty Mental Health Services Consolidation Waiver

Interdependent Policy Changes:

Not Applicable

Background:

County mental health plans have begun submitting Medi-Cal specialty mental health service claims for clients with Letters of Authorization for late eligibility determinations. When an over one-year claim is determined as eligible by the Department, the county has 60 days to submit the claim for payment.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. One-year claims are based on actual claims received from the counties.

(In Thousands)	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2012-13	\$4,000	\$2,000	\$2,000
FY 2013-14	\$4,000	\$2,000	\$2,000

Funding:

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

SPECIALTY MENTAL HEALTH LAWSUIT

REGULAR POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1715

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$370,000	\$0
- STATE FUNDS	\$180,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$370,000	\$0
STATE FUNDS	\$180,000	\$0
FEDERAL FUNDS	\$190,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of the lawsuit settlement with three mental health providers.

Authority:

Hillsides Home for Children, et al. v. California, et al,
Hathaway-Sycamores Child and Family Services, et al. v. California, et al, and
Five Acres v. California, et al

Interdependent Policy Changes:

Not Applicable

Background:

Three Los Angeles Mental Health Plan contract providers filed a writ of mandate requesting the court to direct the Department to approve certain Specialty Mental Health service claims from FY 1999-00 and FY 2000-01. The cases are referred to as:

- *Hillsides Home for Children, et al. v. California, et al,*
- *Hathaway-Sycamores Child and Family Services, et al. v. California, et al, and*
- *Five Acres v. California, et al*

The Department denied the original claims for various reasons, including lack of Medi-Cal eligibility on the date of service. Upon subsequent review with corrected claim information from the providers, the Department determined that these service claims were for Medi-Cal eligible beneficiaries. The settlement agreement requires Los Angeles County to pay the providers for the claims, certify the public expenditures, and submit the claims to the Department for FFP.

Reason for Change from Prior Estimate:

There is no change.

SPECIALTY MENTAL HEALTH LAWSUIT

REGULAR POLICY CHANGE NUMBER: 67

Methodology:

1. The costs are based on approved claims at issue in the lawsuit.

Funding:

State Only General Fund (4260-101-0001)

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

SISKIYOU COUNTY MENTAL HEALTH PLAN OVERPAYMENT

REGULAR POLICY CHANGE NUMBER: 68
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1660

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$6,217,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$6,217,000	\$0
FEDERAL FUNDS	-\$6,217,000	\$0

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

During the audit and cost settlement process, the Department identified overpayments to Siskiyou County Mental Health Plan as result of improper Medi-Cal billing practices. Pursuant to federal statute, the Department must remit the overpaid FFP to CMS within a year of the discovery date. While the county acknowledged its Medi-Cal billing problems, it is also unable to repay the amounts owed in a significant or timely manner. Consequently, the County will reimburse the Department in the amount of \$200,000 per year until it fulfills its obligation for repayment.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The Department began making repayments to CMS in January 2012.
2. Siskiyou County will reimburse \$200,000 annually to the GF beginning August 2012. As a result, of the total FFP repayment of \$6,217,000 that the Department will make in FY 2012-13, \$6,017,000 will be paid from the GF. Reimbursements are shown in the Management Summary.

**SISKIYOU COUNTY MENTAL HEALTH PLAN
OVERPAYMENT
REGULAR POLICY CHANGE NUMBER: 68**

<u>Date of Overpayment Discovery</u>	<u>FY 2012-13 Repayment</u>	<u>FY 2013-14 Repayment</u>
8/4/2011	\$2,189,000	
11/15/2011	\$ 580,000	
12/21/2011	\$ 91,000	
3/12/2012	\$3,357,000	
Total:	\$6,017,000	
	GF (\$200,000)	(\$200,000) Reimbursement

Funding:

GF (4260-101-0001)

Title XIX FFP (4260-101-0890)

Reimbursement GF (4260-610-0995)

IMD ANCILLARY SERVICES

REGULAR POLICY CHANGE NUMBER: 69
 IMPLEMENTATION DATE: 7/1999
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 35

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$6,000,000	\$6,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$6,000,000	\$6,000,000
FEDERAL FUNDS	-\$6,000,000	-\$6,000,000

DESCRIPTION

Purpose:

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

Authority:

Title 42, Code of Federal Regulations 435.1009
 Welfare & Institutions Code 14053.3

Interdependent Policy Changes:

Not Applicable

Background:

Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible State or Federal reimbursement. These ancillary services are to be county-funded. Separate aid codes or other identifiers are not available to indicate a Medi-Cal beneficiary is residing in an IMD; therefore, the Department's Fiscal Intermediary is unable to determine that these claims are ineligible for reimbursement. CMS requires repayment of the FFP, which the Department has calculated retrospectively based on beneficiaries' dates of residence in and IMD as provided by service encounter data.

Effective July 1, 2012, the administration of Medi-Cal Specialty Mental Health Services transferred to the Department from the former Department of Mental Health.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

Not Applicable

IMD ANCILLARY SERVICES
REGULAR POLICY CHANGE NUMBER: 69

<u>Services Rec'd</u>	(In Thousands)	
	<u>FY 2012-13</u>	<u>FY 2013-14</u>
10/01/09 - 09/30/10	\$6,000	\$0
10/01/10 - 09/30/11	\$0	\$6,000
Total:	\$6,000	\$6,000

Funding:

State General Fund (4260-101-0001)

Title XIX FFP (4260-101-0890)

REIMBURSEMENT IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER: 70
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1711

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$12,000,000
- STATE FUNDS	\$0	-\$12,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$12,000,000
STATE FUNDS	\$0	-\$12,000,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change reflects the General Fund (GF) reimbursement for inappropriately claimed Medi-Cal ancillary services provided to beneficiaries in IMDs.

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for federal financial participation (FFP). These ancillary services are to be county-funded. The Department has released billing instructions to the provider community through a Medi-Cal provider bulletin and to counties through an all counties director's letter. Because separate aid codes or other identifiers are not available to indicate if a Medi-Cal beneficiary is residing in an IMD, providers have no indication from the Medi-Cal Eligibility Data System (MEDS) that they should not claim for these Medi-Cal beneficiaries. Repayment of the FFP is required by the Centers for Medicare & Medicaid Services (CMS) and is calculated retrospectively based on claims reimbursed for beneficiaries' ancillary services and dates of residence in an IMD as provided by the counties' service encounter data reporting.

The Department is developing eligibility and claiming processes to stop inappropriate claiming and reimbursement for ancillary services. In addition, the Department anticipates utilizing a three-step approach as outlined below:

1. The Department has developed one list of IMD facilities, which has been distributed to IMD facilities.

REIMBURSEMENT IN IMD ANCILLARY SERVICES COSTS

REGULAR POLICY CHANGE NUMBER: 70

2. The Department will publish policy guidance through an All County Welfare Director's Letter (ACWDL) or similar instruction that will instruct counties that claims for IMD ancillary services shall not be submitted to Medi-Cal.
3. The Department will establish an indicator in MEDS that would inform providers to bill the counties for beneficiaries who are residents of an IMD and that would deny inappropriate claiming for ancillary services.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The costs for ancillary services provided to beneficiaries in IMDs are in the Medi-Cal base estimate.
2. In FY 2013-14, the Department expects to collect costs beginning with FY 2008-09.
3. The reimbursement includes repayment for both federal and general fund.

Dates of Service	(In Thousands) FY 2013-14
FY 2008-09	<u>(\$12,000)</u>

Funding:

State Only General Fund (4260-101-0001)
Reimbursement (4260-610-0995)

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1714

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$450,000	-\$450,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$450,000	-\$450,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$450,000	-\$450,000

DESCRIPTION

Purpose:

This policy change estimates the savings from on-site chart reviews of adults and children.

Authority:

Title 9, California Code of Regulations 1810.380

Interdependent Policy Changes:

Not Applicable

Background:

Since January 2005, the Department has been conducting on-site chart reviews by comparing claims to the corresponding patient chart entries.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. In FY 2011-12, the Department recovered approximately \$450,000 in federal reimbursement conducting on-site chart reviews.
2. Assume a similar number of chart reviews will be conducted in FY 2012-13 and FY 2013-14 as in FY 2011-12.
3. Assume the Department will recover the same amount as FY 2011-12.

	<u>TF</u>	<u>FFP</u>
FY 2012-13	-\$450,000	-\$450,000
FY 2013-14	-\$450,000	-\$450,000

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 71

Funding:

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1713

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$26,634,000	-\$65,939,000
- STATE FUNDS	\$1,151,000	\$39,261,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$26,634,000	-\$65,939,000
STATE FUNDS	\$1,151,000	\$39,261,000
FEDERAL FUNDS	-\$27,785,000	-\$105,200,000

DESCRIPTION

Purpose:

This policy change estimates the interim and final cost settlements for specialty mental health services.

Authority:

Welfare & Institution Code 14705(c)
 Title 9, California Code of Regulations 1840.105

Interdependent Policy Changes:

Not Applicable

Background:

Within two years following the end of a fiscal year, the Department must reconcile interim settlements to MHPs for children, adults, and Healthy Families specialty mental health services to county cost reports and process correcting payments or recoupments. Final settlement is to be completed within three years of the last amended cost report submitted by the county mental health plan.

The reconciliation process for each Fiscal Year may result in an overpayment or underpayment to the county and will be handled as follows:

- For counties that have been determined to be overpaid, the Department will recoup any overpayments.
- For counties that have been determined to be underpaid, the Department will make a payment equal to the difference between the counties cost report and the Medi-Cal payments.

Reason for Change from Prior Estimate:

The fiscal was revised based on the Department completing additional settlements.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72

Methodology:

1. Interim cost settlement is based upon the difference between each county mental health plan's filed cost report and the payments they received from the Department.
2. Final cost settlement is based upon the difference between each county mental health plan's final audited cost report and the payments they received from the Department.
3. Cost settlements for services, administration, utilization review/quality assurance, and mental health Medi-Cal administrative activities are each determined separately.
4. Cost settlements may result in an overpayment or underpayment to the county mental health plans. Cost settlements will be handled as follows:
 - For counties that have been determined to be overpaid, the Department will recoup the overpayments.
 - For counties that have been determined to be underpaid, the Department will pay the difference.

Interim Settlements FY 2008-09	(In Thousands)		
	<u>Underpaid</u>	<u>Overpaid</u>	<u>Net</u>
Children and Adults	\$7,466	(\$60,879)	(\$53,413)
M-CHIP*	\$254	(\$1,419)	(\$1,165)
Healthy Families*	\$1,869	(\$2,353)	(\$484)
Final Settlement			
Children and Adults	\$38,014	(\$10,152)	\$27,862
M-CHIP*	\$734	\$0	\$734
Healthy Families*	\$1,324	(\$1,492)	(\$168)
Total FY 2012-13	\$49,661	(\$76,295)	(\$26,634)
Interim Settlements FY 2009-10	(In Thousands)		
	<u>Underpaid</u>	<u>Overpaid</u>	<u>Net</u>
Children and Adults	\$50,739	(\$80,501)	(\$29,761)
M-CHIP*	\$2,942	(\$2,441)	\$501
Healthy Families*	\$671	(\$4,213)	(\$3,542)
FY 2010-11			
Children and Adults	\$51,005	(\$81,100)	(\$30,094)
M-CHIP*	\$2,942	(\$2,441)	\$501
Healthy Families*	\$671	(\$4,213)	(\$3,542)
Total FY 2013-14	\$108,970	(\$174,909)	(\$65,939)

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72

5. Cost settlements prior to realignment may consist of General Fund (GF) and federal funds.

	(In Thousands)		
	TF	GF	FFP
Children and Adults	(\$25,551)	\$1,151	(\$26,702)
M-CHIP*	(\$431)	\$0	(\$431)
Healthy Families*	(\$652)	\$0	(\$652)
Total FY 2012-13	(\$26,634)	\$1,151	(\$27,785)
Children and Adults	(\$59,855)	\$39,261	(\$99,116)
M-CHIP*	\$1,001	\$0	\$1,001
Healthy Families*	(\$7,085)	\$0	(\$7,085)
Total FY 2013-14	(\$65,939)	\$39,261	(\$105,200)

Funding:

Title XIX FFP (4260-101-0890)

Title XXI FFP (4260-113-0890)*

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 73
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1578

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$3,089,199,000	\$1,365,003,000
- STATE FUNDS	\$503,975,000	\$233,311,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,089,199,000	\$1,365,003,000
STATE FUNDS	\$503,975,000	\$233,311,000
FEDERAL FUNDS	\$2,585,224,000	\$1,131,692,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The LIHP is effective November 1, 2010, through December 31, 2013, under the BTR and consists of two components, the MCE and the Health Care Coverage Initiative (HCCI). The MCE will cover eligibles with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (CI). AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

Local government Certified Public Expenditures (CPEs) and Intergovernmental Transfers (IGTs) associated with capitated rate payments are used to obtain the federal funding for LIHP. The Department has used the CI cost claiming protocol for the MH/UCD as the basis for payments made on claims for dates of service in FY 2010-11 and the first quarter of FY 2011-12. The Centers for Medicare and Medicaid Services (CMS) allowed payments to follow this prior protocol through September 30, 2011. The Department submitted the new cost claiming protocol for health care services provided under the LIHP – Claims Based on CPEs to CMS for approval. CMS approved the new CPE cost claiming protocol on August 13, 2012. The Department currently uses the new CPE cost claiming protocol for payments made on claims for dates of service beginning the second quarter

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 73

of FY 2011-12. The Department submitted the cost claiming protocol for health care services provided under the LIHP – Claims Based on capitation to CMS for approval. CMS required the use of the capitated rate payment mechanism for the MCE component of LIHP. The Department submitted the capitated rate contract amendments on April 25, 2012 and letter of Certification of Capitation Rates on August 20, 2012 for the following eight local LIHPs for CMS approval: Alameda, Los Angeles, Kern, Riverside, San Bernardino, San Francisco, Santa Clara, and San Mateo. Upon CMS approval of the capitation protocol, the capitated rates, the capitated rate contract amendments, and the capitation rates for these local LIHPs will be effective retroactively to July 1, 2011.

The local LIHPs that choose the capitation payment mechanism and are approved by CMS to use this mechanism for federal reimbursement of the MCE component of their program, will continue to use CPEs for allowable program services that are excluded from their capitation rates to obtain federal funding. The local LIHPs that do not choose the capitation payment mechanism will only use CPEs to obtain federal funding. The MCE program is not subject to a federal funding cap.

Reason for Change from Prior Estimate:

Estimates have been revised based on CMS approval.

Methodology:

1. The eight local LIHPs with capitated rate contract amendments will continue to be paid using CPEs until the capitation cost claiming protocol is approved. Once approved, prior CPE payments retroactive to July 1, 2011 will be reconciled with the new capitated rate payments and CPEs for excluded services.
2. Assume reconciliation for FY 2011-12 payments to the new capitated rates will occur in FY 2012-13.
3. The payment reconciliation may result in an overpayment or underpayment in FFP. The Department will recover the appropriate amount of FFP from the affected local LIHPs.

The estimated MCE payments on a cash basis are:

(In thousands)				
FY 2012-13	TF	IGT	FFP	CPE
2010-11 (CPEs)	\$22,364	\$0	\$22,364	\$22,364
2011-12 (CPEs)	\$360,566	\$0	\$360,566	\$360,566
2011-12 (IGTs)	\$447,940	\$223,970	\$223,970	\$0
2012-13 (CPEs)	\$1,698,319	\$0	\$1,698,319	\$1,698,319
2012-13 (IGTs)	\$560,010	\$280,005	\$280,005	\$0
Total FY 2012-13	\$3,089,199	\$503,975	\$2,585,224	\$2,081,249
FY 2013-14	TF	IGT	FFP	CPE
2012-13 (CPEs)	\$223,329	\$0	\$223,329	\$223,329
2013-14 (CPEs)	\$675,052	\$0	\$675,052	\$675,052
2013-14 (IGTs)	\$466,622	\$233,311	\$233,311	\$0
Total FY 2013-14	\$1,365,003	\$233,311	\$1,131,692	\$898,381

BTR - LIHP - MCE
REGULAR POLICY CHANGE NUMBER: 73

Funding:

LIHP IGT Fund (4260-607-8502)

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

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 74
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1073

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,740,006,000	\$1,731,652,000
- STATE FUNDS	\$600,754,000	\$599,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,740,006,000	\$1,731,652,000
STATE FUNDS	\$600,754,000	\$599,500,000
FEDERAL FUNDS	\$1,139,252,000	\$1,132,152,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Effective July 1, 2005, based on State Plan Amendment (SPA) 05-022, the federal DSH allotment is available for uncompensated Medi-Cal and uninsured costs incurred by DSHs. The 2012-13 and 2013-14 DSH allotments are estimated to be \$1,132,152,000.

- Designated Public Hospitals (DPHs) receive their allocation of federal DSH payments from the Demonstration DSH Fund based on the hospitals' certified public expenditures (CPEs), up to 100% of uncompensated Medi-Cal and uninsured costs. DPHs may also receive allocations of federal and nonfederal DSH funds through intergovernmental transfer-funded payments for expenditures above 100% of costs, up to 175% of the hospitals' uncompensated Medi-Cal and uninsured costs.
- Non-Designated Public Hospitals (NDPHs) receive their allocation from the federal DSH allotment and State General Fund based on hospitals' uncompensated Medi-Cal and uninsured costs up to the Omnibus Budget Reconciliation Act of 1993 (OBRA) limits. OBRA 1993 limits NDPH DSH payments to 100% of the unreimbursed costs associated with serving Medi-Cal patients and the uninsured.

MH/UCD & BTR—DSH PAYMENT

REGULAR POLICY CHANGE NUMBER: 74

- Private DSH hospitals, under the Special Terms and Conditions, are allocated a total of \$160.00 from the federal DSH allotment and State General Fund (GF) each demonstration year. All DSH eligible Private hospitals receive a pro-rata share of the \$160.00.

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

Pursuant to the Affordable Care Act (ACA), DSH allotments will be reduced beginning FY 2013-14 through FY 2019-20. The reductions for each state will be determined by the Centers for Medicare and Medicaid Services (CMS). See the Disproportionate Share Hospital Reduction policy change for more information.

Reason for Change from Prior Estimate:

The changes are due to updated program expenditures.

Methodology:

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

(In Thousands)

	TF	GF**	FF	IGT*
FY 2012-13				
DSH 2008-09	\$5,182	\$2	\$5,180	\$0
DSH 2009-10	\$1,421	\$376	\$1,045	\$0
DSH 2010-11	\$3,035	\$1,517	\$1,517	\$0
DSH 2011-12	\$143,020	\$1,188	\$93,704	\$48,129
DSH 2012-13	\$1,587,348	\$11,000	\$1,037,806	\$538,542
	\$1,740,006	\$14,083	\$1,139,252	\$586,671
FY 2013-14				
DSH 2012-13	\$144,304	\$1,000	\$94,346	\$48,958
DSH 2013-14	\$1,587,348	\$11,000	\$1,037,806	\$538,542
	\$1,731,652	\$12,000	\$1,132,152	\$587,500

Funding:

Demonstration DSH Fund (4260-601-7502)

MIPA Fund (4260-606-0834)*

Title XIX 50/50 GF/DSH (4260-101-0001/7502)**

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

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 75
 IMPLEMENTATION DATE: 3/2011
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1570

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,437,063,000	\$1,400,000,000
- STATE FUNDS	\$718,531,500	\$700,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,437,063,000	\$1,400,000,000
STATE FUNDS	\$718,531,500	\$700,000,000
FEDERAL FUNDS	\$718,531,500	\$700,000,000

DESCRIPTION**Purpose:**

This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the Delivery System Reform Incentive Pool (DSRIP) to support California's Designated Public Hospitals' (DPH) efforts in enhancing the quality of care and the health of the patients and families they serve.

Authority:

AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.77
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

Not Applicable

Background:

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

There are four areas for which funding is available under the DSRIP in the Medi-Cal program:

- (1) Infrastructure Development
- (2) Innovation and Redesign
- (3) Population-focused Improvement
- (4) Urgent Improvement in Care

DPHs submitted their DSRIP proposal for approval and are paid based on meeting milestones. DPHs provide the non-federal share of their DSRIP through IGTs.

The total federal funding for DSRIP shall not exceed total computable expenditures of \$6.506 billion over the five Demonstration Years (DYs). Annual federal funds available will be the applicable Federal Medical Assistance Percentage (FMAP) of annual total computable expenditure limits as follows:

BTR— DPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 75

(In Thousands)

Demonstration Year	Total Computable	DSRIP
2010-11	\$ 1,006,880	\$ 591,601
2011-12	\$ 1,300,000	\$ 650,000
2012-13	\$ 1,400,000	\$ 700,000
2013-14	\$ 1,400,000	\$ 700,000

Reason for Change from Prior Estimate:

Less payments for DY 2011-12 were paid in FY 2011-12, allowing for an increase in payments of \$62,063,000 TF in FY 2012-13.

Methodology:

- In DY 2011-12 and subsequent demonstration years, payments are expected to be made in March of the same fiscal year and September of the subsequent fiscal year.
- DSRIP payments are estimated to be:

(In Thousands)

FY 2012-13

	TF	FF	IGT
DY 2011-12	\$387,063	\$193,531	\$193,532
DY 2012-13	\$1,050,000	\$525,000	\$525,000
	\$1,437,063	\$718,531	\$718,532

FY 2013-14

DY 2012-13	\$350,000	\$175,000	\$175,000
DY 2013-14	\$1,050,000	\$525,000	\$525,000
	\$1,400,000	\$700,000	\$700,000

Funding:

Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)
Title XIX FFP (4260-101-0890)

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 76
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1071

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$506,702,000	\$541,279,000
- STATE FUNDS	\$253,351,000	\$270,639,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$506,702,000	\$541,279,000
STATE FUNDS	\$253,351,000	\$270,639,500
FEDERAL FUNDS	\$253,351,000	\$270,639,500

DESCRIPTION**Purpose:**

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

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.11
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 SB 90 (Chapter 19, Statutes of 2011)
 SB 335 (Chapter 286, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

As part of the MH/UCD and BTR, changes were made to hospital inpatient DSH and other supplemental payments. Beginning July 1, 2005, based on SB 1100, private hospitals receive Medi-Cal DSH replacement payment adjustments. The payments are determined using the formulas and methodology that were previously in effect for the 2004-05 fiscal year. These payments along with \$160.00 of the annual DSH allotment satisfy the State's payment obligations under the Federal DSH statute.

The federal share of the DSH replacement payments is regular Title XIX funding and will not be claimed from the federal DSH allotment. The non-federal share of these payments is State General Fund.

Pursuant to the Affordable Care Act (ACA), DSH allotments will be reduced beginning FY 2013-14 through FY 2019-20. The reductions for each state will be determined by the Centers for Medicare and Medicaid Services (CMS). The private DSH replacement payments are affected because, as required by SB 1100, the methodology to determine the DSH replacement payments is based on the DSH allotment. See the Private DSH Replacement Payment Reduction policy change for more information.

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 76

Reason for Change from Prior Estimate:

The change in FY 2012-13 is due to the removal of 2009-10 payments and the inclusion of 2008-09 and 2010-11 payments. Payments for 2011-12 are anticipated to be delayed and paid in FY 2013-14.

Methodology:

- 2008-09 payments resulting from data corrections and 2010-11 final payments are assumed to be paid in FY 2012-13.
- SB 90 reduces Medi-Cal DSH replacement payments to private hospitals by \$150 million TF (\$75 million GF) in FY 2011-12.
- Approximately one month of 2011-12 payments is assumed to be paid in FY 2013-14. The prorated FY 2011-12 SB 90 reductions are \$12,277,000 TF (\$6,138,500 GF) in FY 2013-14.
- SB 335 reduces Medi-Cal DSH replacement payments to private hospitals by \$21 million TF (\$10.5 million GF) in FY 2012-13 and \$10.5 million TF (\$5.25 million GF) in FY 2013-14.
- 11 months of 2012-13 payments are assumed to be paid in FY 2012-13 and one month is assumed to be paid in FY 2013-14. The prorated FY 2012-13 SB 335 reductions are \$19,250,000 TF (\$9,625,000 GF) in FY 2012-13 and \$1,750,000 TF (\$875,000 GF) in FY 2013-14.
- 11 months of 2013-14 payments are assumed to be paid in FY 2013-14. The prorated FY 2013-14 SB 335 reductions are \$9,625,000 TF (\$4,812,500 GF) in FY 2013-14.

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

FY 2012-13	TF	GF	FFP
2008-09	\$209,000	\$104,500	\$104,500
2010-11	\$46,094,000	\$23,047,000	\$23,047,000
2012-13	\$479,649,000	\$239,824,500	\$239,824,500
SB 335	(\$19,250,000)	(\$9,625,000)	(\$9,625,000)
Net	\$460,399,000	\$230,199,500	\$230,199,500
Total FY 2012-13	\$506,702,000	\$253,351,000	\$253,351,000
FY 2013-14			
2011-12	\$41,678,000	\$20,839,000	\$20,839,000
SB 90	(\$12,277,000)	(\$6,138,500)	(\$6,138,500)
Net	\$29,401,000	\$14,700,500	\$14,700,500
2012-13	\$43,604,000	\$21,802,000	\$21,802,000
SB 335	(\$1,750,000)	(\$875,000)	(\$875,000)
Net	\$41,854,000	\$20,927,000	\$20,927,000

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 76

2013-14	\$479,649,000	\$239,824,500	\$239,824,500
SB 335	<u>(\$9,625,000)</u>	<u>(\$4,812,500)</u>	<u>(\$4,812,500)</u>
Net	\$470,024,000	\$235,012,000	\$235,012,000
Total FY 2013-14	\$541,279,000	\$270,639,500	\$270,639,500

Funding:

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

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 77
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1573

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$390,166,000	\$317,250,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$390,166,000	\$317,250,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$390,166,000	\$317,250,000

DESCRIPTION**Purpose:**

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

Authority:

AB 1066 (Chapter 86, Statutes of 2011), Welfare & Institutions Code 14166.71
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

Not Applicable

Background:

Effective for dates of service on or after November 1, 2010 until October 31, 2015, based on the Special Terms and Conditions of the BTR, a new SNCP was established to support the provision of services to the uninsured. The SNCP is to be distributed through the certified public expenditures (CPEs) of DPHs for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

The Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD) was extended for two months, until October 31, 2010. Funding for the two-month extension of the prior MH/UCD SNCP is included in Demonstration Year (DY) 6 of the BTR demonstration. This policy change estimates the SNCP for the DPHs for the two-month extension for the prior demonstration and for the BTR. SNCP funding for the State-Only Funded Programs under the BTR is budgeted in the BTR—Designated State Health Programs policy change.

Reason for Change from Prior Estimate:

There is no change.

BTR—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 77

Methodology:

- Interim payments are made to the DPHs on a quarterly basis, in four equal payments, with the exception of the fourth quarter payment being made in two payments. Payments are made in October, January, April, June, and July. The June payment includes the months of April and May, while the July payment is for the month of June.
- The estimated SNCP FFP on an accrual basis for the state-funded programs and the DPHs are:

(In Thousands)	State-Only Funded Programs	Due to DPHs
Demonstration Year		
2010-11	\$400,000	\$565,422
2011-12	\$400,000	\$436,000
2012-13	\$400,000	\$386,000
2013-14	\$400,000	\$311,000

- Assume 11/12 of the DPH payments for a DY are made during the same fiscal year and the remaining 1/12 is paid in the subsequent fiscal year.
- The estimated payments to the DPHs on a cash basis are:

(In Thousands)	FY 2012-13	FY 2013-14
Demonstration Year		
2011-12	\$36,333	
2012-13	\$353,833	\$32,167
2013-14		\$285,083
Total	\$390,166	\$317,250

Funding:

Health Care Support Fund (4260-601-7503)

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 78
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1572

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$315,881,000	\$67,429,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$315,881,000	\$67,429,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$315,881,000	\$67,429,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The LIHP, effective November 1, 2010 through December 31, 2013, consists of two components, the Medicaid Coverage Expansion (MCE) and the HCCI. The MCE will cover eligibles with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI will cover those with family incomes above 133% through 200% of the FPL. Both are statewide county elective programs. The LIHP HCCI replaced the HCCI under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (CI) which was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

Local government certified public expenditures (CPEs), and intergovernmental transfers (IGTs) associated with capitated rate payments, are used to obtain the federal funding for the LIHP. The Department has used the CI cost claiming protocol as the basis for payments made on claims for dates of service in FY 2010-11 and the first quarter of FY 2011-12. The Department submitted the new cost claiming protocol for health care services provided under the LIHP – claims based on CPEs to the Centers for Medicare and Medicaid Services (CMS) for approval. The MCE program is not subject to a federal funding cap while HCCI funding is subject to a cap of \$180 million each full demonstration year. Federal funding will be provided through the Health Care Support Fund (HCSF).

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 78

Federal funding for the program is capped at \$360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13, and \$180 million for DY 2013-14. However, local spending under the HCCI has not reached \$360 million. The Department has obtained approval of a waiver amendment from the CMS to reallocate unspent HCCI money to the SNCP uncompensated care component.

Reason for Change from Prior Estimate:

Payments have been revised based on CMS approval of the waiver amendment to reallocate unspent HCCI money.

Methodology:

1. The estimated HCCI payments on a cash basis are:

FY 2012-13	TF	FFP	CPE*
2010-11	\$36,137,000	\$36,137,000	\$36,137,000
Rollover 2010-11	\$88,000,000	\$88,000,000	\$88,000,000
2011-12	\$35,312,000	\$35,312,000	\$35,312,000
Rollover 2011-12	\$73,000,000	\$73,000,000	\$73,000,000
2012-13	\$44,432,000	\$44,432,000	\$44,432,000
Rollover 2012-13	\$39,000,000	\$39,000,000	\$39,000,000
Total	\$315,881,000	\$315,881,000	\$315,881,000

FY 2013-14	TF	FFP	CPE*
2011-12	\$18,623,000	\$18,623,000	\$18,623,000
Rollover 2012-13	\$10,000,000	\$10,000,000	\$10,000,000
2013-14	\$38,806,000	\$38,806,000	\$38,806,000
Total	\$67,429,000	\$67,429,000	\$67,429,000

Funding:

Health Care Support Fund (4260-601-7503)
Title XIX 100% FFP (4260-101-0890)

*Not included in Total Fund

MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 79
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1085

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$249,080,000	\$213,000,000
- STATE FUNDS	\$124,540,000	\$106,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$249,080,000	\$213,000,000
STATE FUNDS	\$124,540,000	\$106,500,000
FEDERAL FUNDS	\$124,540,000	\$106,500,000

DESCRIPTION

Purpose:

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

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code (W&I) 14166.12
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 AB 1467 (Chapter 23, Statutes of 2012), W&I Code, section 14166.14

Interdependent Policy Changes:

PC 106 Hospital Stabilization

Background:

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

Private hospitals will receive payments from the Private Hospital Supplemental Fund (Item 4260-601-3097) using General Fund, intergovernmental transfers (IGTs), interest accrued in the Private Hospital Supplemental Fund as the non-federal share of payments, and 33.60% of the Stabilization funding for private hospitals as calculated by the formulas set forth in SB 1100 and SB 474 (Chapter 518, Statutes of 2007). This funding, along with the federal reimbursement, will replace the amount of funding the private hospitals previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers), the Graduate Medical Education Program (GME), and the Small and Rural Hospital Supplemental Payment Program (Fund 0688).

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

**MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL
PAYMENT**
REGULAR POLICY CHANGE NUMBER: 79

Selective Provider Contracting Program (OSPCCP).

Reason for Change from Prior Estimate:

The changes are due to updated program expenditures.

Methodology:

1. The State Funds (SF) item includes the annual General Fund appropriation, unspent funds from prior year, interest that has been accrued/estimated, and IGTs. The annual appropriation has been reduced to reflect that the expenditures are on a cash basis.
2. Interest earned in a fiscal year will be available for distribution in the following fiscal year.
3. IGTs are estimated to total \$12,000,000 in FY 2012-13 and FY 2013-14, generating \$6,000,000 in FFP each year.
4. Stabilization funding for private hospitals is calculated based on the interim reconciliation and won't be paid out until the interim payout process is developed.
5. Distribution of the Private Hospital Supplemental Fund will be determined through negotiations with the OSPCCP. The ending balance shown is on a cash basis and does not necessarily mean that the remaining funds are available. Funds in the ending balance may be committed and scheduled to be expended in the following year.
6. SB 87 (Chapter 33, Statutes of 2011) authorizes the transfer of \$32,700,000 from the Private Hospital Supplemental Fund to the State General Fund in FY 2011-12.
7. SB 335 (Chapter 286, Statutes of 2011) reduces the Private Hospital Supplemental Fund by \$17,500,000 in FY 2012-13 and \$8,750,000 in FY 2013-14.
8. AB 1467 authorizes the redirection of stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to the GF. GF savings are budgeted in the Hospital Stabilization policy change.
9. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.

**MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL
PAYMENT
REGULAR POLICY CHANGE NUMBER: 79**

	<u>TF</u>	<u>SF</u>	<u>FFP</u>
FY 2011-12			
FY 2010-11 Ending Balance	\$135,030,000	\$67,515,000	\$67,515,000
Appropriation (from GF)	\$236,800,000	\$118,400,000	\$118,400,000
FY 2010-11 interest	\$802,000	\$401,000	\$401,000
Est. 2005-06 Stabilization Transfer	\$3,556,000	\$1,778,000	\$1,778,000
IGT	\$16,000,000	\$8,000,000	\$8,000,000
Total	\$392,188,000	\$196,094,000	\$196,094,000
Cash Expenditures to Hospitals	\$252,104,000	\$126,052,000	\$126,052,000
Cash Expenditures to GF	\$65,400,000	\$32,700,000	\$32,700,000
FY 2011-12 Ending Balance	\$74,684,000	\$37,342,000	\$37,342,000
FY 2012-13			
FY 2011-12 Ending Balance	\$74,684,000	\$37,342,000	\$37,342,000
Appropriation (from GF)	\$236,800,000	\$118,400,000	\$118,400,000
Est. FY 2011-12 interest	\$170,000	\$85,000	\$85,000
Est. 2006-07 Stabilization Transfer	\$6,432,000	\$3,216,000	\$3,216,000
Est. 2008-09 Stabilization Transfer	\$1,308,000	\$654,000	\$654,000
Est. 2009-10 Stabilization Transfer	\$24,784,000	\$12,392,000	\$12,392,000
IGT	\$12,000,000	\$6,000,000	\$6,000,000
Total	\$356,178,000	\$178,089,000	\$178,089,000
Cash Expenditures to Hospitals	\$213,000,000	\$106,500,000	\$106,500,000
Redirect Stabilization Fund to GF	\$36,080,000	\$18,040,000	\$18,040,000
SB 335 Reduction	\$35,000,000	\$17,500,000	\$17,500,000
FY 2012-13 Ending Balance	\$72,098,000	\$36,049,000	\$36,049,000
FY 2013-14			
FY 2012-13 Ending Balance	\$72,098,000	\$36,049,000	\$36,049,000
Appropriation (from GF)	\$236,800,000	\$118,400,000	\$118,400,000
Est. FY 2012-13 interest	\$352,000	\$176,000	\$176,000
IGT	\$12,000,000	\$6,000,000	\$6,000,000
Total	\$321,250,000	\$160,625,000	\$160,625,000
Cash Expenditures to Hospitals	\$213,000,000	\$106,500,000	\$106,500,000
SB 335 Reduction	\$17,500,000	\$8,750,000	\$8,750,000
FY 2013-14 Ending Balance	\$90,750,000	\$45,375,000	\$45,375,000

Funding:

Private Hospital Supplemental Fund (4260-601-3097)
Title XIX FFP (4260-101-0890)
Title XIX 50/50 FFP (4260-101-0001/0890)

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 80
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1622

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$172,800,000	\$259,200,000
- STATE FUNDS	\$86,400,000	\$129,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$172,800,000	\$259,200,000
STATE FUNDS	\$86,400,000	\$129,600,000
FEDERAL FUNDS	\$86,400,000	\$129,600,000

DESCRIPTION

Purpose:

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

Authority:

SB 335 (Chapter 286, Statutes of 2011)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 SB 920 (Hernandez, Statutes of 2012)

Interdependent Policy Changes:

PC 154 Hospital QAF – Hospital Payments

Background:

SB 335 establishes the LIHP MCE Out-of-Network Emergency Care Services Fund, effective July 1, 2011 to December 31, 2013. Moneys shall be allocated from the fund by the Department to be matched with federal funds in accordance with the Special Terms and Conditions for the BTR. The Department shall disburse moneys from the fund to the LIHPs solely for the purposes of funding the out-of-network hospital emergency care services for emergency medical conditions and required poststabilization care provided by private hospitals that are outside the LIHP coverage network. This program is currently pending approval from the Centers for Medicare and Medicaid Services (CMS). SB 920 changes the amount transferred from the Hospital Quality Assurance Revenue Fund (HQARF) and subsequent payments. SB 920 further removes the non-designated public hospitals eligibility for this program.

Reason for Change from Prior Estimate:

Revisions to the HQARF and eligibility.

Methodology:

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

**LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS
FUND
REGULAR POLICY CHANGE NUMBER: 80**

2. LIHPs will provide utilization data for FY 2011-12 and FY 2012-13 to the Department after the fiscal year. The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations. As a result, payments for these fiscal years will be paid in the subsequent fiscal year. The program ends December 31, 2013.
3. The HQARF will transfer funds to the LIHP Medicaid Coverage Expansion (MCE) Out-of-Network Emergency Care Services Fund.
4. The LIHP funds will be used to reimburse out-of-network hospitals.
5. IGTs will be deposited into and paid from the LIHP MCE Out-of-Network Emergency Care Services Fund.
6. The HQARF transfer will be displayed in the Hospital QAF – Hospital Payments policy change.

(In Thousands)				
FY 2012-13	<u>TF</u>	<u>IGT</u>	<u>LIHP</u>	<u>FF</u>
2011-12	\$172,800	\$20,000	\$66,400	\$86,400
FY 2013-14	<u>TF</u>	<u>IGT</u>	<u>LIHP</u>	<u>FF</u>
2012-13	\$172,800	\$20,000	\$66,400	\$86,400
2013-14	\$86,400	\$10,000	\$33,200	\$43,200
Total	\$259,200	\$30,000	\$99,600	\$129,600

Funding:

Reimbursement Fund (4260-610-0995)

LIHP MCE OON Emergency Care Services Fund (4260-610-3201)

Title XIX FFP (4260-101-0890)

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 81
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1698

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$100,000,000	\$5,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$100,000,000	\$5,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$100,000,000	\$5,000,000

DESCRIPTION**Purpose:**

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

BTR—INCREASE SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 81

Reason for Change from Prior Estimate:

The change in FY 2013-14 is due to a decrease in the amount of funding available to rollover.

Methodology:

1. The total computable federal funding is \$360 million for DYs 2010-11, 2011-12, and 2012-13.
2. The Department projects LIHP-HCCI expenditures will be \$184 million in DY 2010-11, \$214 million in DY 2011-12, and \$263 million in DY 2012-13.
3. At a Federal Medical Assistance Percentage (FMAP) of 50%, \$88 million FFP is available to rollover from DY 2010-11, \$73 million FFP is available to rollover from DY 2011-12, and \$49 million FFP will be available to rollover from DY 2012-13.
4. Assume funds will be split 50/50 between the state and DPHs.

(In Millions)		
FY 2012-13	FFP	GF
HCCI Rollover		
DY 2010-11	(\$88.00)	\$0.00
DY 2011-12	(\$73.00)	\$0.00
DY 2012-13	(\$39.00)	\$0.00
Total	(\$200.00)	\$0.00
SNCP-DPHs	\$100.00	\$0.00
SNCP-DSHPs	\$100.00	(\$100.00)
FY 2013-14		
HCCI Rollover		
DY 2012-13	(\$10.00)	\$0.00
SNCP-DPHs	\$5.00	\$0.00
SNCP-DSHPs	\$5.00	(\$5.00)

Funding:

Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—DPH & NDPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 82
 IMPLEMENTATION DATE: 5/2008
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1078

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$98,709,000	\$97,450,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$98,709,000	\$97,450,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$98,709,000	\$97,450,000

DESCRIPTION

Purpose:

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

Authority:

Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

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

AB 1467 changes the NDPH reimbursement methodology to a CPE methodology. The Department will submit a SPA to allow NDPHs to receive reimbursement based on CPEs for their uncompensated costs incurred for physician and non-physician practitioner professional services effective July 1, 2012.

The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. Each DPH's and NDPH's physician and non-physician costs will be reconciled to the Medi-Cal 2552-96 cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

**MH/UCD & BTR—DPH & NDPH PHYSICIAN & NON-PHYS.
COST
REGULAR POLICY CHANGE NUMBER: 82**

Reason for Change from Prior Estimate:

The change is due to \$5.9 million in 2011-12 service claims that will be paid in FY 2012-13, an increase of \$3.5 million in 2012-13 service claims, and the inclusion of \$18.6 million in NDPH payments.

Methodology:

1. Payments for the DPH June 2012 dates of service claims are expected to be made in FY 2012-13. In FY 2012-13 and 2013-14, one annual payment will be made for DPHs and NDPHs.
2. Reconciliation/final settlement of the first program year 2005-06 is anticipated to be completed during FY 2012-13 upon conclusion of the Physician/Non-Physician Practitioner time studies that are a required component of the reconciliation process.

(In Thousands)	Estimated Expenditures	
FY 2012-13	TF	FFP
DPH 2011-12	\$ 5,900	\$ 5,900
DPH 2012-13	\$ 74,247	\$ 74,247
NDPH 2012-13	\$ 18,562	\$ 18,562
Total	\$ 98,709	\$ 98,709
FY 2013-14		
DPH	\$ 77,960	\$ 77,960
NDPH	\$ 19,490	\$ 19,490
Total	\$ 97,450	\$ 97,450

Funding:

Title XIX FFP (4260-101-0890)

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 83
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1153

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$98,006,000	\$9,473,000
- STATE FUNDS	\$62,681,000	\$9,473,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$98,006,000	\$9,473,000
STATE FUNDS	\$62,681,000	\$9,473,000
FEDERAL FUNDS	\$35,325,000	\$0

DESCRIPTION**Purpose:**

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

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.75
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration
 AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:

Not Applicable

Background:

Stabilization funding is provided as follows:

- Non-designated public hospitals (NDPHs) will receive total funds payments equal to the difference between:
 - a. The NDPHs' aggregate payment increase, and
 - b. The sum of \$0.544 million and 0.64% of total stabilization funding.
- Private Hospitals will receive total funds payment equal to the difference between:
 - a. The Private Hospitals' aggregate payment increase, and
 - b. The sum of \$42.228 million and an additional amount, based on the formulas specified in W&I Code 14166.20.
- Distressed Hospitals will receive total funds payments equal to the lesser of \$23.5 million or 10% of total stabilization funding, with a minimum of \$15.3 million.
- DPHs will receive General Fund (GF) payments to the extent that the state-funded programs certified public expenditures (CPEs) are used for federal financial participation (FFP) from the Safety Net Care Pool (SNCP) and the corresponding GF savings exceed what is needed for the stabilization funding to the NDPHs, Private Hospitals, and Distressed Hospitals.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 83

Reason for Change from Prior Estimate:

The amounts and timing of the DPH stabilization payments have been updated. DPH stabilization payments for 2005-06 and 2008-09 were delayed to the next fiscal year, FY 2012-13 and FY 2013-14, respectively. DPH stabilization payments for 2007-08 are anticipated to be paid in FY 2012-13.

In addition, FY 2009-10 savings from redirected stabilization funds were used to offset payments to hospitals, thus reducing the FY 2009-10 redirected savings by \$23.78 million TF.

Methodology:

1. Stabilization funding is calculated after the interim reconciliation of the DPH interim payments is completed.
2. Until the final reconciliation of the SNCP payments is complete, the final stabilization payments to the NDPHs, Private Hospitals, Distressed Hospitals, and DPHs are not known.
3. Stabilization funding to NDPHs, private hospitals, and distressed hospitals is comprised of GF made available from the federalizing of four state-only programs and applicable FFP. Any payments made from the stabilization funding to DPHs will consist only of the GF portion budgeted, as DPHs are not allowed to draw additional FFP from any stabilization funding. Currently, all GF is matched with FFP until the final stabilization payments are calculated.
4. Once the final reconciliation is finalized, the Department will be able to determine the distribution of the stabilization funds.
 - Stabilization funds to DPHs, if any, will be GF only. DPHs will not receive the federal fund match.
 - Stabilization funds to NDPHs, if any, will be split. The Department will distribute 75% of any allocated NDPH stabilization funds directly and the remaining 25% will be transferred to the NDPH Supplemental Fund. Payments through the NDPH Supplemental fund are negotiated between the hospitals and the Office of the Selective Provider Contracting Program (OSPCP).
 - Stabilization funds to Private Hospitals, if any, will be split. The Department will distribute 66.4% of any allocated Private Hospital stabilization funds directly and the remaining 33.6% will be distributed to the Private Hospital Supplemental Fund. Payments through the Private Hospital Supplemental fund are negotiated between the hospitals and OSPCP.
 - Distressed Hospital payments will be distributed as negotiated between the hospitals and OSPCP.
5. The MH/UCD was extended for 60 days to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. Stabilization Funding is not applicable under the BTR. Funding for the 60-day extension of the prior MH/UCD SNCP is included in the new BTR.
6. A total of \$36,078,000 TF (\$18,039,000 GF) will be transferred to the Private Hospital Supplemental Fund. This amount will be paid from the MH/UCD & BTR—Private Hospital Supplemental Payment policy change.
7. A total of \$538,000 TF (\$269,000 GF) will be transferred to the NDPH Supplemental Fund. This

MH/UCD—STABILIZATION FUNDING**REGULAR POLICY CHANGE NUMBER: 83**

amount will be paid from the MH/UCD & BTR—NDPH Supplemental Payment policy change.

8. Pursuant to AB 1467, the Department redirected the stabilization funding available to the NDPHs and private hospitals that was not paid for FY 2005-06 through FY 2009-10 to the GF. GF savings are budgeted in the Hospital Stabilization policy change.
9. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission (CMAC) under section 14165(b) of the W&I Code.
10. A total of \$23.78 million TF (\$11.89 million GF) of the savings from the redirection of stabilization funding for FY 2009-10 was used to make payments to hospitals that incorrectly received underpayments for FY 2005-06 and FY 2006-07. As a result, savings from FY 2009-10 private hospital redirected stabilization funds were reduced by the amount of the payment.

MH/UCD—STABILIZATION FUNDING

REGULAR POLICY CHANGE NUMBER: 83

The estimated stabilization payments are:

FY 2012-13		
	TF	GF
2005-06		
DPHs*	\$17,655,000	\$17,655,000
Redirect to GF-Private	\$7,022,000	\$3,511,000
2005-06 Total	\$24,677,000	\$21,166,000
2006-07		
DPHs*	\$777,000	\$777,000
Redirect to GF-Private	\$12,714,000	\$6,357,000
2006-07 Total	\$13,491,000	\$7,134,000
2007-08		
DPHs*	\$8,924,000	\$8,924,000
Redirect to GF-NDPH	\$1,614,000	\$807,000
Distressed	\$9,350,000	\$4,675,000
2007-08 Total	\$19,888,000	\$14,406,000
2008-09		
Redirect to GF-Private	\$2,586,000	\$1,293,000
Distressed	\$5,866,000	\$2,933,000
2008-09 Total	\$8,452,000	\$4,226,000
2009-10		
Distressed	\$6,298,000	\$3,149,000
Redirect to GF-Private	\$48,980,000	\$24,490,000
Payments to hospitals receiving underpayments	(\$23,780,000)	(\$11,890,000)
2009-10 Total	\$31,498,000	\$15,749,000
Total FY 2012-13	\$98,006,000	\$62,681,000
 FY 2013-14		
2008-09		
DPHs*	\$9,473,000	\$9,473,000
Total FY 2013-14	\$9,473,000	\$9,473,000

Funding:

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

GF (4260-101-0001)*

MH/UCD—DPH INTERIM & FINAL RECONS

REGULAR POLICY CHANGE NUMBER: 84
 IMPLEMENTATION DATE: 10/2007
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1152

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$81,545,000	\$227,400,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$81,545,000	\$227,400,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$81,545,000	\$227,400,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the Special Terms and Conditions of MH/UCD and BTR, each DPH's fiscal year interim per diem rate, comprised of 100% federal funds, for inpatient hospital costs for Medi-Cal beneficiaries will be reconciled to its filed Medi-Cal 2552-96 cost report for the respective fiscal year ending. Payments resulting from the Interim Reconciliation will be funded with federal funds. The reconciliations, interim and final, are based on the hospitals' Certified Public Expenditures (CPE).

This reconciliation process may result in an overpayment or underpayment to a DPH and will be handled as follows:

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and a DPH's payments consisting of: share of cost, third party liability, other health coverage, Medicare, and Medi-Cal administrative day, crossover, and interim payments.

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

MH/UCD—DPH INTERIM & FINAL RECONS**REGULAR POLICY CHANGE NUMBER: 84****Reason for Change from Prior Estimate:**

The change in FY 2012-13 is due to delays in final reconciliations causing 2005-06 to be paid in FY 2012-13 and 2007-08 to be paid in FY 2013-14. In addition, the 2005-06 final reconciliation amounts were updated.

Methodology:

1. DPHs' interim reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the filed Medi-Cal 2552-96 cost report costs and their respective payments.
2. DPH's final reconciliation for all years under the Demonstration will be the difference between the FMAP rate of the audited Medi-Cal 2552-96 cost report costs and the respective payments.
3. The final reconciliation for 2005-06 is expected to be completed by December 2012. When reconciled with the tentative settlement of \$42,891,000, there is an estimated payout of \$14,145,000.
4. The final reconciliation for 2006-07 is expected to be completed by June 2013 and is estimated to be \$67,400,000. There are no plans to issue a tentative settlement for 2006-07.
5. The final reconciliation for 2007-08 is expected to be completed by December 2013 and is estimated to be \$91,900,000. There are no plans to issue a tentative settlement for 2007-08.
6. The final reconciliation for 2008-09 is expected to be completed by June 2014 and is estimated to be \$135,500,000. There are no plans to issue a tentative settlement for 2008-09.

FY 2012-13	FFP
2005-06 Final Reconciliation	\$14,145,000
2006-07 Final Reconciliation	\$67,400,000
Total	\$81,545,000
FY 2013-14	
2007-08 Final Reconciliation	\$91,900,000
2008-09 Final Reconciliation	\$135,500,000
Total	\$227,400,000

Funding:

Title XIX FFP (4260-101-0890)

NDPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 85
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1689

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$80,000,000	\$125,000,000
- STATE FUNDS	\$40,000,000	\$62,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$80,000,000	\$125,000,000
STATE FUNDS	\$40,000,000	\$62,500,000
FEDERAL FUNDS	\$40,000,000	\$62,500,000

DESCRIPTION

Purpose:

This policy change estimates the intergovernmental transfers (IGTs) and the federal funds for the Delivery System Reform Incentive Pool (DSRIP) to support California's Non-Designated Public Hospitals' (NDPHs) efforts in enhancing the quality of care and the health of the patients and families they serve.

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare & Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) effective November 1, 2010. The BTR establishes the DSRIP for Designated Public Hospitals (DPHs). The Department is seeking approval of a waiver amendment from CMS to increase federal funding through a new DSRIP fund for NDPHs.

There are four areas for which funding is available under the NDPH DSRIP:

- (1) Infrastructure Development
- (2) Innovation and Redesign
- (3) Population-focused Improvement
- (4) Urgent Improvement in Care

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

NDPH DELIVERY SYSTEM REFORM INCENTIVE POOL

REGULAR POLICY CHANGE NUMBER: 85

Annual federal funds available will be the applicable Federal Medical Assistance Percentage (FMAP) of annual total computable expenditure limits as follows:

(In Thousands)		
Demonstration Year	Total Computable	DSRIP
2012-13	\$80,000	\$40,000
2013-14	\$125,000	\$62,500

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

Reason for Change from Prior Estimate:

The change in FY 2012-13 is due to updated data.

Methodology:

1. DSRIP payments will be based on CMS approval on the amount of federal funds that can be claimed and the amount of IGTs provided by the NDPHs.
2. DSRIP payments are estimated to be:

(In Thousands)			
FY 2012-13	TF	FF	IGT
DY 2012-13	<u>\$80,000</u>	<u>\$40,000</u>	<u>\$40,000</u>
FY 2013-14			
DY 2013-14	\$125,000	\$62,500	\$62,500

Funding:

Public Hospital Investment, Improvement, and Incentive Fund (4260-601-3172)
Title XIX FFP (4260-101-0890)

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 86
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1576

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$72,462,000	\$31,056,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$72,462,000	\$31,056,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$72,462,000	\$31,056,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

AB 1628 and SB 92 authorize the Department to claim federal funding for inpatient hospital services for certain inmates of CDCR correctional facilities. The inpatient hospital services would be those that are provided at hospitals that are off the grounds of the correctional facilities and the inmates would be those with family incomes at or below 133% of the Federal Poverty Level determined eligible by the Department for either the Medi-Cal program or the LIHP operated by the counties. The LIHP is established under the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR).

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

CDCR/California Correctional Health Care Services (CCHCS) will forward applications to the Department for the purpose of determining LIHP eligibility. CDCR/CCHCS will pay the hospitals under contract for covered inpatient services. CDCR/CCHCS will provide paid claims data to the individual county programs for certification and attestation of the Certified Public Expenditures (CPEs) and allowable inpatient hospital services for reimbursement of federal funding at the usual FMAP.

**BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR
INMATES
REGULAR POLICY CHANGE NUMBER: 86**

Reason for Change from Prior Estimate:

Three local LIHPs executed their contracts with CDCR/CCHCS and the remaining 13 anticipate to execute contracts with CDCR/CCHCS in FY 2012-13.

Methodology:

1. CDCR/CCHCS began to submit LIHP claims for inpatient hospital services beginning in March 2012 for services provided retroactive to July 2011.
2. Applications for LIHP will be processed by the Department and no additional county administrative costs will be incurred.
3. Assume the Department will process 375 applications per month for LIHP eligible inmates in FY 2011-12, FY 2012-13, FY 2013-14.
4. SB 92 authorizes CDCR/CCHCS to sign applications on behalf of inmates.
5. Assume that 96% of processed inmate LIHP applications will be approved.

375 x 96% = 360 applications
6. The average cost per inpatient admission is estimated to be \$19,170.
7. Inmates enrolled in LIHP will transition to Medi-Cal upon full health care reform implementation on January 1, 2014.
8. The annual cost will be:
 - FY 2011-12: 360 inpatient admissions per month x 12 months x \$19,170 per inpatient stay x 50.00% FMAP = \$41,407,000 FFP
9. Assume dates of service began July 1, 2011.
10. Claiming protocols were approved by the Centers for Medicare and Medicaid Services (CMS) in August 2012. The estimated amount of \$41,407,000 in claims for FY 2011-12 will be claimed in FY 2012-13.
11. For FY 2012-13 payments, assume three quarters will be paid in FY 2012-13 and one quarter will be paid in FY 2013-14.
12. Assuming health care reform will be implemented on January 1, 2014 and LIHP will transition into Medi-Cal, the estimated costs incurred for FY 2013-14 will be:
360 inpatient admissions per month x 6 months x \$19,170 per inpatient stay
x 50.00% FMAP = \$20,704,000 FFP

The estimated payments for inmates on a cash basis are:

FY 2012-13	TF	FFP	CPE
FY 2011-12	\$82,814,000	\$41,407,000	\$41,407,000
FY 2012-13	\$62,110,000	\$31,055,000	\$31,055,000
	\$144,924,000	\$72,462,000	\$72,462,000

**BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR
INMATES**
REGULAR POLICY CHANGE NUMBER: 86

FY 2013-14	TF	FFP	CPE
FY 2012-13	\$20,704,000	\$10,352,000	\$10,352,000
FY 2013-14	\$41,408,000	\$20,704,000	\$20,704,000
	\$62,112,000	\$31,056,000	\$31,056,000

Funding:

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

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 87
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1108

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$71,004,000	\$71,004,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$71,004,000	\$71,004,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$71,004,000	\$71,004,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

PC 93 BTR—Designated State Health Programs

Background:

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

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

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 87

Reason for Change from Prior Estimate:

There is no change.

Methodology:

- Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF savings is reflected in the Family Health Estimate. The GF savings created will be used to support safety net hospitals under the MH/UCD and BTR.
- Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional \$423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change budgets those federal funds that are claimed using CPEs from the CCS and GHPP programs.
- The Department will conduct the final reconciliations for DY 2009-10 in FY 2012-13 and estimates that the Department will have to repay the federal government \$15.967 million in FY 2012-13 as a result of the final reconciliations. The CCS and GHPP federal reimbursements are reduced by the final reconciliation amounts in this policy change.
- The final reconciliation for DY 2010-11, anticipated to be completed in FY 2013-14, is estimated to be the same as the final reconciliation in DY 2009-10.

The estimated CCS/GHPP federal reimbursements are:

	CCS	GHPP	Total
FY 2005-06	\$ 15,523,000	\$ 8,485,000	\$ 24,008,000
FY 2006-07	\$ 46,856,000	\$ 15,300,000	\$ 62,156,000
FY 2007-08	\$ 18,000,000	\$ 8,000,000	\$ 26,000,000
FY 2008-09	\$ 20,958,000	\$ 21,336,000	\$ 42,294,000
FY 2009-10	\$ 114,023,000	\$ 41,073,000	\$ 155,096,000
FY 2010-11	\$ 59,959,000	\$ 25,613,000	\$ 85,572,000
FY 2011-12	\$ 102,046,000	\$ 55,019,000	\$ 157,065,000
FY 2012-13			
DSHP-BTR (DY 2012-13)	\$ 59,324,000	\$ 27,647,000	\$ 86,971,000
DY 2009-10 Final Reconciliation	(\$ 11,372,000)	(\$ 4,595,000)	(\$ 15,967,000)
Total	\$ 47,952,000	\$ 23,052,000	\$ 71,004,000
FY 2013-14			
DSHP-BTR (DY 2013-14)	\$ 59,324,000	\$ 27,647,000	\$ 86,971,000
DY 2010-11 Final Reconciliation	(\$ 11,372,000)	(\$ 4,595,000)	(\$ 15,967,000)
Total	\$ 47,952,000	\$ 23,052,000	\$ 71,004,000

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 87

Funding:

Health Care Support Fund (4260-601-7503)

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 88
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1672

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$55,000,000	\$110,000,000
- STATE FUNDS	\$27,500,000	\$55,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$55,000,000	\$110,000,000
STATE FUNDS	\$27,500,000	\$55,000,000
FEDERAL FUNDS	\$27,500,000	\$55,000,000

DESCRIPTION**Purpose:**

This policy change estimates the federal funds for the Delivery System Reform Incentive Pool (DSRIP) Category 5 Human Immunodeficiency Virus (HIV) Transition Projects.

Authority:

SB 208 (Chapter 714, Statutes of 2010)
 California Bridge to Reform section 1115(a) Medicaid Demonstration (BTR) (Waiver 11-W-00193/0)
 Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

The Department proposed an amendment to the Demonstration to CMS which authorizes the implementation of quality improvement projects within Designated Public Hospitals (DPHs). The DPHs support continuity of quality care, care coordination and other coverage transition issues concerning LIHP enrollees diagnosed with HIV, particularly those enrollees who previously received services under

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS**REGULAR POLICY CHANGE NUMBER: 88**

the Ryan White program. CMS approved the amendment to the Demonstration on June 28, 2012.

The Department developed a DSRIP Category 5 HIV Transition Projects proposal (Proposal) which describes the framework, performance measures, deliverables, and incentive payment structure for DSRIP Category 5 HIV Transition Projects. This Proposal was submitted to CMS on July 20, 2012, for its review and approval. Once approved by CMS, the Proposal serves as the foundation for the development of two new supplements to the Special Terms and Conditions (STC Attachment P – Supplement 1 and Attachment Q – Supplement 1) authorized by the June 28, 2012 amendment to the Demonstration. The Department must submit the proposed new supplements to CMS for review and approval.

As of July 1, 2011, any DPH system with an approved DSRIP 5-year plan located within a county operating a LIHP and is a participating provider in that LIHP network may propose DSRIP Category 5 HIV Transition projects as a modification to its existing five year plan.

DPHs that elect to implement approved DSRIP Category 5 HIV Transition Projects will receive incentive payments under the Safety Net Care Pool (SNCP) upon achievement of project milestones. The non-federal share of the payments will be through intergovernmental transfers (IGTs). The DSRIP Category 5 HIV Transition Projects will be effective for 18 months from July 1, 2012 through December 31, 2013.

Reason for Change from Prior Estimate:

Revised the implementation date from July 1, 2011 to July 1, 2012 per CMS changing the scope of the LIHP HIV Transition Incentive program.

Methodology:

1. During the term of the LIHP component of the Demonstration commencing with FY 2012-13, a total of \$110 million in DSRIP Category 5 HIV Transition Project payments (total computable) will be available annually.
2. \$55 million (total computable) will be available for July 1 - December 31, 2013. The total available payments will be consistent with the Demonstration budget neutrality limit.
3. Total payment amounts will be allocated to each participating DPH on the basis of its approved proposal. Payment amounts will be disbursed in semi-annual payments, if project milestones are achieved.

FY 2012-13	TF	IGT	FFP
Total	\$55,000,000	\$27,500,000	\$27,500,000
FY 2013-14	TF	IGT	FFP
2012-13	\$55,000,000	\$27,500,000	\$27,500,000
2013-14	\$55,000,000	\$27,500,000	\$27,500,000
Total	\$110,000,000	\$55,000,000	\$55,000,000

Funding:

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

MH/UCD & BTR—DPH INTERIM RATE GROWTH

REGULAR POLICY CHANGE NUMBER: 89
 IMPLEMENTATION DATE: 7/2009
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1162

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$48,440,000	\$95,132,000
- STATE FUNDS	\$24,220,000	\$47,566,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$48,440,000	\$95,132,000
STATE FUNDS	\$24,220,000	\$47,566,000
FEDERAL FUNDS	\$24,220,000	\$47,566,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 98 MH/UCD & BTR — DPH Interim Rate

Background:

In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. The DPHs' interim rate receives a growth percent increase to reflect an increase in hospital's costs. This growth increase is expected to be different from the Selective Provider Contracting Program (SPCP) negotiated rate trend for some DPHs and requires an adjustment to the Medi-Cal Estimate base. The interim per diem rate consists of 100% federal funding.

Reason for Change from Prior Estimate:

The changes are due to updated program expenditures.

Methodology:

1. Assume the DPHs will receive an increase in their interim per diem rates for dates of services on or after July 1, 2012, of 6.37%.
2. Assume the DPHs will receive an increase in their interim per diem rates for dates of services on or after July 1, 2013, of 6.37%.
3. An additional cost of \$48,440,000 is estimated to occur in FY 2012-13.

MH/UCD & BTR—DPH INTERIM RATE GROWTH**REGULAR POLICY CHANGE NUMBER: 89**

4. An additional cost of \$95,132,000 is estimated to occur in FY 2013-14.
5. The interim payments are 100% federal funds, after the Department's adjustment. Until the adjustment is made, the payments are 50% GF/50% FFP and are budgeted as 50% GF/50% FFP. The full adjustment is shown in the MH/UCD & BTR—DPH Interim Rate policy change.

Funding:

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

MH/UCD—SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 90
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1072

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$45,683,000	\$147,683,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,683,000	\$147,683,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$45,683,000	\$147,683,000

DESCRIPTION**Purpose:**

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

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions Code 14166.7
 MH/UCD

Interdependent Policy Changes:

Not Applicable

Background:

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

In 2007, SB 474 (Chapter 518, Statutes of 2007) allocated an annual \$100,000,000 of the SNCP FFP for the South Los Angeles Medical Services Preservation (SLAMSP) Fund for the last three years of the MH/UCD. These funds were claimed using the CPEs of the County of Los Angeles or its DPHs.

If the DPHs require more of the SNCP funds than what is available after the Department utilizes the CPEs from the four state-funded programs to draw down FFP, the DPHs will be paid GF which will be

MH/UCD—SAFETY NET CARE POOL**REGULAR POLICY CHANGE NUMBER: 90**

budgeted in the Stabilization policy change. The FFP paid to the DPHs, SLAMSP, and drawn down by the state-funded programs cannot exceed \$586 million.

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

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

Reason for Change from Prior Estimate:

The change in FY 2012-13 is due to the delay of final reconciliations for DY 2005-06.

Methodology:

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

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

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

(In Thousands)	FY 2012-13	FY 2013-14
Demonstration Year		
2005-06	\$1,949	
2006-07	\$36,917	
2007-08	\$6,817	
2008-09		\$64,176
2009-10		\$83,507
Total	\$45,683	\$147,683

Funding:

Health Care Support Fund (4260-601-7503)

NDPH SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 91
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1688

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$45,000,000	\$50,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$45,000,000	\$50,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$45,000,000	\$50,000,000

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Effective for dates of service on or after November 1, 2010, based on the Special Terms and Conditions of the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR), a new SNCP was established to support the provision of services to the uninsured. The Department is seeking approval of a waiver amendment from the Centers for Medicare & Medicaid Services (CMS) to increase SNCP funding and make the increased funding available to NDPHs. The NDPH SNCP is to be distributed through the certified public expenditures (CPEs) of NDPHs for uncompensated care to the uninsured and the federalizing of Designated State Health Programs.

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

Reason for Change from Prior Estimate:

The change in FY 2012-13 is due to updated data.

NDPH SAFETY NET CARE POOL

REGULAR POLICY CHANGE NUMBER: 91

Methodology:

1. NDPH SNCP payments will be based on the CMS approval of the amount of federal funds that can be claimed from the uncompensated care component of NDPH CPEs.

2. The estimated SNCP FFP on an accrual basis is:

(In Thousands)	
<u>Demonstration Year (DY)</u>	<u>Due to NDPHs</u>
2012-13	\$45,000
2013-14	\$50,000

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

(In Thousands)		
FY 2012-13	<u>TF</u>	<u>FF</u>
DY 2012-13	\$45,000	\$45,000
FY 2013-14		
DY 2013-14	\$50,000	\$50,000

Funding:

Health Care Support Fund (4260-601-7503)

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 92
 IMPLEMENTATION DATE: 9/2007
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1154

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$20,826,000	\$31,467,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,826,000	\$31,467,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$20,826,000	\$31,467,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

Under the MH/UCD, \$180 million in federal funds is available annually under the Safety Net Care Pool (SNCP) to expand health care coverage to eligible low-income, uninsured persons for Demonstration Year (DY) 2007-08 through DY 2009-10. The funding for the HCCI is linked to the SNCP requirements reflected in the MH/UCD-Safety Net Care Pool policy change.

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

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

In FY 2012-13 and FY 2013-14, reallocation of unspent funds and final reconciliation of payments will occur for DY 2007-08 through DY 2009-10. The payment reconciliations may result in additional FFP

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 92

payments to or recovery of FFP payments from affected counties.

Reason for Change from Prior Estimate:

The delay of final reconciliation for DY 2007-08, DY 2008-09, and DY 2009-10, updated claims information, and reallocation of unspent funds for DY 2007-08, DY 2008-09, and DY 2009-10.

Methodology:

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

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

2. Payments due to reallocation and final reconciliation for DY 2007-08, DY 2008-09, and DY 2009-10 under the MH/UCD HCCI are expected to be paid in FY 2012-13 and FY 2013-14.

The estimated HCCI payments on a cash basis are:

FY 2012-13	TF	FFP	CPE
2007-08	\$24,836,000	\$12,418,000	\$12,418,000
2008-09	\$6,834,000	\$3,417,000	\$3,417,000
2009-10	\$9,982,000	\$4,991,000	\$4,991,000
Total	<u>\$41,652,000</u>	<u>\$20,826,000</u>	<u>\$20,826,000</u>
FY 2013-14	TF	FFP	CPE
2007-08	\$60,750,000	\$30,375,000	\$30,375,000
2008-09	\$2,184,000	\$1,092,000	\$1,092,000
Total	<u>\$62,934,000</u>	<u>\$31,467,000</u>	<u>\$31,467,000</u>

Funding:

Health Care Support Fund (4260-601-7503)

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 93
 IMPLEMENTATION DATE: 11/2010
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1571

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$17,150,000	\$17,150,000
- STATE FUNDS	-\$493,199,000	-\$277,112,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$17,150,000	\$17,150,000
STATE FUNDS	-\$493,199,000	-\$277,112,000
FEDERAL FUNDS	\$510,349,000	\$294,262,000

DESCRIPTION**Purpose:**

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

Authority:

SB 208 (Chapter 71, Statutes 2009), Welfare & Institutions Code 14182.3
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 Interagency Agreement 10-87249 A 01
 AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 87 MH/UCD & BTR —CCS and GHPP
 PC 96 MH/UCD & BTR —MIA-LTC
 PC 97 MH/UCD & BTR —BCCTP

Background:

The Centers for Medicare & Medicaid Services (CMS) approved the BTR effective November 1, 2010. The Special Terms and Conditions allow the State to claim FFP using the CPEs of approved Designated State Health Programs (DSHP) listed below (exceptions as noted):

BTR—DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 93

State Only Medical Programs
California Children Services (CCS)
Genetically Handicapped Persons Program (GHPP)
Medically Indigent Adult Long Term Care (MIA-LTC)
Breast & Cervical Cancer Treatment Program (BCCTP)
AIDS Drug Assistance Program (ADAP)
Expanded Access to Primary Care (EAPC)
County Mental Health Services Program
Department of Developmental Services (DDS)
Every Woman Counts (EWC)
Prostate Cancer Treatment Program (PCTP)
Workforce Development Programs
Office of Statewide Health Planning & Development (OSHPD)
· Song-Brown HealthCare Workforce Training
· Steven M. Thompson Physician Corps Loan Repayment Program
· Mental Health Loan Assumption Program
University of California*
California State University*
California Community Colleges*
County Medical Services Program (CMSP); effective 11/01/10 to 12/31/11.

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

The annual limit the State-Only programs may claim for DSHP is \$400 million each Demonstration Year (DY) for a five year total of \$2 billion. In addition to the above programs, AB 1467 allows the DPHs to voluntarily provide excess CPEs as necessary for the State to claim the full \$400 million.

Reason for Change from Prior Estimate:

The change is due to updated program expenditures, a delay in CMS approval on claiming protocols for UC, CSU, and CCCs, and a delay in CMSP claiming to FY 2012-13.

Methodology:

1. The FFP for other departments is offset against General Fund expenses in Item 4260-101-0001. In FY 2012-13 and FY 2013-14, of the \$66,339,000 ADAP FFP available, \$49,189,000 is offset against Item 4260-101-0001 and \$17,150,000 is offset against the CDPH budget for each fiscal year, respectively.
2. The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the MH/UCD & BTR —MIA-LTC and MH/UCD & BTR —BCCTP policy changes. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR —CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF savings are reflected in that estimate.

BTR—DESIGNATED STATE HEALTH PROGRAMS**REGULAR POLICY CHANGE NUMBER: 93**

3. In FY 2012-13, for all programs except for UC, CSU, CCCs, and CMSP, the Department will claim DSHPs for FY 2012-13 on a cash basis. Due to delays, the Department will claim for FY 2010-11, FY 2011-12, and FY 2012-13 for the UC, CSU, CCCs, and CMSP programs in FY 2012-13.
4. In FY 2013-14, on a cash basis, the Department will claim all DSHPs for FY 2013-14.

The estimated BTR DSHP federal reimbursements are as follows:

(In Thousands)	Total DSHP (Accrual Basis)		Included in this PC (Cash Basis)	
	FFP	FFP	FFP	FFP
	FY 2012-13	FY 2013-14	FY 2012-13	FY 2013-14
CCS	\$59,324	\$59,324		
GHPP	\$27,647	\$27,647		
MIA-LTC	\$17,589	\$17,589		
BCCTP	\$1,178	\$1,178		
DHCS Total	\$105,738	\$105,738		
ADAP	\$66,339	\$66,339	\$66,339	\$66,339
Co. Mental Health	\$20,067	\$20,067	\$20,067	\$20,067
DDS	\$88,124	\$88,124	\$88,124	\$88,124
EWC	\$5,796	\$5,796	\$5,796	\$5,796
PCTP	\$907	\$907	\$907	\$907
OSHPD	\$6,980	\$6,980	\$6,980	\$6,980
Univ. of Calif.	\$2,575	\$2,575	\$7,168	\$2,575
CSU/Comm. Colleges	\$29,362	\$29,362	\$80,210	\$29,362
CMSP	\$0	\$0	\$160,646	\$0
Miscellaneous Programs	\$74,112	\$74,112	\$74,112	\$74,112
Total Other Programs	\$294,262	\$294,262	\$510,349	\$294,262
Grand Total	\$400,000	\$400,000	\$510,349	\$294,262

Funding:

GF (4260-101-0001)

Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 94
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1076

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$5,252,000	\$3,803,000
- STATE FUNDS	\$2,626,000	\$1,901,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,252,000	\$3,803,000
STATE FUNDS	\$2,626,000	\$1,901,500
FEDERAL FUNDS	\$2,626,000	\$1,901,500

DESCRIPTION

Purpose:

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

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & Institutions (W&I) Code 14166.17
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Demonstration (MH/UCD)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)
 AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 106 Hospital Stabilization
 PC 102 Eliminate NDPH Supplemental Payment

Background:

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

Payments to the NDPHs will be from the NDPH Supplemental Fund using State General Fund and interest accrued in the NDPH Supplemental Fund as the non-federal share of costs. It is assumed that interest accrued in a fiscal year will be paid in the subsequent fiscal year. This funding along with the federal reimbursement will replace the amount of funding the NDPHs previously received under the Emergency Services and Supplemental Payments Program (SB 1255, Voluntary Governmental Transfers).

Effective FY 2012-13, the Department is eliminating the NDPH supplemental payments. See the Eliminate NDPH Supplemental Payment policy change for more information.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 94

Reason for Change from Prior Estimate:

The change is due to revised estimate based on updated program expenditures.

Methodology:

1. The State Funds (SF) item includes the annual General Fund (GF) appropriation, any unspent appropriations from prior years, and interest that has been accrued/estimated.
2. SB 1100 requires that \$1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments.
3. Distribution of the NDPH Supplemental Fund will be determined through negotiations with the Office of the Selective Provider Contracting Program (OSPCP).
4. The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the BTR effective November 1, 2010.
5. AB 1467 authorizes the redirection of the stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to the GF. GF savings are budgeted in the Hospital Stabilization policy change.
6. AB 1467 authorizes the Department to continue to exercise the authority to finalize the payments rendered under the responsibilities transferred to it with the dissolution of California Medical Assistance Commission under section 14165(b) of the W&I Code.

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

	TF	SF	FFP
FY 2012-13			
FY 2011-12 Ending Balance	\$898,000	\$449,000	\$449,000
Appropriation (GF)	\$3,800,000	\$1,900,000	\$1,900,000
Est. FY 2011-12 Interest Earned	\$16,000	\$8,000	\$8,000
Est. 2007-08 Stabilization Transfer	\$538,000	\$269,000	\$269,000
Total Funds Available	\$5,252,000	\$2,626,000	\$2,626,000
Redirect Stabilization Fund to GF	\$538,000	\$269,000	\$269,000
Redirect Supplemental Payments to GF	\$3,800,000	\$1,900,000	\$1,900,000
Cash Expenditures in FY 2012-13	\$914,000	\$457,000	\$457,000
Total Expenditures	\$5,252,000	\$2,626,000	\$2,626,000
FY 2012-13 Ending Balance	\$0	\$0	\$0
FY 2013-14			
FY 2012-13 Ending Balance	\$0	\$0	\$0
Appropriation (GF)	\$3,800,000	\$1,900,000	\$1,900,000
Est. FY 2012-13 Interest Earned	\$3,000	\$1,500	\$1,500
Total Funds Available	\$3,803,000	\$1,901,500	\$1,901,500
Redirect Supplemental Payments to GF	\$3,800,000	\$1,900,000	\$1,900,000
Cash Expenditures in FY 2013-14	\$3,000	\$1,500	\$1,500
Total Expenditures	\$3,803,000	\$1,901,500	\$1,901,500
FY 2013-14 Ending Balance	\$0	\$0	\$0

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 94

Funding:

NDPH Supplemental Fund (4260-601-3096)

Title XIX FFP (4260-101-0890)

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

MH/UCD—DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 95
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1070

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,054,000	\$0
- STATE FUNDS	\$527,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,054,000	\$0
STATE FUNDS	\$527,000	\$0
FEDERAL FUNDS	\$527,000	\$0

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

As part of MH/UCD, changes were made to hospital inpatient Disproportionate Share Hospital (DSH) and other supplemental payments. Effective July 1, 2005, based on the requirements of SB 1100, the Distressed Hospital Fund, was established for hospitals that participate in the Selective Provider Contracting Program (SPCP). SB 1100 requires the transfer of 20% of the July 2005 balance of the "Prior Supplemental Funds" (PSFs) to the Distressed Hospital Fund in each year for five years. PSFs are defined in SB 1100 as the following:

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

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

MH/UCD—DISTRESSED HOSPITAL FUND

REGULAR POLICY CHANGE NUMBER: 95

Reason for Change from Prior Estimate:

The final payments from the Distressed Hospital Fund were delayed to FY 2012-13.

Methodology:

1. Contract hospitals that meet the following requirements, as determined by OSPCP, are eligible for distressed funds:
 - a. The hospital serves a substantial volume of Medi-Cal patients.
 - b. The hospital is a critical component of the Medi-Cal program's health care delivery system.
 - c. The hospital is facing a significant financial hardship.
2. The MH/UCD was extended to October 31, 2010. The Centers for Medicare and Medicaid Services (CMS) approved the California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR), effective November 1, 2010. No additional funding for the Distressed Hospital Fund was included in the BTR.
3. The final payment from the PSFs will be made in FY 2012-13 depleting any remaining accumulated interest and fund balance.
4. The stabilization funding amounts to the Distressed Hospital Fund will be determined following the completion of the final reconciliations of the interim Medicaid inpatient hospital payment rates, interim Disproportionate Share Hospital payments, and interim Safety Net Care Pool payments for each fiscal year under the MH/UCD and paid in FY 2012-13. The stabilization payments are reflected in the MH/UCD —Stabilization Funding policy change.

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

FY 2011-12	TF	SF	FFP
FY 2010-11 Ending Balance	\$ 2,222,000	\$ 1,111,000	\$ 1,111,000
Transfer from Prior Supplement Funds	\$ 22,000	\$ 11,000	\$ 11,000
Estimated Interest Earned in Distressed Fund	\$ 6,000	\$ 3,000	\$ 3,000
Distressed Funds Available	\$ 2,250,000	\$ 1,125,000	\$ 1,125,000
Cash Expenditures in FY 2011-12	\$ 1,200,000	\$ 600,000	\$ 600,000
FY 2011-12 Ending Balance	\$ 1,050,000	\$ 525,000	\$ 525,000
FY 2012-13			
FY 2011-12 Ending Balance	\$ 1,050,000	\$ 525,000	\$ 525,000
Estimated Interest Earned in Distressed Fund	\$ 4,000	\$ 2,000	\$ 2,000
Distressed Funds Available	\$ 1,054,000	\$ 527,000	\$ 527,000
Cash Expenditures in FY 2012-13	\$ 1,054,000	\$ 527,000	\$ 527,000
FY 2012-13 Ending Balance	\$ -	\$ -	\$ -

Funding:

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

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 96
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1079

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$14,493,000	-\$14,493,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$14,493,000	-\$14,493,000
FEDERAL FUNDS	\$14,493,000	\$14,493,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

PC 93 BTR—Designated State Health Programs

Background:

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

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

Reason for Change from Prior Estimate:

There is no change.

MH/UCD & BTR—MIA-LTC

REGULAR POLICY CHANGE NUMBER: 96

Methodology:

1. The FFP received for the MIA-LTC program will be deposited in the Health Care Support Fund, Item 4260-601-7503.
2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional \$423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the MIA-LTC programs.
3. The Department will conduct the final reconciliation for DY 2009-10 in FY 2012-13 and estimates it will have to repay the federal government \$3.096 million in FY 2012-13. The MIA-LTC federal reimbursements are reduced by the final reconciliation amounts in this policy change.
4. The final reconciliation for DY 2010-11, anticipated to be completed in FY 2013-14, is estimated to be the same as the final reconciliation for DY 2009-10.

The MIA-LTC federal reimbursements are:

	FFP
FY 2005-06	\$ 12,834,000
FY 2006-07	\$ 7,328,000
FY 2007-08	\$ 14,743,000
FY 2008-09	\$ 23,160,000
FY 2009-10	\$ 28,147,000
FY 2010-11	\$ 11,386,000
FY 2011-12	\$ 33,737,000
FY 2012-13	
DSHP-BTR (DY 2012-13)	\$ 17,589,000
DY 2009-10 Final Reconciliation	(\$ 3,096,000)
Total	\$ 14,493,000
FY 2013-14	
DSHP-BTR (DY 2013-14)	\$ 17,589,000
DY 2010-11 Final Reconciliation	(\$ 3,096,000)
Total	\$ 14,493,000

Funding:

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

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 97
 IMPLEMENTATION DATE: 9/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1084

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$988,000	-\$988,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$988,000	-\$988,000
FEDERAL FUNDS	\$988,000	\$988,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

PC 93 BTR—Designated State Health Programs

Background:

Effective September 1, 2005, based on the Special Terms and Conditions of the MH/UCD, the Department may claim federal reimbursement for State-Only BCCTP costs from the Safety Net Care Pool (SNCP) funding established by the MH/UCD.

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

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

MH/UCD & BTR—BCCTP

REGULAR POLICY CHANGE NUMBER: 97

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The FFP received for the BCCTP will be deposited in the Health Care Support Fund, Item 4260-601-7503.
2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional \$423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change reflects those federal funds that are claimed using CPEs from the BCCTP program.
3. The Department will conduct the final reconciliation for the BCCTP for DY 2009-10 in FY 2012-13 and estimates that the Department will have to repay the federal government \$190,000 in FY 2012-13 as a result of the reconciliations. The BCCTP federal reimbursements are reduced by the final reconciliation amounts in this policy change.
4. The final reconciliation for DY 2010-11, anticipated to be completed in FY 2013-14, is estimated to be the same as the final reconciliation for DY 2009-10.

The BCCTP federal reimbursements are:

	FFP
FY 2005-06	\$ 591,000
FY 2006-07	\$ 291,000
FY 2007-08	\$ -
FY 2008-09	\$ 1,211,000
FY 2009-10	\$ 2,137,000
FY 2010-11	\$ 1,095,000
FY 2011-12	\$ 2,439,000
 FY 2012-13	
DSHP-BTR (DY 2012-13)	\$ 1,178,000
DY 2009-10 Final Reconciliation	(\$ 190,000)
Total	\$ 988,000
 FY 2013-14	
DSHP-BTR (DY 2013-14)	\$ 1,178,000
DY 2010-11 Final Reconciliation	(\$ 190,000)
Total	\$ 988,000

MH/UCD & BTR—BCCTP
REGULAR POLICY CHANGE NUMBER: 97

Funding:

Health Care Support Fund (4260-601-7503)

GF (4260-101-0001)

MH/UCD & BTR—DPH INTERIM RATE

REGULAR POLICY CHANGE NUMBER: 98
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1161

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$453,592,500	-\$495,210,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$453,592,500	-\$495,210,000
FEDERAL FUNDS	\$453,592,500	\$495,210,000

DESCRIPTION**Purpose:**

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

Authority:

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

Interdependent Policy Changes:

PC 89 MH/UCD & BTR — DPH Interim Rate Growth

Background:

In conjunction with the MH/UCD and BTR, a number of changes were made to Medi-Cal hospital inpatient reimbursement. Effective July 1, 2005, DPHs no longer receive the negotiated per diem rates under the Selective Provider Contracting Program (SPCP) for inpatient hospital costs for services rendered to Medi-Cal beneficiaries on and after July 1, 2005. Instead, DPHs receive interim per diem rates based on estimated costs using the hospitals' two years prior Medi-Cal costs trended forward. These interim payments are 100% federal funds based on the hospitals' certified public expenditures (CPEs), resulting in 50% FFP and 50% CPE.

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

Reason for Change from Prior Estimate:

The changes are due to updated program expenditures.

MH/UCD & BTR—DPH INTERIM RATE**REGULAR POLICY CHANGE NUMBER: 98****Methodology:**

- Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP due to ARRA on a date-of-service basis. In FY 2012-13 and 2013-14 the increase due to ARRA is assumed to be \$21,704,000, on a cash basis.
- The funding adjustment is estimated at:

	<u>Expenditures</u>	<u>GF to FF shift</u>
FY 2012-13	\$ 907,185,000	\$ 453,592,500
FY 2013-14	\$ 990,420,000	\$ 495,210,000

Funding:

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

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

REGULAR POLICY CHANGE NUMBER: 99
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1460

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION**Purpose:**

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

Authority:

Welfare & Institutions Code 14166.221
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Interdependent Policy Changes:

PC 87 MH/UCD & BTR —CCS and GHPP
 PC 96 MH/UCD & BTR —MIA-LTC
 PC 97 MH/UCD & BTR —BCCTP

Background:

Under ARRA, the California's FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. Because of the increased FMAP, the annual Safety Net Care Pool (SNCP) federal funds allotment under the MH/UCD will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional \$423.769 million federal funds available in the SNCP.

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

MH/UCD—FEDERAL FLEX. & STABILIZATION - SNCP ARRA**REGULAR POLICY CHANGE NUMBER: 99****Reason for Change from Prior Estimate:**

There is no change.

Methodology:

1. The Department may claim these funds using certified public expenditures from Designated Public Hospitals, the Coverage Initiative Program, and State-Only funded programs, including Breast and Cervical Cancer Treatment (BCCTP), Medically Indigent Adults/Long Term Care (MIA-LTC), California Children's Services (CCS), Genetically Handicapped Persons (GHPP), County Medical Services Program, County Mental Health Services for the Uninsured, and AIDS Drug Assistance Program.
2. AB 1653 (Chapter 218, Statutes of 2010) allowed the state to retain up to \$420 million from the portion of the Hospital Quality Assurance Revenue Fund (HQARF) set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of federal flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the Hospital Quality Assurance Revenue Fund (Item 4260-601-3158). The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for the QAF Hospital payment. \$284.917 million of the total \$420 million was applied to the policy change and paid in FY 2010-11.
3. The Department will conduct the final reconciliation for DY 2009-10 in FY 2012-13 and estimates it will have to repay the federal government \$19.253 million in FY 2012-13.
4. This policy change is for informational purposes only because all CPEs being used are in the Department's budget. No other Department's CPEs were needed to claim the full amount. The additional FFP received for CPEs using MIA-LTC and BCCTP are budgeted in the MH/UCD & BTR —MIA-LTC and MH/UCD & BTR —BCCTP policy changes. The additional FFP received for MIA-LTC and BCCTP are used to offset General Fund expense in Item 4260-101-0001. The additional FFP received for CPEs using the CCS and GHPP programs are budgeted in the MH/UCD & BTR —CCS and GHPP policy change. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate and the GF savings are reflected in that estimate.

The final reconciliations are as follows:

	FFP
	FY 2012-13
CCS	(\$11,372,000)
GHPP	(\$4,595,000)
MIA LTC	(\$3,096,000)
BCCTP	(\$190,000)
Grand Total	(\$19,253,000)

Funding:

Not Applicable

BTR—INCREASE DESIGNATED STATE HEALTH PROGRAMS

REGULAR POLICY CHANGE NUMBER: 100
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1697

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$100,000,000	-\$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$100,000,000	-\$5,000,000
FEDERAL FUNDS	\$100,000,000	\$5,000,000

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

**BTR—INCREASE DESIGNATED STATE HEALTH
PROGRAMS**
REGULAR POLICY CHANGE NUMBER: 100

Reason for Change from Prior Estimate:

The change in FY 2013-14 is due to a decrease in the amount of funding available to rollover.

Methodology:

1. The total computable federal funding is \$360 million for DYs 2010-11, 2011-12, and 2012-13.
2. The Department projects LIHP-HCCI expenditures will be \$184 million in DY 2010-11, \$214 million in DY 2011-12, and \$263 million in DY 2012-13.
3. At a Federal Medical Assistance Percentage (FMAP) of 50%, \$88 million FFP is available to rollover from DY 2010-11, \$73 million FFP is available to rollover from DY 2011-12, and \$49 million FFP will be available to rollover from DY 2012-13.
4. Assume funds will be split 50/50 between the state and DPHs.

(In Millions)		
FY 2012-13	FFP	GF
HCCI Rollover		
DY 2010-11	(\$88.00)	\$0.00
DY 2011-12	(\$73.00)	\$0.00
DY 2012-13	(\$39.00)	\$0.00
Total	(\$200.00)	\$0.00
SNCP-DPHs	\$100.00	\$0.00
SNCP-DSHPs	\$100.00	(\$100.00)
FY 2013-14		
HCCI Rollover		
DY 2012-13	(\$10.00)	\$0.00
SNCP-DPHs	\$5.00	\$0.00
SNCP-DSHPs	\$5.00	(\$5.00)

Funding:

100% State GF (4260-101-0001)

Health Care Support Fund (4260-601-7503)

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 101
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1708

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$142,595,000
- STATE FUNDS	\$0	-\$71,297,500
PAYMENT LAG	1.0000	0.8277
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$118,025,900
STATE FUNDS	\$0	-\$59,012,940
FEDERAL FUNDS	\$0	-\$59,012,940

DESCRIPTION

Purpose:

This policy change estimates savings that will occur by implementing the Diagnosis Related Group (DRG) payment methodology for Medi-Cal inpatient services for private hospitals and freezing rates at the 2012-13 level.

Authority:

SB 853 (Chapter 717, Statutes 2010), Welfare & Institutions Code 14105.28

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax - Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax - Funding Adjustment

Background:

Currently, private hospitals receive reimbursement for Medi-Cal fee-for-service (FFS) acute inpatient services according to the negotiated per-diem rates under the Selective Provider Contracting Program (SPCP). Contract hospitals bill for some services carved-out of the per-diem charges separately. For non-contract private hospitals, Medi-Cal reimburses FFS inpatient services with cost-based interim per-diem rates.

Under the current payment system, private hospitals bill Medi-Cal the daily inpatient service charges on a per day usage. Providers receive payment for the actual number of days a beneficiary remains in their care, and not on a diagnosis or treatment strategy basis.

On July 1, 2013, the Department will transition to a DRG payment system which correlates reimbursement to the Medi-Cal beneficiary's assigned DRG. Each DRG category is designed to treat all patients assigned to a specific DRG as having a similar clinical condition requiring similar interventions and the same number of days of inpatient stay. The payment system pays the average cost for treating patients in the same DRG. FY 2013-14 rates will be set based on 2012-13 rates.

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 101

In Medi-Cal managed care counties, the Department contracts with health plans to provide services, including inpatient services, to Medi-Cal beneficiaries enrolled in the plans. Each plan receives a per member per month capitation rate for enrolled beneficiaries. Implementation of a DRG payment system that freezes base rates at the 2012-13 level will directly impact managed care capitation rates.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume the DRG payment methodology will be implemented on July 1, 2013.
2. Using 2009 trended data, adjusted to reflect the Senior and Persons with Disabilities (SPD) transition into managed care, and assuming stable utilization and patient case mix and projected rate increases, FY 2013-14 expenditures under the current methodology are estimated to be \$3,217,878,000 TF.
3. FY 2013-14 FFS payments under the DRG payment system that will be frozen at the 2012-13 level are estimated to be \$3,115,067,000 TF.
4. Annual FFS savings are estimated to be:

$$\$3,217,878,000 - \$3,115,067,000 = \$102,811,000 \text{ TF } (\$51,046,000 \text{ GF}) \text{ FFS Savings}$$
5. Managed care savings are estimated to be \$39,784,000 TF (\$19,892,000 GF) in FY 2013-14, based on the FFS actuarial equivalent.

(In Thousands)	<u>TF</u>	<u>GF</u>
Annual		
FFS	(102,811)	(51,406)
Managed Care	(39,784)	(19,892)
Total savings	(142,595)	(71,298)

Funding:

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

ELIMINATE NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 102
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1691

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$3,800,000	-\$3,800,000
- STATE FUNDS	-\$1,900,000	-\$1,900,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,800,000	-\$3,800,000
STATE FUNDS	-\$1,900,000	-\$1,900,000
FEDERAL FUNDS	-\$1,900,000	-\$1,900,000

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Effective July 1, 2005, based on the requirements of SB 1100 (Chapter 560, Statutes of 2005), supplemental reimbursements are available to NDPHs. Currently, SB 1100 requires that \$1,900,000 annually be transferred from the General Fund to the NDPH Supplemental Fund to be used for the non-federal share of payments. See the policy change MH/UCD & BTR—NDPH Supplemental Payment for more information.

AB 1467 eliminates \$3.8 million in annual NDPH supplemental payments effective July 1, 2012.

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

Reason for Change from Prior Estimate:

There is no change.

ELIMINATE NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 102

Methodology:

The estimated fiscal impact is:

	<u>TF</u>	<u>SF</u>	<u>FFP</u>
FY 2012-13	(\$3,800,000)	(\$1,900,000)	(\$1,900,000)
FY 2013-14	(\$3,800,000)	(\$1,900,000)	(\$1,900,000)

Funding:

NDPH Supplemental Fund (4260-601-3096)

Title XIX FFP (4260-101-0890)

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 103
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1459

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$9,187,000	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$9,187,000	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$9,187,000	\$0

DESCRIPTION**Purpose:**

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

Authority:

Welfare & Institutions Code 14166.221
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration (MH/UCD)

Interdependent Policy Changes:

Not Applicable

Background:

Under the MH/UCD, \$180 million in federal funds is available annually for 2005-06 through 2009-10 to expand health care coverage. In 2005-06 and 2006-07, \$360 million of the funding was unused. On February 1, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the proposed amendment to the MH/UCD Special Terms and Conditions, amended October 5, 2007. The amendment incorporates federal flexibilities to expand the Department's ability to claim additional state expenditures to utilize unused federal funding under the SNCP.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The Department may claim these funds using the certified public expenditures from Designated Public Hospitals, the Coverage Initiative Program, and State-Only funded programs, including Expanded Access to Primary Care (EAPC), County Medical Services Program (CMSP), County Mental Health Services for the Uninsured (CMHS), and AIDS Drug Assistance Program (ADAP).
2. AB 1653 (Chapter 218, Statutes of 2010) allows the State to retain up to \$420 million from the portion of the Hospital Quality Assurance Fee (QAF) fund set aside for direct grants to designated public hospitals for the State's use while the bill is in effect. In exchange, a portion of the federal

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP**REGULAR POLICY CHANGE NUMBER: 103**

flexibility funding would be allocated to the designated public hospitals and be identical in amount to the sum retained by the State from the QAF fund. The Department would claim these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and would distribute those funds in conformity with the payment schedule for Hospital QAF payments. \$135.083 million of the total \$420 million was applied to this policy change and paid in FY 2010-11.

- Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional federal financial participation (FFP) for FY 2010-11 and FY 2011-12. The additional FFP due to these changes in FMAP is budgeted in the Federal Flex. & Stabilization — SNCP ARRA policy change.

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

(In Thousands)	TF	FFP
FY 2012-13		
Final Reconciliation	(\$9,187)	(\$9,187)
(EAPC, CMSP, & ADAP)		

Funding:

Health Care Support Fund (4260-601-7503)

ELIMINATE NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 104
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1690

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$70,000,000	-\$70,000,000
- STATE FUNDS	-\$35,000,000	-\$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$70,000,000	-\$70,000,000
STATE FUNDS	-\$35,000,000	-\$35,000,000
FEDERAL FUNDS	-\$35,000,000	-\$35,000,000

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

AB 113 (Chapter 20, Statutes of 2011) established an NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. See the NDPH IGT Supplemental Payments policy change for more information.

AB 1467 eliminates this supplemental payment effective July 1, 2012.

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

Reason for Change from Prior Estimate:

There is no change.

ELIMINATE NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 104

Methodology:

The estimated fiscal impact is:

(In Thousands)				
FY 2012-13	TF	GF	IGT	FF
Payments to NDPHs	(\$70,000)	\$0	(\$35,000)	(\$35,000)
Children's Services	\$0	\$3,322	(\$3,322)	\$0
Total 2012-13	(\$70,000)	\$3,322	(\$38,322)	(\$35,000)
FY 2013-14	TF	GF	IGT	FF
Payments to NDPHs	(\$70,000)	\$0	(\$35,000)	(\$35,000)
Children's Services	\$0	\$3,322	(\$3,322)	\$0
Total 2013-14	(\$70,000)	\$3,322	(\$38,322)	(\$35,000)

Funding:

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

NDPH IP FFS PAYMENT METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 105
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1686

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$77,800,000	-\$70,740,000
- STATE FUNDS	-\$95,830,000	-\$95,830,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$77,800,000	-\$70,740,000
STATE FUNDS	-\$95,830,000	-\$95,830,000
FEDERAL FUNDS	\$18,030,000	\$25,090,000

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

For Medi-Cal hospital inpatient services prior to FY 2012-13, NDPHs received either:

- The Selective Provider Contracting Program (SPCP) negotiated per diem rates if they were a contract facility or
- Cost-based reimbursement if they were a non-contract facility.

The SPCP negotiated per diem rate or non-contract cost reimbursement was paid with 50% federal financial participation (FFP) and 50% General Fund (GF).

As a result of AB 1467, the Department will seek approval of a State Plan Amendment (SPA) from the Centers for Medicare & Medicaid Services (CMS) to authorize NDPHs to receive reimbursement based on CPEs. Under this methodology, hospitals will receive interim payments that are 100% federal funds matching the hospitals CPEs, resulting in 50% FFP and 50% local spending.

Because they would no longer be funded with GF, NDPHs would be exempt from the Diagnosis Related Group (DRG) payment methodology for inpatient services that will replace the current inpatient reimbursement methodology effective July 1, 2013.

NDPH IP FFS PAYMENT METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 105

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

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

Reason for Change from Prior Estimate:

The change in FY 2012-13 is due to updated data.

Methodology:

1. Assume previous annual NDPH inpatient FFS payments of \$191.66 million under the prior reimbursement methodologies.
2. Assume the new annual NDPH inpatient FFS payment is \$113.86 million in FY 2012-13 and \$120.92 million in FY 2013-14 under CPE methodology reimbursement.

The tables below show the overall fiscal impact:

(In Thousands)

FY 2012-13

	TF	GF	FF	IGT
Eliminate Current IP FFS Payments	(\$191,660)	(\$95,830)	(\$95,830)	\$0
CPE Methodology Reimbursement	\$113,860		\$113,860	\$0
Total IP FFS Payments	(\$77,800)	(\$95,830)	\$18,030	\$0
NDPH SNCP	\$45,000	\$0	\$45,000	\$0
NDPH DSRIP	\$80,000	\$0	\$40,000	\$40,000
Eliminate SB 1100 Supplemental Payments	(\$3,800)	(\$1,900)	(\$1,900)	\$0
Eliminate AB 113 IGT Supplemental Payments	(\$70,000)	\$3,322	(\$35,000)	(\$38,322)
Total	(\$26,600)	(\$94,408)	\$66,130	\$1,678

NDPH IP FFS PAYMENT METHODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 105

(In Thousands)

FY 2013-14

	TF	GF	FF	IGT
Eliminate Current IP FFS Payments	(\$191,660)	(\$95,830)	(\$95,830)	\$0
CPE Methodology Reimbursement	\$120,920		\$120,920	\$0
Total IP FFS Payments	(\$70,740)	(\$95,830)	\$25,090	\$0
NDPH SNCP	\$50,000	\$0	\$50,000	\$0
NDPH DSRIP	\$125,000	\$0	\$62,500	\$62,500
Eliminate SB 1100 Supplemental Payments	(\$3,800)	(\$1,900)	(\$1,900)	\$0
Eliminate AB 113 IGT Supplemental Payments	(\$70,000)	\$3,322	(\$35,000)	(\$38,322)
Total	\$30,460	(\$94,408)	\$100,690	\$24,178

The tables below show the net impact to NDPHs:

(In Thousands)

FY 2012-13

	TF
Eliminate Current IP FFS Payments	(\$191,660)
CPE Methodology Reimbursement	\$113,860
NDPH SNCP	\$45,000
NDPH DSRIP	\$40,000
Eliminate SB 1100 Supplemental Payments	(\$3,800)
Eliminate AB 113 IGT Supplemental Payments	(\$35,000)
Total	(\$31,600)

(In Thousands)

FY 2013-14

	TF
Eliminate Current IP FFS Payments	(\$191,660)
CPE Methodology Reimbursement	\$120,920
NDPH SNCP	\$50,000
NDPH DSRIP	\$62,500
Eliminate SB 1100 Supplemental Payments	(\$3,800)
Eliminate AB 113 IGT Supplemental Payments	(\$35,000)
Total	\$2,960

Funding:

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

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

HOSPITAL STABILIZATION

REGULAR POLICY CHANGE NUMBER: 106
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1644

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$85,754,000	\$0
- STATE FUNDS	-\$42,877,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$85,754,000	\$0
STATE FUNDS	-\$42,877,000	\$0
FEDERAL FUNDS	-\$42,877,000	\$0

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012), Welfare & Institutions Code 14166.14 and 14166.19

Interdependent Policy Changes:

PC 79 MH/UCD & BTR—Private Hospital Supplemental Payment

PC 83 MH/UCD—Stabilization Funding

PC 94 MH/UCD & BTR—NDPH Supplemental Payment

Background:

AB 1467 allows the Department to redirect stabilization funding that has not been paid for fiscal year (FY) 2005-06 through FY 2009-10 for private hospitals and NDPHs. The stabilization funding was estimated to be paid in FY 2012-13. A portion of the GF savings achieved was used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 and FY 2006-07.

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

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

Stabilization funding distributed through negotiations with the Office of the Selective Provider Contracting Program (OSPCP) are shown in the MH/UCD & BTR—Private Hospital Supplemental Payment and MH/UCD & BTR—NDPH Supplemental Payment policy changes.

HOSPITAL STABILIZATION

REGULAR POLICY CHANGE NUMBER: 106

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. A total of \$85.754 million TF (\$42.877 million GF) NDPH and private DSH hospitals stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 will be redirected for GF relief in FY 2012-13.

The estimated GF savings are:

FY 2012-13	TF	GF
FY 2005-06 Private	(\$10,578,000)	(\$5,289,000)
FY 2006-07 Private	(\$19,146,000)	(\$9,573,000)
FY 2007-08 NDPH	(\$2,152,000)	(\$1,076,000)
FY 2008-09 Private	(\$3,894,000)	(\$1,947,000)
FY 2009-10 Private	(\$49,984,000)	(\$24,992,000)
Total:	(\$85,754,000)	(\$42,877,000)

Funding:

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

BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER FUNDS

REGULAR POLICY CHANGE NUMBER: 107
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1694

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$200,000,000	-\$10,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$200,000,000	-\$10,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$200,000,000	-\$10,000,000

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

PC 78 BTR—Low Income Health Program - HCCI
 PC 81 BTR—Increase Safety Net Care Pool
 PC 100 BTR—Increase Designated State Health Programs

Background:

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

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

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

**BTR—HEALTH CARE COVERAGE INITIATIVE ROLLOVER
FUNDS
REGULAR POLICY CHANGE NUMBER: 107**

changes BTR-Increase Safety Net Care Pool and BTR-Increase Designated State Health Programs (DSHPs) for more information.

Reason for Change from Prior Estimate:

The change in FY 2013-14 is due to a decrease in the amount of funding available to rollover.

Methodology:

1. The total computable federal funding is \$360 million for DYs 2010-11, 2011-12, and 2012-13.
2. The Department projects LIHP-HCCI expenditures will be \$184 million in DY 2010-11, \$214 million in DY 2011-12, and \$263 million in DY 2012-13.
3. At a Federal Medical Assistance Percentage (FMAP) of 50%, \$88 million FFP is available to rollover from DY 2010-11, \$73 million FFP is available to rollover from DY 2011-12, and \$49 million FFP will be available to rollover from DY 2012-13
4. Assume funds will be split 50/50 between the state and DPHs.

(In Millions)		
FY 2012-13	FFP	GF
HCCI Rollover		
DY 2010-11	(\$88.00)	\$0.00
DY 2011-12	(\$73.00)	\$0.00
DY 2012-13	(\$39.00)	\$0.00
Total	(\$200.00)	\$0.00
SNCP-DPHs	\$100.00	\$0.00
SNCP-DSHPs	\$100.00	(\$100.00)
FY 2013-14		
HCCI Rollover		
DY 2012-13	(\$10.00)	\$0.00
SNCP-DPHs	\$5.00	\$0.00
SNCP-DSHPs	\$5.00	(\$5.00)

Funding:

Health Care Support Fund (4260-601-7503)

MANAGED CARE PUBLIC HOSPITAL IGTs

REGULAR POLICY CHANGE NUMBER: 111
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1588

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$900,000,000	\$554,000,000
- STATE FUNDS	\$450,000,000	\$277,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$900,000,000	\$554,000,000
STATE FUNDS	\$450,000,000	\$277,000,000
FEDERAL FUNDS	\$450,000,000	\$277,000,000

DESCRIPTION

Purpose:

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

Authority:

SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 125 Managed Care IGT Admin. & Processing Fee

Background:

Effective June 1, 2011, SB 208 requires Two-Plan and Geographic Managed Care model counties to enroll Seniors and Persons with Disabilities (SPDs) into managed care health plans. SB 208 allows DPHs to voluntarily provide the state an IGT to be used as the non-federal share of capitation rate increases. The increases enable Medi-Cal managed care plans to compensate DPHs in amounts that are no less than what they have received for providing services to these beneficiaries under the Fee-For-Service model, including supplemental payments. These IGTs allow managed care plans to compensate DPHs in an amount sufficient to preserve and strengthen the availability and quality of services provided. Transferring public entities are expected to provide IGTs in an amount that is at least equivalent to the amount of the nonfederal share that they would have provided under FFS, as adjusted for utilization.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 111

(In Thousands)	IGT	FFP	TF
FY 2012-13			
FY 2011-12	\$173,000	\$173,000	\$346,000
FY 2012-13	\$277,000	\$277,000	\$554,000
Total	\$450,000	\$450,000	\$900,000
FY 2013-14	\$277,000	\$277,000	\$554,000

Reason for Change from Prior Estimate:

There is no change.

Methodology:

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

Funding:

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

Reimbursement GF (4260-610-0995)

MANAGED CARE RATE RANGE IGTS

REGULAR POLICY CHANGE NUMBER: 112
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1054

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$533,935,000	\$458,062,000
- STATE FUNDS	\$234,338,000	\$221,007,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$533,935,000	\$458,062,000
STATE FUNDS	\$234,338,000	\$221,007,000
FEDERAL FUNDS	\$299,597,000	\$237,055,000

DESCRIPTION

Purpose

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

Authority:

Welfare & Institutions Code 14163 and 14164

Interdependent Policy Changes:

PC 125 Managed Care IGT Admin. And Processing Fee
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

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

Reason for Change from Prior Estimate:

The policy change was revised to incorporate updated IGTs.

Methodology:

COHS:

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

MANAGED CARE RATE RANGE IGTS**REGULAR POLICY CHANGE NUMBER: 112**

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

The IGTS for Marin County are expected to be effective July 1, 2011. Once approved by Centers for Medicare and Medicaid Services (CMS), it is anticipated the IGTS will continue on an ongoing basis.

Two Plan Model:

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

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

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

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of MCO Tax to General Fund policy change.

(In Thousands)**FY 2012-13**

	<u>IGT*</u>	<u>Regular FFP</u>	<u>ARRA FFP</u>	<u>T21 FFP</u>	<u>Total FFP</u>	<u>TF</u>
Total	\$234,338	\$259,130	\$23,450	\$17,016	\$299,597	\$533,935

FY 2013-14

	<u>IGT*</u>	<u>Regular FFP</u>	<u>T21 FFP</u>	<u>Total FFP</u>	<u>TF</u>
Total	\$221,007	\$212,365	\$24,690	\$237,055	\$458,062

Funding:

Title XIX FFP (4260-101-0890)

Title XXI FFP (4260-113-0890)

Reimbursement (4260-610-0995)*

TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 113
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1653

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,021,648,000
- STATE FUNDS	\$0	\$1,021,648,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,021,648,000
STATE FUNDS	\$0	\$1,021,648,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

SB 1008 (Chapter 33, Statutes of 2012)

SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:

Not applicable.

Background:

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles who receive LTC institutional services, IHSS, and other Home and Community-Based Services (HCBS) to managed care health plans beginning September 1, 2013.

The IHSS program provides an alternative to out-of-home care, such as nursing homes or board and care facilities. The transition and coordination of care for this group will help beneficiaries live in their homes and communities as long as possible by rebalancing the current avoidable institutionalized services toward enhanced provision of HCBS. It is assumed that the transition to managed care will increase the use of IHSS and other HCBS by 3.5%.

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

TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 113

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

Reason for Change from Prior Estimate:

The implementation date changed from March 2013 to September 2013.

Methodology:

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

(In Thousands)

FY 2013-14	TF	GF	FFP	Reim- bursement
Medicare Shared Savings	(\$62,931)	(\$62,931)	\$0	\$0
Managed Care Payments:				
Non HCBS	\$2,361,355	\$1,180,678	\$1,180,677	\$0
HCBS	\$1,030,825	\$485,812	\$545,013	\$0
Total	\$3,392,180	\$1,666,490	\$1,725,690	\$0
FFS Savings:				
Non HCBS	(\$2,026,691)	(\$1,013,346)	(\$1,013,345)	\$0
HCBS	(\$8,863)	(\$4,431)	(\$4,432)	\$0
Defer Mgd. Care Payment	(\$639,662)	(\$319,831)	(\$319,831)	\$0
Total	(\$2,675,216)	(\$1,337,608)	(\$1,337,608)	\$0
IHSS FFS Savings (In the Base)	(\$522,931)	\$0	(\$522,931)	\$0
Delay 1 Checkwrite (In the Base)	\$49,086	\$24,543	\$24,543	\$0
Transfer of IHSS Costs to DHCS	\$0	(\$463,731)	\$0	\$463,731
Transfer of IHSS Costs to CDSS	\$1,021,648	\$0	\$0	\$1,021,648
Other Administration Costs	\$5,172	\$2,543	\$2,630	\$0
Total of CCI PCs including pass through	\$1,207,008	(\$170,695)	(\$107,677)	\$1,485,379
IHSS Funding (CCI-IHSS Funding Adjustment)	\$0	(\$1,049)	\$1,049	\$0
Grand Total	\$1,207,008	(\$171,744)	(\$106,628)	\$1,485,379

TRANSFER OF IHSS COSTS TO CDSS

REGULAR POLICY CHANGE NUMBER: 113

Funding:

100% Reimbursement (4260-610-0995)

RETRO MC RATE ADJUSTMENTS FOR FY 2011-12

REGULAR POLICY CHANGE NUMBER: 114
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1750

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$388,718,000	\$0
- STATE FUNDS	\$194,359,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$388,718,000	\$0
STATE FUNDS	\$194,359,000	\$0
FEDERAL FUNDS	\$194,359,000	\$0

DESCRIPTION

Purpose:

This policy change estimates managed care capitation rate increases for FY 2011-12.

Authority:

Welfare & Institutions Code 14087.3

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

Due to a delay in CMS approval, capitation rate increases for FY 2011-12 will be paid in FY 2012-13.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Calculate the difference between what was calculated to be paid in FY 2011-12 and what was actually paid in FY 2011-12. This is the amount of the rate increase that will be paid in FY 2012-13.

	<u>FF</u>	<u>GF</u>	<u>TF</u>
Two Plan	\$99,327,000	\$99,327,000	\$198,654,000
COHS	\$90,456,000	\$90,456,000	\$180,912,000
GMC	\$4,576,000	\$4,576,000	\$9,152,000
Total	\$194,359,000	\$194,359,000	\$388,718,000

Funding:

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

MANAGED CARE COST BASED REIMBURSEMENT CLINICS

REGULAR POLICY CHANGE NUMBER: 116
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1618

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$110,417,000	\$75,000,000
- STATE FUNDS	\$55,208,500	\$37,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$110,417,000	\$75,000,000
STATE FUNDS	\$55,208,500	\$37,500,000
FEDERAL FUNDS	\$55,208,500	\$37,500,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14105.24 (a)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

Reason for Change from Prior Estimate:

Adjustments were made to accommodate for the CBRCs rates that will not be received and approved until FY 12-13. Payments will not be made until approval is received from the Centers for Medicare and Medicaid Services (CMS). FY 11-12 costs have been moved to FY 12-13.

MANAGED CARE COST BASED REIMBURSEMENT CLINICS

REGULAR POLICY CHANGE NUMBER: 116

Methodology:

1. Assume managed care payments will be retroactive to October 1, 2011.
2. Assume managed care payments will be \$75,000,000 per year.
3. While the transition of these costs from FFS to managed care is effective October 1, 2011, the adjustment to the managed care plan payments will not begin until FY 2012-13 when CMS approval is anticipated.
4. Assume managed care payments will begin June 1, 2013. Retro payments for October 2011 through May 2013 will also be paid in June 2013.
5. The FFS savings which began in October 2011 are fully reflected in the base estimate.

	FY 2012-13	FY 2013-14
Managed Care Costs	\$116,667,000	\$75,000,000
Defer Managed Care Payment	\$-6,250,000	\$0
Total	\$110,417,000	\$75,000,000

Funding:

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

INCREASE IN CAPITATION RATES FOR GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 120
 IMPLEMENTATION DATE: 11/2009
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1455

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$11,896,000	\$5,193,000
- STATE FUNDS	\$5,186,000	\$2,554,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,896,000	\$5,193,000
STATE FUNDS	\$5,186,000	\$2,554,000
FEDERAL FUNDS	\$6,710,000	\$2,639,000

DESCRIPTION

Purpose:

This policy change estimates the cost of capitation rate increases that are offset by the Gross Premium Tax proceeds. These funds will be used for the non-federal share of capitation rate increases.

Authority:

AB 1422 (Chapter 157, Statutes of 2009)
 SB 853 (Chapter 717, Statutes of 2010)
 ABX1 21 (Chapter 11, Statutes of 2011)

Interdependent Policy Changes:

PC 112 Managed Care Rate Range IGTs
 PC 127 Funding Adjustment of Gross Premium Tax to GF

Background:

AB 1422 imposed a Gross Premium Tax on the total operating revenue of the following Medi-Cal Managed Care plans: Two-Plan, COHS, GMC, AIDS Healthcare Centers (AHF), and Senior Care Action Network (SCAN). Total operating revenue does not include 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 Gross Premium Tax imposed by AB 1422 was effective retroactively to January 1, 2009 through December 31, 2010. SB 853 extended the Gross Premium Tax through June 30, 2011. ABX1 21 extended the Gross Premium Tax through June 30, 2012. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period will be matched with federal funds at the level in effect at that time.

The Managed Care Intergovernmental Transfer provides for capitation rate increases to the managed care plans. Because a portion of the IGTs from prior periods won't occur until FY 2012-13, the Gross Premium Tax applies to these payments and will be reflected in FY 2012-13 and FY 2013-14 costs.

**INCREASE IN CAPITATION RATES FOR GROSS PREMIUM
TAX
REGULAR POLICY CHANGE NUMBER: 120**

Reason for Change from Previous Estimate:

Updated to reflect the FY 2010-11 and FY 2011-12 IGTs.

Methodology:

1. The Gross Premium Tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the Gross Premium Tax.
2. Capitation rate increases due to the Gross Premium Tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to GF policy change.
3. While most of Medi-Cal's expenditures receive the applicable Federal Medicaid Assistance Percentage (FMAP) in place on the date that payment occurs, there will be some expenditures made in FY 2011-12 that will receive the increased American Recovery and Reinvestment Act of 2009 (ARRA) FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as Gross Premium Tax, and Medi-Cal draws the federal funds in a subsequent FY.
4. FY 2012-13 amounts are one-time retroactive rate adjustments using FY 2011-12 Gross Premium Taxes.

	2012-13	2013-14
Gross Premium Tax (Item 4260-601-3156)	\$5,186,000	\$2,554,000
FF (Title XIX) (Item 4260-101-0890)	\$5,781,000	\$2,454,000
FF (Title XXI) (Item 4260-113-0890)	\$378,000	\$185,000
ARRA (Item 4260-101-0890)	\$551,000	\$0
Total	\$11,896,000	\$5,193,000

NOTICES OF DISPUTE/ADMINISTRATIVE APPEALS

REGULAR POLICY CHANGE NUMBER: 121
 IMPLEMENTATION DATE: 7/1998
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 95

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$2,000,000
- STATE FUNDS	\$2,000,000	\$2,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,000,000	\$2,000,000
STATE FUNDS	\$2,000,000	\$2,000,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

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

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

Reason for Change from Prior Estimate:

There is no change.

Funding:

100% General Fund (4260-101-0001)

CAPITATED RATE ADJUSTMENT FOR FY 2013-14

REGULAR POLICY CHANGE NUMBER: 123
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1338

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$344,811,000
- STATE FUNDS	\$0	\$172,405,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$344,811,000
STATE FUNDS	\$0	\$172,405,500
FEDERAL FUNDS	\$0	\$172,405,500

DESCRIPTION

Purpose:

The policy change estimates the increase for the Managed Care capitation rate for fiscal year (FY) 2013-14.

Authority:

Not Applicable

Interdependent Policy Changes:

PC 108 Two Plan Model
 PC 109 County Organized Health Systems
 PC 110 Geographic Managed Care
 PC 119 AIDS Healthcare Centers (Other M/C)
 PC 122 Family Mosaic Capitated Case Mgmt. (Other M/C)
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

Managed care capitation rates will be rebased in FY 2013-14 as determined by the rate methodology based on more recent data. Adjustments will be implemented based on the rate year of the managed care model types.

This policy change budgets a placeholder increase of 2.97% for the FY 2013-14 rates based on the FY 2000-11 to FY 2011-12 overall rate increase. The managed care rate adjustments for FY 2013-14 will be available for the May 2013 Estimate.

CAPITATED RATE ADJUSTMENT FOR FY 2013-14

REGULAR POLICY CHANGE NUMBER: 123

(Rounded)	<u>Cost by Plan</u>	<u>Rate Adjustment</u>	<u>Rate Increase</u>
COHS	\$ 3,657,882,000	2.97%	\$ 108,639,000
Two Plan	\$ 6,777,200,000	2.97%	\$ 201,283,000
GMC	\$ 1,160,129,000	2.97%	\$ 34,456,000
AHF	\$ 14,579,000	2.97%	\$ 433,000
Total	\$11,609,790,000	2.97%	\$ 344,811,000

Reason for Change from Prior Estimate:

This is a new policy change.

Funding:

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

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 125
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1601

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose

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

Authority:

AB 102 (Chapter 29, Statutes of 2011)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

The counties or other approved public entities transfer funds as IGTs to the Department to provide capitation rate increases to the managed care plans. These funds provide the nonfederal share of capitation rate increases, which are budgeted in the Managed Care Rate Range IGT policy change. The Department develops an actuarially sound rate range that consists of a lower and upper bound rate. The state has the option of paying plans any rate that is within 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.

Per AB 102, beginning July 1, 2011, the Department began charging counties or other approved public entities a 20% administrative and processing fee for their IGTs. These fees are not charged for certain IGTs related to designated public hospitals and IGTs authorized pursuant to Welfare & Institutions Code Sections 14168.7 and 14182.15. FY 2012-13 savings includes all entities participating in an IGT other than the FY 2010-11 San Mateo IGT. The FY 2010-11 San Mateo IGT was paid in FY 2010-11, prior to implementation of the administrative processing fee.

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 125

Reason for Change from Prior Period:

There is no change.

Methodology:

1. The fee will be 20% of each IGT.
2. The state support costs are budgeted under state support.

(In Thousands)	IGT	20% Admin. & Processing Fee	Support Cost Reimbursement to GF	Local Assistance Reimbursement to GF
FY 2012-13	\$ 234,345	\$ 45,866	\$ 251	\$ 45,615
FY 2013-14	\$ 209,280	\$ 41,856	\$ 251	\$ 41,605

Funding:

Reimbursement (4260-610-0995)

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 126
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1605

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

SB 208 (Chapter 714, Statutes of 2010)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

Beginning in FY 2013-14, DPHs will reimburse the GF for costs that are built into the managed care capitation rates that would not have been incurred had the SPDs remained in FFS.

Reason for Change from Prior Estimate:

Due to delays in CMS approval, the payments and reimbursements reflected in this policy change will now occur in 2013-14 instead of 2012-13.

Methodology:

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

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 126

2. Assume the initial General Fund repayment for the period June 1, 2011 through June 30, 2012, will be \$93,959,000 and will be made in FY 2013-14.
3. Assume the FY 2012-13 annual payment of \$150,335,000 will be paid to the General Fund in FY 2013-14.
4. Beginning in FY 2013-14, \$150,335,000 will be repaid annually to the General Fund.

	FY 2013-14
June 2011 - June 2012 reimbursement from DPHs	\$ 93,959,000
FY 2012-13 Reimbursement from DPHs	\$ 150,335,000
FY 2013-14 Reimbursement from DPHs	\$ 150,335,000
Total Reimbursement	\$ 394,629,000
GF	-\$ 394,629,000
Net Impact	\$ 0

Funding:

Reimbursement (4260-610-0995)

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 127
 IMPLEMENTATION DATE: 2/2011
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1586

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 120 Increase in Capitation Rates for Gross Premium Tax

Background:

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

The Gross Premium Tax imposed by AB 1422 was effective retroactively to January 1, 2009, through December 31, 2010. SB 853 extended the Gross Premium Tax through June 30, 2011. ABX1 21 extended the Gross Premium Tax through June 30, 2012. Proceeds from the tax are used to offset payments made to the State by the plans during the extended time period and will be matched with federal funds at the level in effect at that time.

Capitation rate increases due to the Gross Premium Tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax fund on a quarterly basis. These funding adjustments reflect Gross Premium Tax amounts that were used to increase capitation rates in prior periods.

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 127

Reason for Change from Prior Estimate:

The most recent estimates of Gross Premium Tax revenues have been used to estimate the funding adjustment.

Methodology:

1. Funding adjustments for FY 2010-11 of \$57.8 million and \$9.0 were made in July 2011 and October 2011, respectively.
2. Annually, the plans are required to file a tax return (reconciliation) by April 1 for the previous calendar year.
3. Calendar year 2012 payment reconciliation will be paid by April 1, 2013.

	FY 2012-13
Total Gross Premium Tax	\$5,991,000
GF	-\$5,991,000
Total	\$0

	FY 2013-14
Total Gross Premium Tax	\$1,565,000
GF	-\$1,565,000
Total	\$0

Funding:

100% State GF (4260-101-0001)

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

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 128
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1082

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change is for informational purposes only.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

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

In Fiscal Year 2011-2012 FFS payments for managed care enrollees totaled:

	Expenditures by Aid Category		
	<u>Other</u>	<u>CCS/GHPP</u>	<u>Total</u>
Families	\$363,662,000	\$484,530,000	\$848,192,000
Disabled	\$520,828,000	\$383,141,000	\$903,969,000
Aged	\$94,898,000	\$0	\$94,898,000
200% Poverty	\$4,298,000	\$36,512,000	\$40,810,000
MI Child	\$6,418,000	\$17,083,000	\$23,501,000
133% Poverty	\$6,863,000	\$10,717,000	\$17,580,000
Other	\$1,498,000	\$1,000	\$1,499,000
100% Poverty	\$6,947,000	\$21,335,000	\$28,282,000
Blind	\$4,841,000	\$7,429,000	\$12,270,000
MI Adult	\$3,548,000	\$325,000	\$3,873,000
Totals	\$1,013,801,000	\$961,073,000	\$1,974,874,000

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 128

Reason for Change from Prior Estimate:

Updated FFS payment information.

Funding:

Not Applicable

SCAN TRANSITION TO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 129
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1749

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the capitated payments associated with the transition of Medi-Cal beneficiaries out of Senior Care Action Network (SCAN) and into managed care plans.

Authority:

Welfare & Institutions Code 14204

Interdependent Policy Changes:

PC 118 Senior Care Action Network (Other M/C)

Background:

SCAN is a Medicare Advantage Special Needs Plan and contracts with the Department to coordinate and provide health care services on a capitated basis for persons aged 65 and older with both Medicare and Medi-Cal coverage in Los Angeles, San Bernardino, and Riverside counties. SCAN operates as a social health maintenance organization under special waivers and has held a contract with the Centers for Medicare and Medicaid Services (CMS) since 1985.

The Department does not plan to renew the SCAN contract. The current contract expires December 31, 2012. A one-year contract extension of the period of January 1, 2013 through December 31, 2013 has been executed to facilitate transition of the SCAN Medi-Cal population into existing managed care plans.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume the transition of total SCAN membership will occur on January 1, 2014.
2. Assume the transition of total SCAN membership into the managed care plan of the beneficiary's choice.

SCAN TRANSITION TO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 129

3. Assume the cost of SCAN members will be reflected in the capitation rate of the chosen managed care plan.
4. Assume SCAN beneficiaries will continue to enroll into managed care plans for the period of January 1, 2014 through June 30, 2014 at the same rate as during FY 2012-13.
5. The managed care rates used to estimate these costs are based on a weighted average of managed care rates by aid code for Los Angeles, Riverside, and San Bernardino counties.
6. The Department does not anticipate a fiscal impact.

FY 2013-14	Eligible Months	Managed Care	SCAN	Total
Los Angeles	29,319	(\$13,333,163)	(\$13,333,163)	\$0
Riverside	9,849	(\$4,112,052)	(\$4,112,052)	\$0
San Bernardino	6,204	(\$2,716,711)	(\$2,716,711)	\$0
Total (Rounded)	45,372	(\$20,162,000)	(\$20,162,000)	\$0

Funding:

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

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 130
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1482

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$703,000	-\$185,000
- STATE FUNDS	-\$351,500	-\$92,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$703,000	-\$185,000
STATE FUNDS	-\$351,500	-\$92,500
FEDERAL FUNDS	-\$351,500	-\$92,500

DESCRIPTION

Purpose:

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

Authority:

Contract 08-85215

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

Reason for Change from Prior Estimate:

There is no material change.

Methodology:

1. It is assumed the annual member months for undocumented beneficiaries in FY 2012-13 will be 3,407 for Solano County, 1,717 for Napa County, and 1,876 for Yolo County.
2. It is assumed the annual member months for undocumented beneficiaries in FY 2012-13 will be 3,430 for Solano County, 1,718 for Napa County, and 1,880 for Yolo County.
3. The FY 2012-13 undocumented beneficiary rates are assumed to be \$351.19 for Solano County, \$529.67 for Napa County, and \$550.83 for Yolo County.

**DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM
PHC
REGULAR POLICY CHANGE NUMBER: 130**

4. The FY 2013-14 undocumented beneficiary rates are assumed to be \$361.62 for Solano County, \$545.40 for Napa County, and \$567.19 for Yolo County.
5. The FY 2012-13 cost, for period January 1, 2013 through June 30, 2013, for undocumented beneficiaries by county is expected to be:

Solano County: 3,407 x \$351.19 / 12 months x 6 months = \$598,000
 Napa County: 1,717 x \$529.67 / 12 months x 6 months = \$455,000
 Yolo County: 1,876 x \$550.83 / 12 months x 6 months = \$517,000

\$598,000 + \$455,000 + \$517,000 = \$1,570,000

6. The FY 2013-14 cost, for period July 1, 2013 through June 30, 2014, for undocumented beneficiaries by county is expected to be:

Solano County: 3,430 x \$361.62 = \$1,240,000
 Napa County: 1,718 x \$545.40 = \$937,000
 Yolo County: 1,880 x \$567.19 = \$1,066,000

\$1,240,000 + \$937,000 + \$1,066,000 = \$3,243,000

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

FY 2012-13	\$1,570,000	FFS cost
	-\$1,570,000	Managed Care savings
	<u>\$0</u>	FY 2012-13 impact of shift to FFS
FY 2013-14	\$3,243,000	FFS cost
	-\$3,243,000	Managed Care savings
	<u>\$0</u>	FY 2013-14 impact of shift to FFS

8. There will be a net savings in FY 2012-13 and FY 2013-14 due to the capitation payments ending on December 30, 2012. The savings is budgeted in the County Organized Health Systems (COHS) policy change, therefore, the lagged FFS costs is budgeted in this policy change. There will be a lag in FFS payments due to the time it take for providers to bill and be paid for services.

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
Managed Care Savings	-\$1,570,000	-\$3,243,000
FFS Cost	\$1,570,000	\$3,243,000
FFS Payment Lag	0.552	0.943
Lagged FFS Costs	<u>\$867,000</u>	<u>\$3,058,149</u>
Net costs (Rounded)	-\$703,000	-\$185,000

Funding:

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

MANAGED CARE DEFAULT ASSIGNMENT

REGULAR POLICY CHANGE NUMBER: 131
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1645

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,797,000	-\$4,531,000
- STATE FUNDS	-\$898,500	-\$2,265,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,797,000	-\$4,531,000
STATE FUNDS	-\$898,500	-\$2,265,500
FEDERAL FUNDS	-\$898,500	-\$2,265,500

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

Reason for Change from Prior Estimate:

In previous estimates, the figures for average monthly defaults that were used to calculate the savings erroneously included beneficiaries who chose their plan in addition to beneficiaries who were defaulted into a plan. The figures were revised in this estimate to reflect only beneficiaries who default into a plan. Additionally, new counties were included and updated rates were used.

Methodology:

1. Implementation began July 1, 2012.

MANAGED CARE DEFAULT ASSIGNMENT**REGULAR POLICY CHANGE NUMBER: 131**

2. All Two-Plan and GMC counties will participate.
3. The default algorithm will be adjusted to incorporate the cost factor and the ratios for the Family and SPD aid categories will be adjusted.
4. Beneficiaries will be impacted by the change in the default assignment when they initially enroll in Medi-Cal. The 2012-13 impact will be phased in over 12 months.
5. Assume five percent of defaulted beneficiaries will shift into a lower cost plan.
6. Assume a 97% retention factor for the plans and the remaining 3% of defaults will leave the plan each month.
7. Assume there will be a 3.61% growth rate for FY 2012-13 and 2.97% for FY 2013-14, for both Family aid codes and SPDs.
8. Estimated savings for FY 2012-13 are \$1,960,000 and \$4,531,000 for FY 2013-14.
9. This policy change estimates the savings due to implementing a default algorithm; therefore the savings will impact the payment deferral related to managed care capitation payments.

FY 2012-13	TF	GF
Health Plan Default Assignment Method	-\$1,960,000	-\$980,000
Defer Managed Care Payment	\$163,000	\$81,500
Total	-\$1,797,000	-\$898,500
FY 2013-14	TF	GF
Health Plan Default Assignment Method	-\$4,531,000	-\$2,265,500

Funding:

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

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 132
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1651

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$7,181,000	-\$5,463,000
- STATE FUNDS	-\$3,590,500	-\$2,731,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$7,181,000	-\$5,463,000
STATE FUNDS	-\$3,590,500	-\$2,731,500
FEDERAL FUNDS	-\$3,590,500	-\$2,731,500

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

Managed care is currently in 30 counties. AB 1467 expands managed care into the remaining 28 counties across the State. Expanding managed care into rural counties ensures that beneficiaries throughout the state receive health care through an organized delivery system that coordinates their care and leads to better health outcomes and lower costs.

Reason for Change from Prior Estimate:

Updated payment lags.

Methodology:

1. The expansion will occur on June 1, 2013.
2. The expansion of managed care will result in a cost in FY 2012-13 on a cash basis because capitation payments begin immediately, while fee-for-service payments continue for services provided before the expansion due to the time it takes providers to bill for services. The costs are expected to be:

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 132

	FY 2012-13	FY 2013-14
Managed Care Capitation Payments	\$45,512,000	\$546,144,000
FFS Savings	-\$50,569,000	\$606,828,000
FFS Payment Lag	0.142	.909
FFS Lagged Savings	-\$7,181,000	-\$551,607,000
FY Cost (Rounded)	<u>\$38,331,000</u>	<u>-\$5,463,000</u>

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

FY 2012-13	TF	GF
Expand Managed Care into all counties, June 2013	\$38,331,000	\$19,165,500
Defer Managed Care Payment	-\$45,512,000	-\$22,756,000
Total	<u>-\$7,181,000</u>	<u>-\$3,590,500</u>
 FY 2013-14	 -\$5,463,000	 -\$2,731,500

Funding:

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

POTENTIALLY PREVENTABLE ADMISSIONS

REGULAR POLICY CHANGE NUMBER: 133
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1664

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$36,332,000	-\$39,634,000
- STATE FUNDS	-\$18,166,000	-\$19,817,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$36,332,000	-\$39,634,000
STATE FUNDS	-\$18,166,000	-\$19,817,000
FEDERAL FUNDS	-\$18,166,000	-\$19,817,000

DESCRIPTION

Purpose:

This policy change estimates the savings from adjusting managed care capitation rates to account for the cost of potentially preventable hospital admissions.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Medical research finds that there are a number of instances where medical procedures and treatment are not appropriate for the particular condition. Also, in some instances, less expensive but at least equally effective treatment can be substituted. The Department has analyzed historical encounter data to identify situations where an inpatient admission was potentially preventable using criteria in the Agency for Healthcare Research and Quality (AHRQ), Guide to Prevention Quality Indicators (PQIs), and Pediatric Quality Indicators (PedQIs). The Department has quantified the level of inefficiency and/or potentially avoidable expenses present in the base data for each of the Two-Plan, Geographic Managed Care, and County Organized Health System Plans. This results in a reduction in the capitation rates for these plans in FY 2012-13.

Reason for Change from Prior Estimate:

This is a new policy change that breaks out Potentially Preventable Admissions from the Value Based Purchasing policy change. Additionally, the dollars have been updated to reflect new rate studies and caseload data.

POTENTIALLY PREVENTABLE ADMISSIONS

REGULAR POLICY CHANGE NUMBER: 133

Methodology:

1. Assume the savings began July 1, 2012.

	<u>TF</u>	<u>GF</u>
FY 2012-13		
Potentially Preventable Admissions	(\$39,634,000)	(\$19,817,000)
Defer Managed Care Payment	\$3,302,000	\$1,651,000
Total for FY 2012-13	(\$36,332,000)	(\$18,166,000)
FY 2013-14		
Potentially Preventable Admissions	(\$39,634,000)	(\$19,817,000)
Total for FY 2013-14	(\$39,634,000)	(\$19,817,000)

Funding:

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

ALIGN MANAGED CARE BENEFIT POLICIES

REGULAR POLICY CHANGE NUMBER: 134
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1646

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$93,535,000	-\$2,815,000
- STATE FUNDS	-\$46,767,500	-\$1,407,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$93,535,000	-\$2,815,000
STATE FUNDS	-\$46,767,500	-\$1,407,500
FEDERAL FUNDS	-\$46,767,500	-\$1,407,500

DESCRIPTION

Purpose:

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

Authority:

Contract language

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

Reason for Change from Prior Estimate:

Updated payment lags.

Methodology:

1. Assume an average of 53,467 eligibles are affected each month.
2. A per-member-per-month (PMPM) of \$450 was assumed to cover the costs of the retroactive services.
3. Assume a three-month delay due to the time required to enroll potential beneficiaries into Medi-Cal.

ALIGN MANAGED CARE BENEFIT POLICIES

REGULAR POLICY CHANGE NUMBER: 134

4. The FFS payment pattern was used to calculate the potential savings.

	TF	GF
FY 2012-13		
Align Managed Care Benefit Policies	-\$117,595,000	-\$58,797,500
Defer Managed Care Payment	\$24,060,000	\$12,030,000
Total	-\$93,535,000	-\$46,767,500
FY 2013-14		
Align Managed Care Benefit Policies	-\$2,815,000	-\$1,407,500

Funding:

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

TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 135
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1641

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,080,535,000	-\$2,675,216,000
- STATE FUNDS	-\$540,267,500	-\$1,337,608,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,080,535,000	-\$2,675,216,000
STATE FUNDS	-\$540,267,500	-\$1,337,608,000
FEDERAL FUNDS	-\$540,267,500	-\$1,337,608,000

DESCRIPTION

Purpose:

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

Authority:

SB 1008 (Chapter 33, Statutes of 2012)
 SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:

PC 215 CCI-IHSS Funding Adjustment

Background:

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) as well as Medi-Cal only beneficiaries. By enrolling these eligibles into coordinated care delivery models, the CCI will align financial incentives, streamline beneficiary-centered care delivery, and rebalance the current health care system away from avoidable institutionalized services.

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

Initially, the CCI will be implemented in eight pilot counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 135

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

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

For further detail on the IHSS funding adjustment see the CCI-IHSS Funding Adjustment policy change.

Reason for Change from Prior Estimate:

The implementation changed from March 2013 to September 2013.

Methodology:

1. Assume Dual Eligibles and Medi-Cal Only eligible populations receiving LTC institutional and community-based services under the traditional Fee-for-Service (FFS) model will begin enrolling into the CCI on September 1, 2013. Medicare FFS beneficiaries from San Mateo County will enroll at once on September 1, 2013. Medicare FFS beneficiaries from Los Angeles will enroll over 18 months in even increments. Medicare FFS beneficiaries from the other six counties will enroll over 12 months in even increments.
2. Beneficiaries enrolled in a Medicare Advantage plan will all enroll into the CCI on January 1, 2014.
3. Assume there are an estimated 1,010,000 beneficiaries in September 2013 who will start to receive the enhanced LTSS services from a managed care plan in the eight pilot counties. Those beneficiaries currently not enrolled in the managed care plans (most of them are dual eligibles) will be phased into a managed care plan starting in September 2013.
4. Assume Inpatient Care will be reduced by 10.9% in FY 2013-14. Assume it will be reduced by 11% annually thereafter.
5. Assume LTC institutional services will be reduced by 4.2% in FY 2013-14. Assume it will be reduced by 10.9% annually thereafter.
6. Assume IHSS, CBAS, and other HCBS will be increased by 3.5% in FY 2013-14. Assume it will be increased by 2.8% annually thereafter.
7. Assume MSSP services will remain the same.
8. Savings were calculated based on actual expenditures during calendar year 2010 for Medi-Cal beneficiaries utilizing nursing home, HCBS, and dual eligible without LTC institutional services.
9. FY 2012-13 dollars are due to the savings from deferring one managed care payment.
10. Since Medi-Cal is on the cash basis, there will continue to be fee-for-service costs. In order to achieve savings, the budget defers one managed care payment and one check write in FY 2012-13.

TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE**REGULAR POLICY CHANGE NUMBER: 135**

11. The delay in checkwrite is shown here for display purposes. The delay in checkwrite amounts for both FYs 2012-13 and 2013-14 are included in the base trend data.

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

(In Thousands)				
FY 2013-14	TF	GF	FFP	Reim- bursement
Medicare Shared Savings	(\$62,931)	(\$62,931)	\$0	\$0
Managed Care Payments:				
Non HCBS	\$2,361,355	\$1,180,678	\$1,180,677	\$0
HCBS	\$1,030,825	\$485,812	\$545,013	\$0
Total	\$3,392,180	\$1,666,490	\$1,725,690	\$0
FFS Savings:				
Non HCBS	(\$2,026,691)	(\$1,013,346)	(\$1,013,345)	\$0
HCBS	(\$8,863)	(\$4,431)	(\$4,432)	\$0
Defer Mgd. Care Payment	(\$639,662)	(\$319,831)	(\$319,831)	\$0
Total	(\$2,675,216)	(\$1,337,608)	(\$1,337,608)	\$0
IHSS FFS Savings (In the Base)	(\$522,931)	\$0	(\$522,931)	\$0
Delay 1 Checkwrite (In the Base)	\$49,086	\$24,543	\$24,543	\$0
Transfer of IHSS Costs to DHCS	\$0	(\$463,731)	\$0	\$463,731
Transfer of IHSS Costs to CDSS	\$1,021,648	\$0	\$0	\$1,021,648
Other Administration Costs	\$5,172	\$2,543	\$2,630	\$0
Total of CCI PCs including pass through	\$1,207,008	(\$170,695)	(\$107,677)	\$1,485,379
IHSS Funding (CCI-IHSS Funding Adjustment)	\$0	(\$1,049)	\$1,049	\$0
Grand Total	\$1,207,008	(\$171,744)	(\$106,628)	\$1,485,379

Funding:

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

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 136
 IMPLEMENTATION DATE: 3/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1659

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$407,641,000	\$864,549,000
- STATE FUNDS	\$38,745,000	\$77,489,000
PAYMENT LAG	0.8896	0.9898
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$362,637,400	\$855,730,600
STATE FUNDS	\$34,467,550	\$76,698,610
FEDERAL FUNDS	\$328,169,880	\$779,031,990

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

The primary care service codes subject to ACA provisions are evaluation and management (E&M) codes: 99201-99499 and immunization administration procedure codes 90465, 90466, 90467, 90468, 90471, 90472, 90473, and 90474. This provision extends to any subsequent modifications to the coding of these services.

The rate increase applies to primary care services furnished by physicians with a specialty designation of family medicine, general internal medicine, or pediatric medicine and subspecialists related to the primary care specialists, recognized in accordance with the American Board of Medical Specialties. In addition, the rate increase would apply to primary care services that are properly billed under the provider number of a physician who is enrolled as one of the specified primary care specialists,

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 136

regardless of whether furnished by the physician directly or under the physician's personal supervision.

Reason for Change from Prior Estimate:

The implementation date was changed from January 1, 2013 to March 1, 2013 because the federal proposal has not been finalized, and payment system components need changes to implement the rate increase.

Methodology:

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

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

The Department projects costs of \$77,489,000 TF (\$38,744,500 GF) in FY 2012-13 and \$154,979,000 TF (\$77,489,500 GF) in FY 2013-14 to raise rates for primary care services to the July 1, 2009 Medi-Cal levels to qualify for the enhanced federal funding.

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 136

(In Thousands)	Annual FFP
FFS	\$303,493
Managed care	\$390,093
	<u>\$693,586</u>

(In Thousands)

FY 2012-13	TF	FFP	GF
FFS	\$101,164	\$101,164	\$0
FFS Retro	\$33,940	\$33,940	\$0
Managed Care	\$130,031	\$130,031	\$0
Managed Care Retro	\$65,016	\$65,016	\$0
FFS (AB97 Savings Lost)	\$36,416	\$18,208	\$18,208
Managed Care (AB97 Savings Lost)	\$41,074	\$20,537	\$20,537
Total	\$407,641	\$368,896	\$38,745
FY 2013-14	TF	FFP	GF
FFS	\$303,493	\$303,493	\$0
FFS Retro	\$15,984	\$15,984	\$0
Managed Care	\$390,093	\$390,093	\$0
FFS (AB97 Savings Lost)	\$72,832	\$36,416	\$36,416
Managed Care (AB97 Savings Lost)	\$82,147	\$41,074	\$41,073
Total	\$864,549	\$787,060	\$77,489

Funding:

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

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

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 137
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1329

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$189,028,000	\$201,227,000
- STATE FUNDS	\$94,514,000	\$100,613,500
PAYMENT LAG	0.9927	0.9810
% REFLECTED IN BASE	0.63 %	0.61 %
APPLIED TO BASE		
TOTAL FUNDS	\$186,465,900	\$196,199,500
STATE FUNDS	\$93,232,960	\$98,099,760
FEDERAL FUNDS	\$93,232,960	\$98,099,760

DESCRIPTION

Purpose:

This policy change estimates the reimbursement of participating Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) according to the Prospective Payment System (PPS). This policy change also estimates the cost to provide a rate increase to Cost-Based Reimbursement Clinics (CBRCs) after a reconciliation audit has been completed.

Authority:

Welfare and Institutions Code 14170

Interdependent Policy Changes:

Not Applicable

Background:

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

CBRCs, owned or operated by Los Angeles County, are reimbursed at 100% of reasonable and allowable costs. An interim rate is paid to the clinics and is adjusted once the audit reports are finalized. That rate is used for subsequent fiscal year claims. The FY 2007-08 audited levels were used to update the CBRC rates as of July 1, 2012. The Department is scheduled to complete the CBRC reconciliation audit for FY 2008-09 in FY 2012-13 and for FY 2009-10 in FY 2013-14. Interim rates will be adjusted to the FY 2008-09 audited levels beginning in FY 2012-13, and to the FY 2009-10 audited levels in FY 2013-14.

Currently, there are 707 active FQHCs, 307 active RHCs and 29 active CBRCs.

FQHC/RHC/CBRC RECONCILIATION PROCESS

REGULAR POLICY CHANGE NUMBER: 137

Reason for Change from Prior Estimate:

The estimate was updated based on revised audits.

Methodology:

	FY 2012-13	FY 2013-14
FQHCs Reconciliation	\$95,798,000	\$81,390,000
RHCs Reconciliation	\$3,661,000	\$4,883,000
LA CBRCs Reconciliation	\$80,569,000	\$80,954,000
July 2012 LA CBRC Rate Increase	\$9,000,000	\$9,000,000
July 2013 LA CBRC Rate Increase		\$25,000,000
Total	\$189,028,000	\$201,227,000

Funding:

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

NF-B RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 138
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1021

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$99,269,000	\$199,986,000
- STATE FUNDS	\$49,634,500	\$99,993,000
PAYMENT LAG	0.9050	0.9443
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$89,838,400	\$188,846,800
STATE FUNDS	\$44,919,220	\$94,423,390
FEDERAL FUNDS	\$44,919,220	\$94,423,390

DESCRIPTION

Purpose:

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

Authority:

AB 1629 (Chapter 875, Statutes of 2004)
 ABX1 19 (Chapter 4, Statutes of 2011)
 AB 1489 (Chapter 631, Statutes of 2012)

Interdependent Policy Changes:

PC 141 AB 1629 Rate Adjustments Due to QA Fee Increase
 PC 151 Eliminate 2012-13 Rate Increase & Supp. Payment
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

AB 1629 requires the Department to provide a rate adjustment, implement a facility-specific rate methodology, and impose a quality assurance (QA) fee for freestanding skilled nursing facilities (NF-Bs), including adult subacute days. The Department collects QA fees from licensed NF-Bs as a means to enhance federal financial participation for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities. The fee program sunsets on July 31, 2015.

Reason for Change from Prior Estimate:

Estimates were updated to reflect changes in QA fee revenues in FY 2012-13 and FY 2013-14. In addition, AB 1629 facilities will receive the add-on reimbursement to their rates for new mandates.

Methodology:

1. AB 1489 implemented a rate freeze in the 2012-13 rate year and a 3% rate increase in the 2013-14 rate year. Absent AB 1489, the facilities were scheduled to receive a 1.973% rate increase in the 2012-13 rate year. This policy change budgets the cost of the 1.973% rate increase. The savings

NF-B RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 138

from the rate freeze is budgeted in the Eliminate 2012-13 Rate Increase and Supplemental Payment policy change.

2. The increases in reimbursement rates create additional revenue upon which the QA fee is assessed resulting in increased QA fee collections.
3. Centers for Medicare and Medicaid Services (CMS) mandated that freestanding skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. In order to implement the MDS 3.0 upgrade, the Department reimburses facilities for the additional costs associated with formal staff training and increased data-entry workload, through a rate "add-on". The rate adjustment was effective August 1, 2011 retroactive to October 1, 2010, and will be \$0.51 for FY 2012-13.
4. Effective October 2009, the Occupation Safety and Health (Cal/OSHA) of the Department of Industrial Relations required all health care facilities to offer health care workers immunization from airborne diseases. The rate adjustment was effective October 2009 and will be \$0.25 for FY 2012-13.
5. Effective January 2011, the California Department of Public Health (CDPH) mandated SNFs to implement informed consent requirements for the administration of psychotherapeutic drugs. An add-on to the rates to reimburse the facilities for the additional costs will be effective for the 2012-13 and 13-14 rate year.
6. Effective April 2012, CDPH is requiring providers to submit a new standard admission agreement form, which requires additional costs for printing and staff training. An add-on to the rates to reimburse the facilities for the additional costs will be effective for the 2012-13 and 2013-2014 rate year.
7. Effective January 1, 2012, CMS has required providers to upgrade their electronic transaction system from Version 4010/4010A to Version 5010. This system is used to send and receive claims and all other HIPPA adopted electronic transactions. An add-on to the rates to reimburse the facilities for the additional cost will be effective for the 2012-13 rate year only.
8. Under the Affordable Care Act § 6401(a), enrolled facilities have to revalidate their enrollment information under enrollment screening criteria. A CMS revalidation \$0.02 add-on reimburses enrolled facilities for revalidation costs. This add-on will be effective for 2012-13 rate year.
9. The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. A \$0.11 add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
10. Under Elder Justice Act, Federally Funded Long Term Care (LTC) facilities have to report to Law Enforcement of crimes occurring in the facilities. An Elder Justice Act \$0.01 add-on reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and 2013-14 rate year.

NF-B RATE CHANGES

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(In Thousands)		
FFS	<u>FY 2012-13</u>	<u>FY 2013-14</u>
Rate Adjustment	\$56,460	\$147,158
MDS Add-On	\$8,130	\$739
Immunization Add-On	\$3,985	\$362
5010 Transaction Add-On	\$2,869	\$261
Informed Consent Add-On	\$2,072	\$2,261
Std Admin Add-On	\$319	\$348
CMS Revalidation Add-on	\$319	\$29
FUTA Add-on	\$1,754	\$1,913
Elder Justice Act Add-on	\$160	\$174
FFS Total	<u>\$76,068</u>	<u>\$153,245</u>
Managed Care	<u>\$23,201</u>	<u>\$46,741</u>
Total	\$99,269	\$199,986

Funding:

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

10% PYMT REDUCTION RESTORATION FOR AB 1629 FAC.

REGULAR POLICY CHANGE NUMBER: 139
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1617

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$75,803,000	\$0
- STATE FUNDS	\$37,901,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$75,803,000	\$0
STATE FUNDS	\$37,901,500	\$0
FEDERAL FUNDS	\$37,901,500	\$0

DESCRIPTION**Purpose:**

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

Authority:

ABX1 19 (Chapter 4, Statutes of 2011)
 AB 1489 (Chapter 631, Statutes of 2012)

Interdependent Policy Changes:

PC 152 10% Payment Reduction for LTC Facilities

Background:

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

- Provide a one-time supplemental payment by December 31, 2012 that is equivalent to the amount of the 10% reduction, and
- 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.

AB 1489 eliminates the Hold Harmless for the 2013-14 rate year.

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

Reason for Change from Prior Estimate:

Implementation of the payment reduction changed from June 1, 2011 to May 1, 2012 which results in a lower amount needed to pay back the providers.

Methodology:

1. Implementation of the 10% reduction began May 1, 2012 and ended July 31, 2012 for FFS. The reduction was not applied retroactively.

10% PYMT REDUCTION RESTORATION FOR AB 1629 FAC.**REGULAR POLICY CHANGE NUMBER: 139**

2. The cost of the one-time payment is \$75,803,000 TF (\$37,901,500 GF).
3. The amount of the reduction in FY 2011-12 was \$56,852,000 and \$18,951,000 in FY2012-13 for AB 1629 facilities.
4. The Department will issue supplemental payments by December 2012.
5. The increase in revenues due to the one-time payment will increase the amount of Quality Assurance (QA) fee collected. It is shown here for informational purposes, as the revenues are not part of the Medi-Cal budget.

\$75,803,000 (increased payments) - \$4,548,000 (more QA fee collection) = \$71,255,000 (FY 2012-13 net costs)

Funding:

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

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 140
 IMPLEMENTATION DATE: 8/2007
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1046

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$40,475,000	\$67,648,000
- STATE FUNDS	\$20,237,500	\$33,824,000
PAYMENT LAG	0.8943	0.9495
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$36,196,800	\$64,231,800
STATE FUNDS	\$18,098,400	\$32,115,890
FEDERAL FUNDS	\$18,098,400	\$32,115,890

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 150 Non-AB 1629 LTC Rate Freeze
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

ABX4 5 froze rates for rate year 2009-10 and every year thereafter at the 2008-09 levels. On February 25, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute facilities.

Effective June 1, 2011, AB 97 requires the Department to freeze rates and reduce payments by up to 10% for the facilities enjoined from the original rate freeze, which was required by ABX4 5. In addition,

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 140

AB 97 extends this requirement to the other long term care facility types. The Department received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-Bs and to reduce the payments by 10%.

CMS also approved the rate freeze on the Rural Swing Bed rate. However, due to access concerns, payments applicable to the Rural Swing Bed rates will not be reduced.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% reduction and freeze at the 2008-2009 rate level, required by AB 97, with respect to DP/NF-Bs. On December 28, 2011, the federal court issued a preliminary injunction. The Department is complying with the injunction.

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

Reason for Change from Prior Estimate:

Delay in implementation due to pending SPA approvals, ongoing litigation, and additional workload that the litigation has created for the Fiscal Intermediary.

Methodology:

1. No rate increase is assumed for NF-As, DP/NF-Bs, Rural Swing Beds, FS Pediatric Subacute, ICF/DD, ICF/DD-H and ICF/DD-N facilities during rate year 2012-13 and 2013-14.
2. DP Adult Subacute and DP Pediatric Subacute facilities will not be subject to any rate reductions. The Department completed a "Monitoring Access to Medi-Cal Covered Services" study that determined reducing or freezing reimbursement rates for DP Adult Subacute and DP Pediatric Subacute facilities would negatively impact access to care. Therefore, the Department will be increasing reimbursement rates for these facility types under the "normal" rate setting process. It is estimated that the DP Adult Subacute facilities 2012-13 and 2013-14 reimbursement rates may be increased by 6.97% and 6.07% respectively. For DP Pediatric Subacute facilities, 2012-13 and 2013-14 reimbursement rates may be increased by 4.12% and 3.19% respectively.
3. ABX1 19 requires Freestanding Pediatric Subacute Care facilities to pay a QA fee beginning January 1, 2012. Effective October 1, 2011, the QA fee cap increased from 5.5% to 6% of total gross revenues. The fee is used to draw down Federal Financial Participation (FFP) and fund rate increases.
4. Effective October 1, 2010, CMS mandated that freestanding skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0). 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 was effective August 1, 2011. The rate increase for FY 2012-13 and FY 2013-14 will be \$0.51. For NF-A, the FY 2012-13 add-on is \$1.75.
5. Effective October 2009, CalOSHA required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional cost was effective August 1, 2011. For FY 2012-13 and FY 2013-14, the add-on for the

LTC RATE ADJUSTMENT

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above-mentioned providers will be \$0.25 excluding ICF/DD-H and ICF/DD-N facilities, who will receive \$0.48.

6. Adult Day Holiday mandated add-on reimburses ICF/DD facilities for adult day care or transportation service during the period between Christmas and New Years. A \$0.16 add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
7. Effective January 2012, CMS requires all health care organizations that submit transactions electronically to upgrade from Version 4010/4010A to Version 5010 transaction standards. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012 and retroactive to January 2012. An add-on from \$0.13 through 0.18 to the rates to reimburse the facilities for the additional costs will be effective for the 2012-13 rate year.
8. Effective January 2011, the California Department of Public Health (CDPH) mandates LTC facilities to implement informed consent requirements for the administration of psychotherapeutic drugs. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to January 2011. An add-on from \$0.11 through \$0.19 to the rates to reimburse the facilities for the additional costs will be effective for the 2012-13 and 2013-14 rate year.
9. The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. An add-on from \$0.11 through \$0.17 to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
10. Under the Affordable Care Act § 6401(a), enrolled facilities have to revalidate their enrollment information under enrollment screening criteria. A CMS revalidation add-on from \$0.02 through \$0.06 reimburses enrolled facilities for revalidation costs. This add-on will be effective for 2012-13 rate year excluding ICF/DD, ICF/DD-H and ICF/DD-N.
11. Effective April 2012, CDPH requires providers to submit a new standard admission agreement form, which requires additional costs for printing and staff training. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to April 2012. An add-on from \$0.02 through \$0.04 to the rates to reimburse the facilities for the additional costs will be effective for the 2012-13 and 2013-14 rate year excluding ICF/DD, ICF/DD-H and ICF/DD-N facilities.
12. Under Elder Justice Act, Federally Funded Long Term Care (LTC) facilities have to report to Law Enforcement of crimes occurring in the facilities. An Elder Justice Act add-on from \$0.01 through \$0.04 reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and 2013-14 rate year.
13. Effective July 1, 2010, SB 183 (Chapter 19, Statutes of 2010), the Carbon Monoxide Poisoning Prevention Act, requires single-family dwelling units to have installed a carbon monoxide device that is designed to detect carbon monoxide and produce a distinct, audible alarm, which must be approved by the State Fire Marshal. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to July 2011. This add-on is only applicable to ICF/DD Hs and Ns. This 2012-13 add-on from \$0.02 through \$0.05 is only applicable to ICF/DD-Hs and ICF/DD-Ns.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 140

14. The estimated 11-month impact of the August 1, 2012 rate increase in FY 2012-13 for managed care plans is \$5,970,000 and these costs are included in this policy change.

(In Thousands)

Fee-for-Service	FY 2012-13	FY 2013-14
DP Adult Subacute Rate Increase 2012-13	\$20,784	\$22,674
DP Pediatric Subacute Rate Increase 2012-13	\$863	\$942
FS Pediatric Subacute QAF Impact 2012-13	\$8,480	\$9,548
MDS 3.0 2012-13	\$1,106	\$101
Vaccine 2012-13	\$1,524	\$139
Adult Day Holiday 2012-13	\$40	\$4
New - 5010 Transaction Standards 2012-13	\$634	\$58
New - Informed Consent 2012-13	\$198	\$18
New- FUTA 2012-13	\$583	\$53
New- CMS Revalidation 2012-13	\$43	\$4
New - Std Adm Agreement 2012-13	\$39	\$3
New- Elder Justice Act 2012-13	\$107	\$10
New- Carbon Monoxide 2012-13	\$103	\$9
DP Adult Subacute Rate Increase 2013-14		\$19,378
DP Pediatric Subacute Rate Increase 2013-14		\$697
FS Pediatric Subacute QAF Impact 2013-14		\$4,376
MDS 3.0 2013-14		\$721
Vaccine 2013-14		\$1,435
Adult Day Holiday 2013-14		\$40
New - 5010 Transaction Standards 2013-14		
New - Informed Consent 2013-14		\$197
New- FUTA 2013-14		\$583
New- CMS Revalidation 2013-14		
New - Std Adm Agreement 2013-14		\$39
New- Elder Justice Act 2013-14		\$106
New- Carbon Monoxide 2013-14		
Total FFS Cost	\$30,504	\$61,135
Managed care	\$5,971	\$6,513
Total Cost	\$40,475	\$67,648

Funding:

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

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 141
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1508

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$39,072,000	\$42,624,000
- STATE FUNDS	\$19,536,000	\$21,312,000
PAYMENT LAG	0.9211	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$35,989,200	\$42,624,000
STATE FUNDS	\$17,994,610	\$21,312,000
FEDERAL FUNDS	\$17,994,610	\$21,312,000

DESCRIPTION**Purpose:**

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

Authority:

AB 1629 (Chapter 875, Statutes of 2004)
 ABX1 19 (Chapter 4, Statutes of 2011)
 AB 1489 (Chapter 631, Statutes of 2012)

Interdependent Policy Changes:

PC 151 Eliminate 2012-13 Rate Increase & Supp. Payment
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

AB 1629 requires the Department to collect a Quality Assurance (QA) Fee from NF-Bs, including adult subacute days. The Department collects QA fees from licensed NF-Bs as a means to enhance federal financial participation for the Medi-Cal program as well as to provide higher reimbursement to support quality improvement efforts in these facilities. The fee program sunsets on July 31, 2015.

To determine the QAF assessment, the Department uses two-year old data as the base revenues and applies growth and trending adjustments to project the actual revenues expected for the fiscal year. The incremental increase in the QAF revenues from year to year is used to adjust rates for these facilities.

The QAF and other fees, including licensing and certification fees, cannot collectively exceed what is known as the federal safe harbor limit, which is 6.0%, effective October 1, 2011. Changes in the amount of licensing and certification fees for NF-Bs, assessed by the California Department of Public

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 141

Health (CDPH), affect the amount of QAF that can be collected and remain within the federal safe harbor limit.

A rate increase of 1.973% will be provided for the 2012-13 rate year. These rate increases are budgeted in the NF-B Rate Changes policy change. AB 1489 implemented a rate freeze in the 2012-13 rate year, and a 3% increase in the 2013-14 rate year.

Reason for Change from Prior Estimate:

Estimates were updated to reflect projected changes in QA fee revenues in FY 2012-13 and FY 2013-14.

Methodology:

1. The amounts shown below are based upon an August 1 effective date.
2. The General Fund amount shown here is equal to the QAF revenue deposited in the State's General Fund, on an accrual basis.

	FY 2012-13	
	TF	GF
FFS	\$24,852,000	\$12,426,000
Managed care	\$14,220,000	\$7,110,000
Total:	\$39,072,000	\$19,536,000

	FY 2013-14	
	TF	GF
FFS	\$27,111,000	\$13,555,500
Managed care	\$15,513,000	\$7,756,500
Total:	\$42,624,000	\$21,312,000

Funding:

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

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 142
 IMPLEMENTATION DATE: 11/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1612

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$23,523,000	\$14,803,000
- STATE FUNDS	\$11,761,000	\$7,402,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$23,523,000	\$14,803,000
STATE FUNDS	\$11,761,000	\$7,402,000
FEDERAL FUNDS	\$11,762,000	\$7,401,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

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

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

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

Upon federal approval, the Department will implement a two-phased approach to distribute EMATA funds to emergency air medical transportation providers. In the initial phase, the Department will

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 142

provide supplemental payments for Medi-Cal air medical transportation services provided to Medi-Cal beneficiaries from January 7, 2012 to June 30, 2012 (Phase I). For the second phase, effective from July 1, 2012 to January 1, 2018 (Phase II), the Department will provide payment augmentations to air medical transportation services. The payment augmentation per transport amount will be calculated every six months.

Reason for Change from Prior Estimate:

The change is due to:

- Implementation date changed from July 2012 to November 2012 because of delay in expected federal approval and implementing necessary system changes, and
- Revised penalty collections.

Methodology:

1. Implementation date will begin in November 2012.
2. For the Phase I, assume \$7,641,000 EMATA funds will be used to calculate supplemental payments per transport. 20% of this amount will be used to offset the FY 2011-12 GF costs of fee-for-service (FFS) emergency air medical transportation services. The remaining 80% will be matched with federal funds and paid as supplemental payments in FY 2012-13 to FFS air medical transportation providers.

$\$7,641,000 \times 20\% = \$1,528,000$ (GF offset)

$\$7,641,000 - \$1,528,000 = \$6,113,000 \times 2 = \$12,226,000$ (\$6,113,000 EMATA Fund)

3. For the Phase II, the payments for medical emergency Medi-Cal air medical transportation services will be adjusted every six months based on penalties collected from most vehicle violation convictions. 20% of the amount will be used to offset GF costs of emergency air medical transportation services for the same fiscal year. 75% of the remaining 80% of the amount will be matched with federal funds and used to augment the rate for FFS and managed care air medical transportation services. The remaining amount will be kept in the fund as a reserve.
4. The estimated EMATA funds for the Phase II on an accrual basis are:

(in Thousands)	EMATA Fund	GF Offset (20%)	Available for Rate Augmentation
FY 2012-13			
Jul. 2012-Dec. 2012	\$4,767	\$953	\$2,860
Jan. 2013-Jun. 2013	\$6,520	\$1,304	\$3,912
Total	\$11,287	\$2,257	\$6,772
FY 2013-14			
Jul. 2013-Dec. 2013	\$6,520	\$1,304	\$3,912
Jan. 2014-Jun. 2014	\$6,520	\$1,304	\$3,912
Total	\$13,040	\$2,608	\$7,824

AIR AMBULANCE MEDICAL TRANSPORTATION

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5. The estimated payments on a cash basis are:

(In Thousands)

FY 2012-13	TF	GF	FFP	EMATA
GF Offset	\$0	(\$3,786)	\$0	\$3,786
FFS (lagged)	\$20,137		\$10,069	\$10,068
Managed Care	\$3,386		\$1,693	\$1,693
Total	\$23,523	(\$3,786)	\$11,762	\$15,547
FY 2013-14				
GF Offset	\$0	(\$2,608)	\$0	\$2,608
FFS (lagged)	\$10,891	\$0	\$5,445	\$5,446
Managed Care	\$3,912		\$1,956	\$1,956
Total	\$14,803	(\$2,608)	\$7,401	\$10,010

Funding:

Title XIX FFP (4260-101-0890)

Title XIX GF (4260-101-0001)

EMATA Fund (4260-101-3168)

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 143
 IMPLEMENTATION DATE: 10/2005
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 88

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$12,406,000	\$17,511,000
- STATE FUNDS	\$6,203,000	\$8,755,500
PAYMENT LAG	0.8902	0.9010
% REFLECTED IN BASE	49.68 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,557,300	\$15,777,400
STATE FUNDS	\$2,778,620	\$7,888,700
FEDERAL FUNDS	\$2,778,630	\$7,888,710

DESCRIPTION

Purpose:

This policy change estimates the annual Medicare Economic Index (MEI) increase for all Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) under the prospective payment system (PPS) reimbursement methodology.

Authority:

Section 1833 of the Social Security Act

Interdependent Policy Changes:

Not Applicable

Background:

The Benefits Improvement and Protection Act of 2000 required the Department to reimburse FQHCs and RHCs based on the PPS reimbursement methodology. Clinics chose 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. The clinic receives an annual rate adjustment based on the percentage increase in the MEI and is effective October 1st of each year.

Reason for Change from Prior Estimate:

Updated data for the number of visits and dollars became available.

Methodology:

1. Assume utilization will increase 5.35% in year 2012 and 2.83% in year 2013. Utilization is based on the average percent increase of visits over the past three years prior to the preceding year.
2. Apply the utilization factors to the actual 2011 visits.

ANNUAL MEI INCREASE FOR FQHCS/RHCS

REGULAR POLICY CHANGE NUMBER: 143

2011 Visits		2012 Visits
9,260,203	5.35%	9,755,899
2012 Visits		2013 Visits
9,755,899	2.83%	10,032,227

3. The annual MEI increase will be used as a trend factor to calculate the estimated cost per visit (rate). The MEI increase percent is 0.4% for year 2011 and 0.6% for year 2012. The estimated MEI increase percent for year 2013 is 0.73% based on the average percent of MEI increase over the past three years. Therefore, the estimated rates are:

	Rate without MEI	Rate with MEI
2011	\$152.94	$\$152.94 \times (1+0.4\%) = \153.55
2012	\$153.55	$\$153.55 \times (1+0.6\%) = \154.47
2013	\$154.47	$\$154.47 \times (1+0.73\%) = \155.60

4. The estimated expenditures are the estimated rate multiplied the estimated visits. The annual expenditures due to MEI increase are:

(In Thousands)

	Expenditures without MEI	Expenditures with MEI	MEI Increase
2011	\$1,416,255	\$1,421,920	\$5,665
2012	\$1,498,034	\$1,507,022	\$8,988
2013*	\$1,549,654	\$1,561,018	\$11,364

*Calculation may vary due to rounding.

5. For FY 2012-13, the total MEI increase includes an annualized MEI increase for year 2011 and nine months of year 2012 MEI increase.
6. For FY 2013-14, the total MEI increase includes an annualized MEI increase for year 2012 and nine months of year 2013 MEI increase.

(In Thousands)

	TF	GF
FY 2012-13		
2011 MEI Increase	\$5,665	\$2,833
2012 MEI Increase	\$6,741	\$3,371
Total	\$12,406	\$6,203
FY 2013-14		
2012 MEI Increase	\$8,988	\$4,494
2013 MEI Increase	\$8,523	\$4,262
Total	\$17,511	\$8,756

Funding:

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

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 144
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 96

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$7,684,000	\$12,460,000
- STATE FUNDS	\$3,842,000	\$6,230,000
PAYMENT LAG	0.8722	0.9171
% REFLECTED IN BASE	31.46 %	1.14 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,593,500	\$11,296,800
STATE FUNDS	\$2,296,770	\$5,648,400
FEDERAL FUNDS	\$2,296,770	\$5,648,400

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

1. Hospice Services

Medi-Cal hospice service rates are established in accordance with Section 1902(a)(13), (42 USC 1396 a(a)(13)) of the federal Social Security Act. This act requires annual rate increases for hospice care services based on corresponding Medicare rates effective October 1st of each year.

2. Hospice Room and Board

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

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

HOSPICE RATE INCREASES

REGULAR POLICY CHANGE NUMBER: 144

Reason for Change from Prior Estimate:

Estimate changes are due to the use of updated utilization data for hospice services and the addition of hospice room and board rate increases in FY 2012-13 and FY 2013-14.

Methodology:

1. This policy change estimates the annual rate increases for hospice services effective October 1, 2012.
2. The estimated weighted increase for hospice service rates for FY 2012-13 and FY 2013-14 are 2.85% and 2.77% respectively.
3. Effective June 1, 2011, AB 97 allows the Department to implement rate freezes at the 2008-09 levels for all LTCs other than Freestanding Skilled Nursing and Freestanding Adult Subacute Nursing Facilities.

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

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

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

4. The weighted increase for hospice room and board rates for FY 2012-13 and FY 2013-14 is estimated to be 3.93%.

	FY 2012-13	FY 2013-14
FY 2011-12 Hospice Services	\$2,045,000	(In Base)
FY 2012-13 Hospice Services	\$1,634,000	\$2,180,000
FY 2012-13 Room & Board	\$4,005,000	\$4,369,000
FY 2013-14 Hospice Services		\$1,743,000
FY 2013-14 Room & Board		\$4,168,000
TOTAL	\$7,684,000	\$12,460,000

Funding:

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

QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

REGULAR POLICY CHANGE NUMBER: 145
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1563

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$41,402,000
- STATE FUNDS	\$0	\$20,701,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$41,402,000
STATE FUNDS	\$0	\$20,701,000
FEDERAL FUNDS	\$0	\$20,701,000

DESCRIPTION

Purpose:

This policy change estimates the transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund). Additionally, the policy change estimates the supplemental payments expected to be made to freestanding nursing facilities (NF-Bs) through the Special Fund in FY 2013-14.

Authority:

SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code 14126.022
 AB 1489 (Chapter 631, Statutes of 2012)

Interdependent Policy Changes:

PC 151 Eliminate 2012-13 Rate Increase & Supp. Payment

Background:

SB 853 implemented a quality and accountability payments program for NF-Bs. Supplemental payments will begin in rate year 2013-14 and will be paid through the Special Fund. The Special Fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, 1% of the weighted average rate increase on NF-Bs, and the savings achieved from setting the professional liability insurance (PLI) cost category at the 75th percentile. The California Department of Aging (CDA) has direct appropriation authority of \$1.9 million from the Special Fund to pay for the Ombudsman costs that is not matched with Federal Financial Participation (FFP). The California Department of Public Health (CDPH) administrative costs will be reimbursed from the Special Fund by the Department.

Reason for Change from Prior Estimate:

- AB 1489 postpones the supplemental payment from FY 2012-13 to FY 2013-14. The funds associated with the PLI savings and 1% average rate increase set aside that were scheduled to be transferred from the GF to the Special Fund in FY 2012-13 are being retained in the GF.
- The amount of the administrative penalties has been reduced to \$200,000. This reduction is due to a reduction in the total assessed penalties.

QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

REGULAR POLICY CHANGE NUMBER: 145

Methodology:

1. Administrative costs as well as supplemental payments are eligible for an FFP match. CDA Ombudsman costs are not eligible for FFP.
2. In FY 2013-14, \$25,365,000 will be transferred from the GF to the Special Fund for payment of CDA Ombudsman costs, CDPH administrative costs and supplemental payments to nursing facilities.
3. In FY 2012-13 and FY 2013-14, \$200,000 annually administrative penalties will be deposited into the CDPH Skilled Nursing Facility Minimum Staffing Penalty Account and then transferred to the Special Fund. Quality payments will be adjusted in accordance with the amount of administrative penalties deposited into the Special Fund.
4. In FY 2013-14, supplemental payments are estimated to be \$41,402,000 TF (\$20,701,000 Special Fund).

(In Thousands)

	FY 2012-13		FY 2013-14	
	TF	SF	TF	SF
Supplemental Payments***	\$0	\$0	\$41,402	\$20,701
Transfer from GF *	\$0	\$0	\$0	\$25,365
Transfer to Special Fund**	\$0	\$0	\$0	(\$25,365)
Total	\$0	\$0	\$41,402	\$20,701

Funding:

100% General Fund (4260-605-0001)*

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

SNF Quality & Accountability (4260-605-3167)***

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

SB 90 PRESERVING CONTRACT HOSPITALS

REGULAR POLICY CHANGE NUMBER: 146
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1607

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$34,974,000	-\$34,974,000
- STATE FUNDS	-\$17,487,000	-\$17,487,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

SB 90 (Chapter 19, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

SB 90 included a provision that required the amount of any Quality Assurance Fee supplemental payment for a contract hospital that converts to noncontract status be reduced by the amount by which that hospital's overall payment for services for Medi-Cal patients during the program period was increased by reason of it becoming a noncontract hospital. This provision will negate any financial benefit from a contract hospital converting to noncontract status.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

This provision provides the Selective Provider Contracting Program (SPCP) with increased leverage in negotiations with hospitals to reduce the expected rate of growth. Based on additional data, estimated savings are \$34.974 million TF (\$17.487 million GF) in FY 2011-12 and after from the lowered rate of growth in contract hospital negotiated rates.

(In Thousands)	<u>GF</u>	<u>FF</u>	<u>TF</u>
FY 2012-13 & FY 2013-14	(\$17,487)	(\$17,487)	(\$34,974)

SB 90 PRESERVING CONTRACT HOSPITALS

REGULAR POLICY CHANGE NUMBER: 146

Funding:

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

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 147
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1185

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,197,000	\$0
- STATE FUNDS	-\$2,098,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,197,000	\$0
STATE FUNDS	-\$2,098,500	\$0
FEDERAL FUNDS	-\$2,098,500	\$0

DESCRIPTION

Purpose:

This policy change budgets the retroactive adjustments to dental managed care rates impacting prior fiscal years.

Authority:

Welfare & Institutions Code 14301(a)

Interdependent Policy Changes:

Not Applicable

Background:

The W&I code authorizes the Department to determine the annual rate of payment for services provided for Medi-Cal beneficiaries enrolled in a prepaid health plan and to implement the new annual rates through an amendment to the contract.

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

In August 2012, the Department terminated their contracts with one of the plans due to the plan's inability to maintain the requirements of their Knox Keene license. The Department also terminated their contracts with another plan which planned to cease operations effective June 1, 2012. The Department determined \$2 million has been uncollected from the two plans.

Reason for Change from Prior Estimate:

The Department terminated contracts with two dental plans and is in the process of collecting the outstanding amounts owed.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 147

Methodology:

1. Sacramento Geographic Managed Care (GMC) dental rates have changes that are retroactive to January 2012. The prior rate of \$11.83 for those under 21 and \$2.91 for those 21 or over effective January through December 2011 has changed to \$11.46 for those under 21 years of age and \$1.45 for those 21 or over, effective January through June 2012.
2. Prepaid Health Plan (PHP) dental rates have changes that are retroactive to January 2012. The prior rate of \$11.83 for those under 21 and \$2.91 for those 21 or over effective January through December 2011 changed to \$11.46 for those under 21 years of age and \$1.45 for those 21 or over, effective January through June 2012.
3. The Program of All-Inclusive Care for the Elderly (PACE) retroactive rate adjustments are reflected in the PACE (Other M/C) policy change.
4. The Senior Care Action Network (SCAN) retroactive rate adjustments are reflected in the Senior Care Action Network policy change.
5. The revised rates were implemented on an ongoing basis beginning with the January 2012 capitation payments. This policy change budgets the retroactive changes for the period from January 2012 through June 2012.
6. It is assumed that retroactive adjustments for the period of January 2012 through June 2012 will be completed in FY 2012-13.
7. Health Net PHP Dental Plan has been amended and is being paid the current 2012 rates.
8. Assume the Department will receive the outstanding balances owed from the two plans in FY 2012-13.
9. Retroactive adjustments, totaling \$7 million, for the period of July 2009 through February 2011, were collected in FY 2011-12.

	<u>Existing Rate</u>	<u>New Rate</u>	<u>Change</u>	<u>Eligible Months</u>	<u>Dental Retro Rate Adjustment</u>
GMC Jan-June 2012					
<21	\$11.83	\$11.46	(\$0.37)	831,436	(\$307,631)
21+	\$2.91	\$1.45	(\$1.46)	461,876	(\$674,339)
PHP Jan-June 2012					
<21	\$11.83	\$11.46	(\$0.37)	1,272,576	(\$470,853)
21+	\$2.91	\$1.45	(\$1.46)	509,868	(\$744,407)
Total Dental Retroactive Adjustments					(\$2,197,000)

FY 2012-13

Outstanding invoices	(\$2,000,000)
FY 2012-13 Adjustment	(\$2,197,000)
FY 2012-13 Total	(\$4,197,000)

Funding:

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

LABORATORY RATE METHDODOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 148
 IMPLEMENTATION DATE: 3/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1703

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$8,476,000	-\$25,431,000
- STATE FUNDS	-\$4,238,000	-\$12,715,500
PAYMENT LAG	0.7547	0.9800
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$6,396,800	-\$24,922,400
STATE FUNDS	-\$3,198,420	-\$12,461,190
FEDERAL FUNDS	-\$3,198,420	-\$12,461,190

DESCRIPTION

Purpose:

This policy change estimates savings related to a clinical laboratory reimbursement reduction of up to 10%, and the savings from a new clinical laboratory reimbursement methodology.

Authority:

AB 1467 (Chapter 23, Statutes of 2012)
 AB 1494 (Chapter 28, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1494 (Chapter 28, Statutes of 2012) allows the Department to develop a new rate methodology for clinical laboratory and laboratory services. In addition to 10% payment reductions pursuant to AB 97 (Chapter 3, Statutes of 2012), AB 1494 allows payments to be reduced by 10% for clinical lab services for dates of service on and after July 1, 2012. The 10% payment reduction pursuant to AB 1494 shall continue until the new rate methodology has been approved by the Centers for Medicare and Medicaid Services (CMS). The Family Planning, Access, Care, and Treatment Program shall be exempt from the payment reduction as specified in AB 1494.

Reason for Change from Prior Estimate:

Implementation date changed from July 2012 to March 2013 because of delay in expected federal approval.

Methodology:

1. Assume savings will begin upon CMS approval and the subsequent CAMMIS system implementation. The system implementation for the 10% payment reduction is anticipated to take place in March of 2013. The retroactive date for the 10% payment reduction is July 1, 2012.
2. The new laboratory rate methodology will be implemented on July 1, 2013.

LABORATORY RATE METHDOLOGY CHANGE**REGULAR POLICY CHANGE NUMBER: 148**

3. The projected weighted average reduction is 10% for FY 2012-13 and FY 2013-14.
4. The 10% reduction will be assessed after the AB97 (Chapter 3, Statutes of 2011) 10% reduction.
5. Annual savings are projected at \$16,954,000.
6. Savings in 2012-13 will consist of 4 months of the 10% payment reduction and 4 months of retroactive savings.
7. Savings in 2013-14 will consist of 12 months of the new methodology and 12 months of retroactive savings.
8. The total recoupment of retroactive savings from July 1, 2012 to February 28, 2013, is estimated to be \$11,303,000 and is expected to occur over 16 months beginning March 2013.

Total recoupment of retroactive savings:
 Annual Savings is projected at \$16,954,000
 $\$16,954,000 / 12 \text{ months} * 8 \text{ months} = \$11,303,000$
 Monthly recoupment amount is \$706,000

FY 2012-13	TF	GF
Savings	(\$5,651,000)	(\$2,825,500)
Recoupment	(\$2,825,000)	(\$1,412,500)
Total Savings:	(\$8,476,000)	(\$4,238,000)
FY 2013-14		
Savings	(\$16,954,000)	(\$8,477,000)
Recoupment	(\$8,477,000)	(\$4,238,500)
Total Savings:	(\$25,431,000)	(\$12,715,500)

Funding:

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

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 149
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1505

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$30,875,000	-\$50,264,000
- STATE FUNDS	-\$15,437,500	-\$25,132,000
PAYMENT LAG	0.7832	0.9887
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$24,181,300	-\$49,696,000
STATE FUNDS	-\$12,090,650	-\$24,848,010
FEDERAL FUNDS	-\$12,090,650	-\$24,848,010

DESCRIPTION

Purpose:

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

Authority:

SB 853 (Chapter 717, Statutes of 2010), Welfare and Institutions Code 14105.08.

Interdependent Policy Changes:

Not Applicable

Background:

SB 853 mandates that Medi-Cal rates for radiology services may not exceed 80% of Medicare rates with dates of service on or after October 1, 2010. Radiology rates in excess of this amount will be reduced.

Reason for Change from Prior Estimate:

Because of delay in expected federal approval, implementation date was changed from July 2012 to January 2013. Due to the delay, a two-year retroactive application of this reduction could adversely impact access to needed radiology services. In light of the AB 97 (Chapter 3, Statutes of 2011) 10% reduction, and that federal approval of a reduction with a lengthy retroactive recoupment is extremely unlikely, the effective date for retroactive savings shifted from October 1, 2010 to July 1, 2012.

Methodology:

1. Implementation will begin in January 2013.
2. Rate reductions will be retroactive to July 1, 2012.
3. The rate reductions will apply to radiology services that are paid at reimbursement rates exceeding 80% of Medicare rates. The weighted average reduction for rates above 80% of Medicare is 18%.
4. Based on 2010 Medi-Cal payment rate data, the rate reductions will result in an annual fee-for-service savings of \$40,570,000. The 2010 Medi-Cal payment rate includes a 1% reduction to

REDUCTION TO RADIOLOGY RATES**REGULAR POLICY CHANGE NUMBER: 149**

radiology services as required by AB 1183 (Chapter 758, Statutes of 2008).

5. There is no managed care impact as a result of this reduction because managed care capitation rates are calculated using radiology rates that are at or below 80% of Medicare rates.
6. The total recoupment of retroactive savings from July 1, 2012 to December 31, 2012, is estimated to be \$20,285,000 and is expected to occur over 11.49 months beginning January 2013.

Total recoupment of retroactive savings:
 $\$40,570,000 / 12 \text{ months} * 27 \text{ months} = \$91,283,000$
 Monthly recoupment amount is \$1,765,000

FY 2012-13	<u>TF</u>	<u>GF</u>
2012-13 Savings	(\$20,285,000)	(\$10,142,500)
Recoupment of Retro Savings	(\$10,590,000)	(\$5,295,000)
Total	(\$30,875,000)	(\$15,437,500)

FY 2013-14	<u>TF</u>	<u>GF</u>
2012-13 Savings	(\$40,570,000)	(\$20,285,000)
Recoupment of Retro Savings	(\$9,694,000)	(\$4,847,000)
Total	(\$50,264,000)	(\$25,132,000)

Funding:

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

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 150
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1597

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$44,324,000	-\$101,111,000
- STATE FUNDS	-\$22,162,000	-\$50,555,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$44,324,000	-\$101,111,000
STATE FUNDS	-\$22,162,000	-\$50,555,500
FEDERAL FUNDS	-\$22,162,000	-\$50,555,500

DESCRIPTION**Purpose:**

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

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

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

Authority:

ABX4 5 (Chapter 5, Statutes of 2009)

AB 97 (Chapter 3, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

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

ABX4 5 eliminated rate increases for these facilities effective August 1, 2009. In the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute providers, effective February 25, 2010.

Effective June 1, 2011, AB 97 requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5. The Department received approval from the

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 150

Centers for Medicare and Medicaid Services (CMS) to implement a rate freeze on NF-As and DP/NF-B.

The California Hospital Association (CHA) filed a lawsuit challenging the 10% reduction and freeze at the rates established in 2008-2009, required by AB 97, with respect to DP/NF-B facilities. On December 28, 2011, the federal court issued a preliminary injunction. The Department is complying with the injunction according to its provisions.

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

Reason for Change from Prior Estimate:

Delay in implementation due to pending the State Plan Amendment (SPA) approvals, ongoing litigation, and additional workload that the litigation has created for the Fiscal Intermediary.

Methodology:

1. Assume the rate freeze will begin June 1, 2011.
2. For DP/NF-Bs, the rate freeze and payment reduction will be implemented based on dates of service. For dates of services from 06/01/11 to 12/27/11, the Department will only implement the rate freeze and payment reduction for those DP/NF-Bs that have not been reimbursed prior to 12/28/11. For dates of service 12/28/11 and forward, the rate freeze and payment reduction will not be implemented for all payments due to facilities after 12/28/11. The Department assumes to receive favorable rulings on the appeals by October 2012.
3. Rates are currently being paid at the 2010-11 level for Rural Swings Beds. DP/NF-B is assumed to be paid at 2011-12 level.

Funding:

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

ELIMINATE 2012-13 RATE INCREASE & SUPP. PAYMENT

REGULAR POLICY CHANGE NUMBER: 151
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1683

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$81,470,000	-\$81,088,000
- STATE FUNDS	-\$40,735,000	-\$40,544,000
PAYMENT LAG	0.9022	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$73,502,200	-\$81,088,000
STATE FUNDS	-\$36,751,120	-\$40,544,000
FEDERAL FUNDS	-\$36,751,120	-\$40,544,000

DESCRIPTION

Purpose:

This policy change estimates the savings from redirecting the 2012-13 rate increase for AB 1629 freestanding skilled nursing facilities (NF-Bs) and Professional Liability Insurance (PLI) savings to the General Fund (GF).

Authority:

AB 1489 (Chapter 631, Statutes 2012)

Interdependent Policy Changes:

PC 138 NF-B Rate Changes

PC 145 Quality and Accountability Payments Program

Background:

ABX1 19 (Chapter 4, Statutes of 2011) provides AB 1629 facilities an overall rate increase of 1.973% for the 2012-13 rate year.

AB 1489 freezes the AB 1629 facility rates for the 2012-13 rate year at the rate on file as of August 1, 2011 and provides a 3% rate increase for the 2013-14 rate year. These rate increases are budgeted in the NF-B Rate Changes policy change.

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability payments program for AB 1629 facilities. This program provides the supplemental payments to NF-Bs that meet certain performance measures. SB 853 also requires the Department to transfer the GF portion of savings from capping the PLI cost category at the 75th percentile into the program special fund. The Department will provide the mandated supplemental payments starting in the 2013-14 rate year. The supplemental payments are budgeted in the Quality and Accountability Payments Program policy change.

Reason for Change from Prior Estimate:

- Updated reimbursement data became available.

ELIMINATE 2012-13 RATE INCREASE & SUPP. PAYMENT

REGULAR POLICY CHANGE NUMBER: 151

- The savings from the 3rd checkwrite deferral are 100% incorporated in the Base Estimate.

Methodology:

1. The estimated savings from redirecting funding for 12-13 rate increases are \$73,681,000 TF (\$36,840,500 GF) in FY 2012-13 and \$80,380,000 TF (\$40,190,000 GF) in FY 2013-14.
2. The estimated 2012-13 PLI savings are \$7,789,000 TF (\$3,894,500 GF) in FY 2012-13 and \$708,000 TF (\$354,000 GF) in FY 2013-14.
3. The estimated savings from 3rd checkwrite payment deferral are \$74,800,000 TF (\$37,400,000 GF).

	<u>TF</u>	<u>GF</u>
FY 2012-13		
Eliminate 12-13 Rate Increase	(\$73,681,000)	(\$36,840,500)
Retain 12-13 PLI Savings	(\$7,789,000)	(\$3,894,500)
Subtotal	(\$81,470,000)	(\$40,735,000)
Delay 3rd Checkwrite (In Base)	(\$74,800,000)	(\$37,400,000)
Total	(\$156,270,000)	(\$78,135,000)
FY 2013-14		
Eliminate 12-13 Rate Increase	(\$80,380,000)	(\$40,190,000)
Retain 12-13 PLI Savings	(\$708,000)	(\$354,000)
Total	(\$81,088,000)	(\$40,544,000)

Funding:

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

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 152
 IMPLEMENTATION DATE: 5/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1579

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$90,430,000	-\$77,145,000
- STATE FUNDS	-\$45,215,000	-\$38,572,500
PAYMENT LAG	0.9886	1.0000
% REFLECTED IN BASE	21.28 %	0.08 %
APPLIED TO BASE		
TOTAL FUNDS	-\$70,375,000	-\$77,083,300
STATE FUNDS	-\$35,187,480	-\$38,541,640
FEDERAL FUNDS	-\$35,187,490	-\$38,541,640

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 139 10% Pymt Reduction Restoration for AB 1629 Fac.
 PC 171 AB 97 Injunctions
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent reduction. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to specified providers.

Effective June 1, 2011, AB 97 required the Department to reduce payments to long-term care facilities by up to 10% in FFS and the actuarially equivalent of that amount in managed care. However, ABX1 19 required the Department to reduce rates for Freestanding Pediatric Subacute facilities by 5.75% below rate year 2008-09 rates. Additionally, under ABX1 19, the 10% payment reduction for AB 1629 facilities

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 152

ended on July 31, 2012. A one-time supplemental payment will be made by December 2012 to restore the reductions imposed on AB 1629 facilities. The supplemental payment is budgeted in the 10% Payment Reduction Restoration for AB 1629 Facilities policy change.

In addition, the impact of court actions as to the implementation of AB 97 is budgeted in the AB 97 Injunctions policy change.

Reason for Change from Prior Estimate:

Delay in implementation of payment reductions due to pending State Plan Amendment (SPA) approvals, ongoing litigation, and workload issues that the litigation has created for the Fiscal Intermediary.

Methodology:

1. **Managed Care:** Assume there is no retroactive savings for managed care payments and the implementation of the managed care reductions began July 1, 2012.
2. The Department implements the FFS payment reduction in various phases.
3. **AB 1629 Facilities:** This phase includes Freestanding (FS) NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. Since the Department will pay back the 10% payment reduction to this type of facilities in December 2012, there will be no managed care and retroactive FFS savings.
4. **ICF/DDs:** This phase includes ICF/DD, ICF/DD-N, and ICF/DD-H. Assume implementation of payment reductions will begin February 1, 2013. The recoupment effective date is August 1, 2012. Therefore, there are six months of FFS retroactive savings (August 1, 2012 to January 31, 2013). Erroneous Payment Corrections (EPCs) will begin June 1, 2013 to recoup all FFS retroactive savings.
5. **FS Pediatric Subacute:** Implementation of payment reductions will begin March 1, 2013. There are 21 months of FFS retroactive savings (June 1, 2011 to February 28, 2013). EPCs to recoup FFS retroactive savings will begin May 1, 2013.
6. **NF-As:** Implementation of payment reductions began July 1, 2012. There are 13 months of FFS retroactive savings (June 1, 2011 to June 30, 2012). EPCs to recoup FFS retroactive savings began September 1, 2012.
7. **DP/NF-Bs:** This phase includes the enjoined providers. Implementation of payment reductions and EPCs to recoup FFS retroactive savings began July 1, 2012. There are 13 months of FFS retroactive savings (June 1, 2011 to June 30, 2012).
8. Assume the FFS recoupment process will take an average of 24 months to complete once EPCs are implemented. It is estimated that the Department will recoup FFS retroactive savings of \$25,436,000 in FY 2012-13 and \$21,481,000 in FY 2013-14.

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 152

	(In Thousands)	FY 2012-13	FY 2013-14
AB 1629 Facilities	FFS	(\$18,951)	\$0
ICF/DDs	FFS	(\$5,245)	(\$12,588)
	FFS Retro	(\$6,294)	\$0
	Subtotal	(\$11,539)	(\$12,588)
FS Pediatric Subacute	FFS	(\$1,129)	(\$3,388)
	FFS Retro	(\$462)	(\$2,774)
	Subtotal	(\$1,591)	(\$6,162)
NF-As	FFS	(\$338)	(\$338)
	FFS Retro	(\$137)	(\$164)
	Subtotal	(\$475)	(\$502)
DP/NF-Bs (enjoined)	FFS	(\$38,261)	(\$38,261)
	FFS Retro	(\$18,543)	(\$18,543)
	Subtotal	(\$56,804)	(\$56,804)
	Total FFS	(\$63,924)	(\$54,575)
	Total FFS Retro	(\$25,436)	(\$21,481)
	Total Managed Care	(\$1,070)	(\$1,089)
Grand Total		(\$90,430)	(\$77,145)

Funding:

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

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1580

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,041,276,000	-\$1,047,580,000
- STATE FUNDS	-\$520,638,000	-\$523,790,000
PAYMENT LAG	0.9998	1.0000
% REFLECTED IN BASE	6.84 %	6.75 %
APPLIED TO BASE		
TOTAL FUNDS	-\$969,858,700	-\$976,868,400
STATE FUNDS	-\$484,929,360	-\$488,434,180
FEDERAL FUNDS	-\$484,929,360	-\$488,434,180

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 171 AB 97 Injunctions
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

AB 97 requires the Department to implement a 10% provider payment reduction, which will affect all services except:

- Hospital inpatient and outpatient services, critical access hospital, federal rural referral centers;
- Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs);
- Services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs;
- Hospice services;
- Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services; and
- Payments funded by certified public expenditures and intergovernmental transfers.

Effective March 1, 2009, as required by AB 1183, pharmacy and Long-Term Care (LTC) provider payments were reduced by 5% and other fee-for-service (FFS) provider payments were reduced by 1%. Managed care provider payments were reduced by an actuarially equivalent amount. Subsequent court actions enjoined the Department from continuing to implement the payment reductions to

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

specified providers. Therefore, this policy change budgets a 10% payment reduction, effective June 1, 2011, for FFS providers receiving fully restored payments and an additional 9% or 5% payment reduction for FFS providers whose payments are currently reduced by 1% or 5%.

Managed care provider payments will be reduced by the actuarially equivalent amount of the FFS payment reductions.

The Department proposed exempting Pediatric Day Health Care (PDHC) from applying 10% payment reduction effective April 1, 2012. The refund for reduced payment for services on or after April 1, 2012 will be issued in January 2013, or an earlier date.

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

Reason for Change from Prior Estimate:

- Delay in Phase II implementation of payment reductions due to ongoing litigation.
- Workload issues that the litigation has created for the Fiscal Intermediary.

Methodology:

1. **Managed Care:** Assume there is no retroactive savings for managed care payment and the implementation of the managed care reductions began July 1, 2012.
2. The Department implements the FFS payment reduction in three phases.
3. **Phase I:** Phase I includes all subject providers, including the PDHC program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program. Implementation of payment reduction began January 1, 2012. There are seven months of FFS retroactive savings (June 1, 2011 to December 31, 2011). Erroneous Payment Corrections (EPCs) to recoup FFS retroactive savings began July 1, 2012 for payment reductions that are not enjoined. PDHC will be exempt from 10% payment reduction for services provided on or after April 1, 2012. Assume that the PDHC projected refund date is January 1, 2013.
4. **Phase II:** Phase II includes all the enjoined providers. Assume implementation of payment reductions and EPCs to recoup FFS retroactive savings began July 1, 2012. There are 13 months of FFS retroactive savings (June 1, 2011 to June 30, 2012).
5. **Phase III:** Phase III includes the CHDP program providers. Implementation of payment reductions began September 1, 2012. There are 15 months of FFS retroactive savings (June 1, 2011 to August, 31, 2012). EPCs to recoup FFS retroactive savings will begin January 1, 2013.
6. Assume the FFS recoupment process will take an average of 24 months to complete once EPCs are implemented. It is estimated that the Department will recoup FFS retroactive savings of \$246,913,000 in FY 2012-13 and \$247,805,000 in FY 2013-14.

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

	(In Thousands)	FY 2012-13	FY 2013-14
Phase I	FFS	(\$70,504)	(\$70,726)
	FFS Retro	(\$15,661)	(\$15,661)
	Phase I Total	(\$86,165)	(\$86,387)
Phase II	FFS	(\$459,559)	(\$459,560)
	FFS Retro	(\$230,359)	(\$230,359)
	Phase II Total	(\$689,9189)	(\$689,919)
Phase III	FFS	(\$2,573)	(\$3,088)
	FFS Retro	(\$892)	(\$1,785)
	Phase III Total	(\$3,465)	(\$4,873)
	FFS	(\$532,637)	(\$533,374)
	FFS Retro	(\$246,913)	(\$247,805)
	Managed Care	(\$261,726)	(\$266,401)
	Grand Total	(\$1,041,276)	(\$1,047,580)

Funding:

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

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154
 IMPLEMENTATION DATE: 9/2012
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1475

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$7,990,981,000	\$3,420,421,000
- STATE FUNDS	\$4,044,315,000	\$1,731,136,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,990,981,000	\$3,420,421,000
STATE FUNDS	\$4,044,315,000	\$1,731,136,000
FEDERAL FUNDS	\$3,946,666,000	\$1,689,285,000

DESCRIPTION

Purpose:

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

Authority:

AB 1383 (Chapter 627, Statutes of 2009)
 SB 90 (Chapter 19, Statutes of 2011)
 SB 335 (Chapter 286, Statutes of 2011)
 AB 1467 (Chapter 23, Statutes of 2012)
 SB 920 (Chapter 452, Statutes of 2012)

Interdependent Policy Changes:

PC 203 Hospital QAF Program Changes

Background:

AB 1383 authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 1, 2009 through December 31, 2010. AB 1653 (Chapter 218, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

AB 188 (Chapter 645, Statutes of 2009) established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and

HOSPITAL QAF - HOSPITAL PAYMENTS**REGULAR POLICY CHANGE NUMBER: 154**

- Pay for staff and related administrative expenses required to implement the QAF program.

SB 90 extended the Hospital QAF program for the period January 1, 2011 through June 30, 2011 based on a modified amount of payments to hospitals and an increased amount for children's health care coverage.

SB 335 extended the Hospital QAF program from July 1, 2011 through December 31, 2013. On June 22, 2012, the Department received CMS approval to collect fees from the hospitals and make fee-for-services payments to the hospitals retroactive to July 1, 2011.

AB 1467 increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

Reason for Change from Prior Estimate:

AB 1467 changed the funding distribution.

Methodology:

1. The first QAF program was effective April 1, 2009 through December 31, 2010 (QAF I); with a two-quarter extension through June 30, 2011 (QAF II). An additional 30-month QAF program is effective for the time period July 1, 2011 through December 31, 2013 (QAF III).
2. On an accrual basis, the QAF III program fee is expected to generate \$4.3 billion in FY 2011-12, \$4.5 billion in FY 2012-13, and \$2.4 billion in FY 2013-14 in fee-for-service (FFS), managed care capitation, grant payments and mental health payments.
3. First FFS payment of the QAF III program to the hospitals occurred in August 2012.
4. \$22 million of the QAF I program mental health plan payments will be paid in FY 2012-13.
5. \$2 million of the QAF II program FFS payments will be paid in FY 2013-14.
6. \$3.1 million of the QAF II program mental health plan payments will be paid in FY 2013-14.
7. On a cash basis, payments to the hospitals are estimated to be:

	<u>TF</u>	<u>SF(HQARF)</u>	<u>FF</u>
FY 2012-13			
AB 1383*	\$22,000,000	\$11,000,000	\$11,000,000
SB 335***	\$7,968,981,000	\$4,033,315,000	\$3,935,666,000
Total	\$7,990,981,000	\$4,044,315,000	\$3,946,666,000
FY 2013-14			
SB 90**	\$5,143,000	\$2,571,500	\$2,571,500
SB 335***	\$3,415,278,000	\$1,728,564,000	\$1,686,714,000
Total	\$3,420,421,000	\$1,731,135,500	\$1,689,285,500

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

Funding:

Hospital Quality Assurance Revenue Fund (4260-601-3158)*

Hospital Quality Assurance Revenue Fund (4260-610-3158)**

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

Title XIX FFP (4260-101-0890)

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 155
 IMPLEMENTATION DATE: 4/2004
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 78

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$218,418,000	\$205,995,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$218,418,000	\$205,995,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$218,418,000	\$205,995,000

DESCRIPTION

Purpose:

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

Authority:

AB 915 (Chapter 747, Statutes of 2002)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

The Department has received revised claims from counties for FY 2005-06 through FY 2010-11 and conducted a reconciliation of FY 2012-13 claims, which resulted in additional payments of \$9.4 million.

Methodology:

- Under the American Recovery and Reinvestment Act of 2009 (ARRA), FMAP increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.
- The reconciliation mandated by AB 915 against audited cost reports began in FY 2012-13.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT**REGULAR POLICY CHANGE NUMBER: 155**

Additional payments of \$9,385,000 for service year 2002-03 are expected to be made in FY 2012-13 as a result of the reconciliation.

3. Payments of \$209,033,000 are expected to be made in FY 2012-13 based on CPE claims for FY 2005-06 through FY 2011-12. Payments are adjusted for the change in the FMAP.
4. The reconciliation for FY 2003-04 is expected to be done in FY 2013-14. Additional payments of \$9,400,000 are expected to be made as a result of the reconciliation.
5. Payments of \$196,595,000 are expected to be made in FY 2013-14 based on CPE claims.

Estimated costs are as follows:

	Regular FFP	FY 2012-13 ARRA	Total FFP
FY 2002-03 (Reconciliation)	\$9,385,000		\$9,385,000
FY 2005-06	\$531,000		\$531,000
FY 2007-08	\$947,000		\$947,000
FY 2008-09	\$71,000	\$29,000	\$100,000
FY 2010-11	\$16,408,000	\$3,098,000	\$19,506,000
FY 2011-12	\$187,949,000		\$187,949,000
	\$215,291,000	\$3,127,000	\$218,418,000
	Regular FFP	FY 2013-14 ARRA	Total FFP
FY 2003-04 (Reconciliation)	\$9,400,000		\$9,400,000
FY 2012-13	\$196,595,000		\$196,595,000
	\$205,995,000	\$0	\$205,995,000

Funding:

Title XIX FFP (4260-101-0890)

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 156
 IMPLEMENTATION DATE: 2/2006
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 104

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$126,800,000	\$77,200,000
- STATE FUNDS	\$63,400,000	\$38,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$126,800,000	\$77,200,000
STATE FUNDS	\$63,400,000	\$38,600,000
FEDERAL FUNDS	\$63,400,000	\$38,600,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14164 and 14087.3

Interdependent Policy Changes:

Not Applicable

Background:

This program allows Los Angeles and Alameda Counties to submit IGTs used as the non-federal share of costs to draw down Title XIX federal funds. The Department uses the IGTs matched with the federal funds to make supplemental payments to specified hospitals for the costs of trauma care center services provided to Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:

FY 2012-13 costs increased because FY 2010-11 final trauma payments and FY 2011-12 initial trauma payments were added.

Methodology:

1. IGTs are deposited in the Special Deposit Fund (Local Trauma Centers).

(In Thousands)	<u>Special Deposit Fund</u>	<u>FFP</u>	<u>TF</u>
FY 2010-11	\$12,400	\$12,400	\$24,800
FY 2011-12	\$31,700	\$31,700	\$63,400
FY 2012-13	\$19,300	\$19,300	\$38,600
Total Payments for FY 2012-13	\$63,400	\$63,400	\$126,800

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 156

(In Thousands)	Special Deposit Fund	FFP	TF
FY 2012-13	\$19,300	\$19,300	\$38,600
FY 2013-14	\$19,300	\$19,300	\$38,600
Total Payments for FY 2013-14	\$38,600	\$38,600	\$77,200

Funding Table:

Local Trauma Centers Fund 50% (4260-601-0942142)

Title XIX 50% FFP (4260-101-0890)

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1140

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$120,000,000	\$261,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$120,000,000	\$261,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$120,000,000	\$261,000,000

DESCRIPTION

Purpose:

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

Authority:

AB 959 (Chapter 162, Statutes of 2006), Welfare & Institutions Code 14105.965

Interdependent Policy Change:

Not Applicable

Background:

Under this program, freestanding, non-hospital based clinics that are enrolled as Medi-Cal providers and are owned or operated by the State, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments. The supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal match to draw down federal financial participation (FFP) is paid from the public funds of the participating facilities and does not involve State General Funds for non-state facilities.

A State Plan Amendment (SPA) for this program was approved in August 2012. Supplemental payments to freestanding, non-hospital based clinics will be retroactive to July 1, 2006. Since facilities must submit cost reports and the Department must certify expenditures before FFP can be claimed, supplemental payments for services provided during a fiscal year will not be issued until the completion of audited cost reports.

Reason for Change from Prior Estimate:

The implementation date changed from November 2011 to April 2013 because of a delay in federal approval and a delay in developing the payment process.

Methodology:

1. Supplemental payments for freestanding, non-hospital based clinics are expected to begin April 2013.

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

2. Annual supplemental payments to freestanding, non-hospital based clinics are expected to total between \$60,000,000 and \$66,000,000.
3. Supplemental payments are paid after the completion of cost report audits.

Program payment amounts are estimated to be:

FY 2012-13	TF	FFP
FY 2006-07	\$60,000,000	\$60,000,000
FY 2007-08	\$60,000,000	\$60,000,000
Total	\$120,000,000	\$120,000,000
FY 2013-14		
FY 2008-09	\$63,000,000	\$63,000,000
FY 2009-10	\$66,000,000	\$66,000,000
FY 2010-11	\$66,000,000	\$66,000,000
FY 2011-12	\$66,000,000	\$66,000,000
Total	\$261,000,000	\$261,000,000

Funding:

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

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 158
 IMPLEMENTATION DATE: 7/1991
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 82

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$111,976,000	\$112,557,000
- STATE FUNDS	\$45,854,000	\$46,043,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$111,976,000	\$112,557,000
STATE FUNDS	\$45,854,000	\$46,043,000
FEDERAL FUNDS	\$66,122,000	\$66,514,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

SB 1732 and SB 2665 authorized Medi-Cal reimbursement of revenue and general obligation bond debt for principal and interest costs incurred in the construction, renovation and replacement of qualifying disproportionate share contract hospitals.

SB 1128 authorized a distinct part skilled nursing facility (DP-NF) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP-NF must meet other specific hospital and project conditions specified in Section 14105.26 of the Welfare and Institutions Code.

Reason for Change from Prior Estimate:

There is no material change.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 158

Methodology:

Not Applicable

FY 2012-13	TF	GF	FFP
Hospitals	\$91,708,000	\$45,854,000	\$45,854,000
DP-NFs	\$20,268,000	\$0	\$20,268,000
Total	\$111,976,000	\$44,854,000	\$66,122,000
FY 2013-14	TF	GF	FFP
Hospitals	\$92,086,000	\$46,043,000	\$46,043,000
DP-NFs	\$20,471,000	\$0	\$20,471,000
Total	\$112,557,000	\$46,043,000	\$66,514,000

Funding:

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

Capital Debt 50/50 FFP (4260-102-0001/0890)

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 159
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1600

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$70,000,000	\$70,000,000
- STATE FUNDS	\$35,000,000	\$35,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$70,000,000	\$70,000,000
STATE FUNDS	\$35,000,000	\$35,000,000
FEDERAL FUNDS	\$35,000,000	\$35,000,000

DESCRIPTION

Purpose:

This policy change estimates the revenue and payments for a supplemental reimbursement program for Non-Designated Public Hospitals (NDPHs).

Authority:

AB 113 (Chapter 20, Statutes of 2011)

Interdependent Policy Changes:

PC 104 Eliminate NDPH IGT Supplemental Payment

Background:

AB 113 established a NDPH supplemental payment program funded by intergovernmental transfers (IGTs). AB 113 authorizes the State to retain nine percent of each IGT to reimburse the administrative costs of operating the program and for the benefit of Medi-Cal children's health programs. This policy change also reflects the portion of the nine percent that is used to offset GF costs of Medi-Cal children's health services.

NDPH IGT supplemental payments are being eliminated effective July 1, 2012. See the Eliminate NDPH IGT Supplemental Payments policy change for more information.

Reason for Change from Prior Estimate:

There is no change.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 159

Methodology:

1. The estimated NDPH IGT supplemental payments are:

(In Thousands)

<u>FY 2012-13</u>	<u>TF</u>	<u>GF</u>	<u>IGT</u>	<u>FF</u>
Payments to NDPHs	\$70,000	\$0	\$35,000	\$35,000
Children's Services	\$0	(\$3,322)	\$3,322	\$0
Total 2012-13	\$70,000	(\$3,322)	\$38,322	\$35,000
<u>FY 2013-14</u>				
Payments to NDPHs	\$70,000	\$0	\$35,000	\$35,000
Children's Services	\$0	(\$3,322)	\$3,322	\$0
Total 2013-14	\$70,000	(\$3,322)	\$38,322	\$35,000

Funding:

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

CERTIFICATION PAYMENTS FOR DP-NFS

REGULAR POLICY CHANGE NUMBER: 160
 IMPLEMENTATION DATE: 6/2002
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 86

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$58,782,000	\$38,444,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$58,782,000	\$38,444,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$58,782,000	\$38,444,000

DESCRIPTION

Purpose:

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

Authority:

AB 430 (Chapter 171, Statutes of 2001)

Interdependent Policy Changes:

Not Applicable

Background:

This program is designed to allow DP-NFs to claim FFP on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The acute care hospital must be owned and operated by a public entity, such as a city, county, or health care district.

Reason for Change from Prior Estimate:

Audit results from the Office of Inspector General were incorporated into this policy change.

Methodology:

- Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.
- While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2012-13 that will receive the increased ARRA FMAP as allowed by the federal government. Expenditures may receive the applicable FMAP based on date of service, such as DP-NF payments when Medi-Cal draws the federal funds in a subsequent fiscal year.

CERTIFICATION PAYMENTS FOR DP-NFS**REGULAR POLICY CHANGE NUMBER: 160**

3. The reconciliation, against audited cost reports, started in FY 2010-11. This process is mandated by the Office of Inspector General (OIG) Audit (A-09-05-00050) for fiscal years subsequent to the audit year 2003-04. Interim payments, or recoupment of overpaid funds, are expected during the current fiscal year (represented below).
4. Payments are not made through the fiscal intermediary; consequently, they are not reflected in the Medi-Cal base trend data and must be budgeted in this policy change.
5. Based on a funding of historical data, an estimate of \$58,782,000 FFP and \$38,444,000 FFP will be available in FY 2012-13 and FY 2013-14, respectively.

	FISCAL YEAR 2012-13		
	FFP	ARRA	Total FFP
FY 2012-13	\$53,271,000	\$3,398,000	\$56,669,000
FY 2008-09 Reconciliation	\$1,800,000	\$313,000	\$2,113,000
Total	\$55,071,000	\$3,711,000	\$58,782,000
	FISCAL YEAR 2013-14		
	FFP	ARRA	Total FFP
FY 2013-14	\$36,124,000	\$0	\$36,124,000
FY 2009-10 Reconciliation	\$1,883,000	\$437,000	\$2,320,000
Total	\$38,007,000	\$437,000	\$38,444,000

Funding:

Title XIX FFP (4260-101-0890)

IGT FOR NON-SB 1100 HOSPITALS

REGULAR POLICY CHANGE NUMBER: 161
 IMPLEMENTATION DATE: 7/2006
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1158

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$30,000,000	\$20,000,000
- STATE FUNDS	\$15,000,000	\$10,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$30,000,000	\$20,000,000
STATE FUNDS	\$15,000,000	\$10,000,000
FEDERAL FUNDS	\$15,000,000	\$10,000,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14164

Interdependent Policy Changes

Not Applicable

Background:

This program provides general authority for the Department to accept IGTs from any county, other political subdivision of the state, or governmental entity in the state in support of the Medi-Cal program.

Non-SB 1100 hospitals may request that the Department accept an IGT for federal matching and pay the IGT transfer funds and federal match funds to the non-SB 1100 hospital. This policy change provides authority to accept the IGTs and match them with federal funds, and is a placeholder for possible IGT requests. The IGTs are not subject to the conditions stated under W&I Code, section 14166.12.

The Department may enter into an interagency agreement (IA) with a county to accept an IGT to be matched with federal funds and distributed to a hospital designated by the county or health care district.

Reason for Change from Prior Estimate:

Based upon recent interest from counties in using this program, the Department no longer expects an increase in FY 2012-13 from the historical average.

IGT FOR NON-SB 1100 HOSPITALS

REGULAR POLICY CHANGE NUMBER: 161

Methodology:

1. Annual IGTs on an accrual basis are estimated to be \$10,000,000. Cash basis payments vary from year-to-year based on when the IGTs are actually received.

(In Thousands)	FY 2012-13		
	<u>TF</u>	<u>IGT</u>	<u>FFP</u>
FY 2011-12	\$10,000	\$5,000	\$5,000
FY 2012-13	\$20,000	\$10,000	\$10,000
Total	\$30,000	\$15,000	\$15,000

(In Thousands)	FY 2013-14		
	<u>TF</u>	<u>IGT</u>	<u>FFP</u>
FY 2013-14	\$20,000	\$10,000	\$10,000

Funding:

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 162
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1038

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$10,000,000	\$10,000,000
- STATE FUNDS	\$5,000,000	\$5,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$10,000,000	\$10,000,000
STATE FUNDS	\$5,000,000	\$5,000,000
FEDERAL FUNDS	\$5,000,000	\$5,000,000

DESCRIPTION

Purpose:

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

Authority:

SB 2563 (Chapter 976, Statutes of 1988)

Interdependent Policy Changes:

Not Applicable

Background:

A supplemental program was created for hospitals providing a disproportionate share of outpatient services. Eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

In FY 2012-13 \$10,000,000 and in FY 2013-14 \$10,000,000 will be paid through PANs.

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
Ongoing Annual Payment	<u>\$10,000,000</u>	<u>\$10,000,000</u>

Funding:

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

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 163
 IMPLEMENTATION DATE: 1/2005
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1039

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$8,000,000	\$8,000,000
- STATE FUNDS	\$4,000,000	\$4,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$8,000,000	\$8,000,000
STATE FUNDS	\$4,000,000	\$4,000,000
FEDERAL FUNDS	\$4,000,000	\$4,000,000

DESCRIPTION

Purpose:

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

Authority:

AB 2617 (Chapter 158, Statutes of 2000)

Interdependent Policy Changes:

Not Applicable

Background:

This program provides SRHs with increased reimbursement rates. Eligible providers are reimbursed on a quarterly basis through a payment action notice (PAN). The payment represents one quarter of the total annual amount due to each eligible hospital. Due to the payment being made at the end of a quarter, the last quarter of each fiscal year will be paid the following fiscal year.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

- Reimbursements to SRHs providing outpatient services are assumed to be \$8,000,000 when combined with federal matching funds.
- In FY 2012-13 \$8,000,000 and in FY 2013-14 \$8,000,000 will be paid through Payment Action Notices (PANs).

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
Ongoing Annual Payment	\$8,000,000	\$8,000,000

Funding:

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

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 164
 IMPLEMENTATION DATE: 12/2010
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1616

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$3,000,000	\$3,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,000,000	\$3,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$3,000,000	\$3,000,000

DESCRIPTION

Purpose:

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

Authority:

AB 959 (Chapter 162, Statutes of 2006)

Interdependent Policy Changes:

Not Applicable

Background:

Under this program, state veterans' homes that are enrolled as Medi-Cal providers and are owned and operated by the State are eligible to receive supplemental payments. Eligible state veterans' homes may claim federal financial participation (FFP) on the difference between their projected costs and the amount Medi-Cal currently pays under the existing program. The non-federal match to draw down FFP will be paid from the public funds of the eligible state veterans' homes.

Supplemental payments to state veterans' homes were effective retroactively beginning with the rate year August 1, 2006. Since facilities must submit cost reports and the Department must certify expenditures before FFP can be claimed, supplemental payments for services provided during a fiscal year will not be issued until the following fiscal year.

Reasons for Change from Prior Estimate:

Additional expenditures became available for calculating the supplemental payments.

Methodology:

Supplemental payments for state veterans' homes began in FY 2010-11 and payments are estimated based on actual historical reported certified expenditures.

STATE VETERANS' HOMES SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 164

Program payment amounts are estimated to be:

FY 2012-13	FFP	Total FFP
State Veterans' Homes for FY 2011-12	\$3,000,000	\$3,000,000
FY 2013-14		
State Veterans' Homes for FY 2012-13	\$3,000,000	\$3,000,000

Funding:

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

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 165
 IMPLEMENTATION DATE: 8/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1661

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$298,645,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$298,645,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$298,645,000

DESCRIPTION

Purpose:

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

Authority:

AB 678 (Chapter 397, Statutes of 2011)

Interdependent Policy Changes

Not Applicable

Background:

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

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

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

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

Reason for Change from Prior Estimate:

The implementation date changed from December 2012 to August 2013 because of a delay in the expected federal approval.

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 165

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.
2. Funding for services provided between January 30, 2010 through June 30, 2011 will be reimbursed at the appropriate FAMP rate.
3. A payment of \$138,645,000 is expected to be made in August 2013 based on CPE claims.
4. A payment of \$160,000,000 is expected to be made in December 2013 based on CPE claims.

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

(In Thousands)

FY 2013-14	CPE	Regular FFP	ARRA	Total FFP
FY 2009-10	\$70,000	\$35,000	\$8,113	\$43,113
FY 2010-11	\$160,000	\$80,000	\$15,532	\$95,532
FY 2011-12	\$160,000	\$80,000	\$0	\$80,000
FY 2012-13	\$160,000	\$80,000	\$0	\$80,000
Total	\$550,000	\$275,000	\$23,645	\$298,645

Funding:

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1488

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$605,750,000	\$395,625,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$605,750,000	\$395,625,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$605,750,000	\$395,625,000

DESCRIPTION

Purpose:

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

Authority:

American Recovery and Reinvestment Act of 2009 (ARRA)
 SB 945 (Chapter 433, Statutes of 2011)
 AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

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

The Department will expand the current Medicaid Management Information Systems (MMIS) to integrate a State Level Registry (SLR), facilitating eligible hospitals and provider participation in the Medi-Cal EHR Incentive Program, as well as the payment of federal incentive dollars. The payments are intended to accelerate the adoption, implementation, or upgrade of electronic health information technology, and encourage meaningful use of the technology by providers serving the Medi-Cal population. Meaningful use of EHR technology will result in improved quality of care and health outcomes. It is estimated that approximately 20,000 to 22,000 providers and 300 hospitals will be eligible for incentive payments over the life of the program. Provider payments are paid with 100% federal funds.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170

The Medi-Cal Fiscal Intermediary (FI) has partially implemented a system necessary to enroll, pay and audit providers and hospitals who participate in the Medi-Cal EHR Incentive Payments Program. System costs are budgeted in the FI Estimate.

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

Reason for Change from Prior Estimate:

The change in FY 2012-13 is due to updated hospital discharge data and a delay in payments to providers. The SLR has been partially implemented, however, there were also delays in vendor development of a state administrative module (SAM), necessary to review, approve and process provider applications. The delay in SAM implementation has consequently resulted in further delays paying qualified providers, therefore, the number of applications that will be approved in the future quarters has increased.

Methodology:

1. Payments to the providers began in December 2011.
2. Payments to professionals are a fixed amount for the first year of eligibility and a lesser fixed amount for eligibility years two through six. Payments to hospitals are fixed at a computed amount over four years.
3. Assume professionals will receive incentive payments over a six year period. The years do not have to be consecutive. The first eligibility year incentive payment is \$21,250. Incentive payments for years two through six are \$8,500 per eligible year. The maximum incentive payment for a professional over the six year period is \$63,750.
4. Assume the aggregate hospital incentive payment amount is computed on a \$2,000,000 base amount adjusted up or down depending on Medi-Cal discharges for the year. Hospital incentive payments will be made over a period of four years. The years do not have to be consecutive. Payments will be limited to 50% of the aggregate hospital incentive payment for the first eligibility year, 30% for the second eligibility year and 10% for the third and fourth payment eligibility years.
5. Assume for FY 2012-13 and FY 2013-14, the aggregate hospital incentive payment is \$3,000,000. The first year eligibility incentive payment will average \$1,500,000, the second year eligible incentive payment will average \$900,000, and the third and fourth year eligibility incentive payments will average \$300,000.
6. In FY 2012-13, assume 10,000 eligible professionals will receive a first year eligibility incentive payment and 2,500 eligible professionals will receive a second year eligibility incentive payment. Of the eligible hospitals, 170 will receive a first year eligibility incentive payment and 130 will receive a second year eligibility incentive payment in FY 2012-13.

10,000 professionals x \$21,250 = \$212,500,000
2,500 professionals x \$8,500 = \$21,250,000

170 hospitals x \$1,500,000 = \$255,000,000
130 hospitals x \$900,000 = \$117,000,000

7. In FY 2013-14, assume 2,500 eligible professionals will receive a first year eligibility incentive

ARRA HITECH - PROVIDER PAYMENTS**REGULAR POLICY CHANGE NUMBER: 170**

payment, 2,500 eligible professionals will receive a second year eligibility incentive payment, and 2,500 eligible professionals will receive a third year eligibility incentive payment. Of the eligible hospitals, 80 will receive a first year eligibility incentive payment, 150 will receive a second year eligibility incentive payment, and 150 will receive a third year eligibility incentive payment in FY 2013-14.

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

2,500 professionals x \$8,500 = \$21,250,000

2,500 professionals x \$8,500 = \$21,250,000

80 hospitals x \$1,500,000 = \$120,000,000

150 hospitals x \$900,000 = \$135,000,000

150 hospitals x \$300,000 = \$45,000,000

CASH BASIS**FY 2012-13**

	FFP
Eligibility Year 1 Professional Payments	\$212,500,000
Eligibility Year 2 Professional Payments	\$21,250,000
Eligibility Year 1 Hospital Payments	\$255,000,000
Eligibility Year 2 Hospital Payments	\$117,000,000
	\$605,750,000

FY 2013-14

Eligibility Year 1 Professional Payments	\$53,125,000
Eligibility Year 2 Professional Payments	\$21,250,000
Eligibility Year 3 Professional Payments	\$21,250,000
Eligibility Year 1 Hospital Payments	\$120,000,000
Eligibility Year 2 Hospital Payments	\$135,000,000
Eligibility Year 3 Hospital Payments	\$45,000,000
	\$395,625,000

Funding:

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

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 171
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1656

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$826,346,000	-\$21,475,000
- STATE FUNDS	\$413,173,000	-\$10,737,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$826,346,000	-\$21,475,000
STATE FUNDS	\$413,173,000	-\$10,737,500
FEDERAL FUNDS	\$413,173,000	-\$10,737,500

DESCRIPTION

Purpose:

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

Authority:

Not Applicable

Interdependent Policy Changes:

PC 152 10% Provider Payment Reduction for LTC Facilities
 PC 153 10% Provider Payment Reduction
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment

Background:

AB 97 (Chapter 3, Statutes of 2011) requires the Department to implement a 10% provider payment reduction, which will affect all services except hospital inpatient and outpatient services, critical access hospital, federal rural referral centers and Federally Qualified Health Center/ Rural Health Clinic (FQHCs/RHCs), services provided through the Breast and Cervical Cancer Treatment and Family Planning, Access, Care and Treatment (Family PACT) programs, and hospice services. Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services and payments funded by certified public expenditure and intergovernmental transfer are exempt.

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *California Hospital Association, et al. v. Douglas et al.* against the implementation of AB 97 payment reductions for distinct part nursing facilities. In compliance with these injunctions, the Department is prohibited from implementing these reductions. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011, that were not reimbursed prior to that date. Both DHCS and plaintiffs have appealed. The parties have completed their appellate briefs regarding the issuance and modification of

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 171

the injunction, and the hearing is set for October 10, 2012.

On December 28, 2011, the U.S. District Court, Central District of California, issued preliminary injunctions in the cases of *Managed Pharmacy Care, et al. v. Sebelius, et al.* against the implementation of AB 97 payment reductions for pharmacy services. In compliance with these injunctions, the Department is prohibited from implementing these reductions. On March 12, 2012, the district court issued an order modifying the injunction to allow DHCS to apply the payment reduction to services rendered from June 1, 2011 through December 27, 2011, that are reimbursed for the first time on or after December 28, 2011. Both DHCS and plaintiffs have appealed. The parties have completed their briefs regarding the issuance and modification of the injunction, and the hearing on that issue is set for October 10, 2012.

On January 10, 2012, the same court issued a preliminary injunction in the case of *California Medical Transportation Association v. Douglas, et al.* prohibiting the Department from implementing AB 97 payment reductions for non-emergency medical transportation providers. The court subsequently modified the injunction to allow DHCS to implement the 10 percent reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. Both DHCS and plaintiffs have appealed. The parties have completed their appellate briefs regarding the issuance and modification of the injunction, and the hearing is set for October 10, 2012.

On January 31, 2012, a preliminary injunction was issued in the case of *California Medical Association, et al. v. Douglas, et al.* against the implementation of AB 97 payment reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment. In compliance with this injunction, the Department is prohibited from implementing these reductions. This injunction does not preclude the Department from applying the rate reduction to services rendered between June 1, 2011 and January 31, 2012 for which reimbursement has not yet provided. The parties have completed and filed their appellate briefs regarding the issuance of the injunction, and the hearing is set for October 10, 2012.

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

Reason for Change from Prior Estimate:

The estimate assumes positive resolution of the court injunctions in March 2013 instead of summer 2012.

Methodology:

1. It will take the Department at least three months to implement fee-for-services (FFS) reductions if the injunctions were lifted. Assuming the Department receives favorable rulings on the appeals by March 2013, implementation of the AB 97 reductions to the enjoined providers will resume beginning June 2013. As a result, it is estimated that 11 months of FFS savings from the enjoined providers will be lost in FY 2012-13.

AB 97 INJUNCTIONS**REGULAR POLICY CHANGE NUMBER: 171**

2. Assume the Department will implement managed care reductions in April 2013. Consequently, nine months of managed care savings will be lost in FY 2012-13.
3. Assume the Department will recover FFS retroactive savings for the enjoined providers beginning September 2013.
4. Based on the December 28, 2011 preliminary injunctions, assume the loss in savings in FY 2012-13 is \$207,778,000 TF (\$103,889,000 GF). The additional savings in FY 2013-14 is \$10,274,000 TF (\$5,137,000 GF).
5. Based on the January 10, 2012 preliminary injunction, assume the loss in savings in FY 2012-13 is \$13,244,000 TF (\$6,622,000 GF). The additional savings in FY 2013-14 is \$843,000 TF (\$421,500 GF).
6. Based on the January 31, 2012 preliminary injunction, assume the loss in savings in FY 2012-13 is \$408,217,000 TF (\$204,108,500 GF). The additional savings in FY 2013-14 is \$10,398,000 TF (\$5,199,000 GF).

(In Thousands)

Lawsuits

	FY 2012-13	FY2013-14
<i>California Hospital Association, et al. v. Douglas et al.</i>	\$47,872	(\$2,755)
<i>Managed Pharmacy Care, et al. v. Sebelius, et al.</i>	\$159,906	(\$7,519)
<i>California Medical Transportation Association v. Douglas, et al.</i>	\$13,244	(\$843)
<i>California Medical Association, et al. v. Douglas, et al.</i>	\$408,217	(\$10,398)
Managed Care Savings Loss due to Delayed Implementation	\$197,107	\$40
Total	\$826,346	(\$21,475)

Funding:

Title XIX (4260-101-0001/0890)

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 173
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1595

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$360,085,000	\$114,806,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$360,085,000	\$114,806,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$360,085,000	\$114,806,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14132.956
 Affordable Care Act (ACA) 2401

Interdependent Policy Changes:

Not Applicable

Background:

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

The State Plan Amendment (SPA) was approved on August 31, 2012 with an effective date of December 1, 2011.

The CFCO will generate new federal funds and will create General Fund savings to the State and counties who provide matching funds. The anticipated savings would be offset by cost increases to administer CFCO. CMS released final regulations on May 7, 2012.

Reason for Change from Prior Estimate:

This estimate was revised based on the information CMS released in the final regulations.

Methodology:

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 173

1. It is assumed all eligible participants will enroll on November 1, 2012.
2. Assume billing for additional FFP will begin December 2012.
3. Assume costs will be retroactive to December 1, 2011.
4. Costs for Medi-Cal beneficiaries enrolled in CFCO are eligible for an additional enhanced Federal Medical Assistance Percentage (FMAP) rate of 6%.
5. The estimated costs were provided by CDSS on a cash basis.

Funding:

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

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 174
 IMPLEMENTATION DATE: 6/2011
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1232

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$163,067,000	\$66,483,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$163,067,000	\$66,483,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$163,067,000	\$66,483,000

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement (IA)

Interdependent Policy Changes:

Not Applicable

Background:

On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) approved a State Plan Amendment (SPA) to obtain FFP for the transportation and day care costs of ICF-DD beneficiaries. CMS approved reimbursement for these costs retroactive to July 1, 2007.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP was 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. This policy change includes the additional FFP for FY 2012-13 and FY 2013-14. Funding for services provided between October 1, 2008, through June 30, 2011, will be reimbursed at the appropriate FMAP rate.

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

Reason for Change from Prior Estimate:

Updated expenditures.

ICF-DD TRANSPORTATION AND DAY CARE COSTS- CDDS

REGULAR POLICY CHANGE NUMBER: 174

Methodology:

1. The following estimates have been provided by CDDS.

CASH BASIS (In Thousands)	TF	CDDS GF	FFP Regular	FFP ARRA	Total FFP	IA #
FY 2012-13	\$289,702	\$126,635	\$144,851	\$18,216	\$163,067	07-65896
FY 2013-14	\$132,966	\$66,483	\$66,483	\$0	\$66,483	07-65896

Funding:

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

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 180
 IMPLEMENTATION DATE: 9/2012
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 110

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$14,471,000	\$0
- STATE FUNDS	\$14,471,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$14,471,000	\$0
STATE FUNDS	\$14,471,000	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

Public Law 95-452

Interdependent Policy Changes:

Not Applicable

Background:

An audit settlement was reached with the Office of Inspector General (OIG) for Federal audit A-09-07-00039 regarding "unsupported drug expenditures." The OIG found several claims that were not eligible for federal financial participation (FFP), the majority of claims were traced to beneficiaries with aid codes that do not qualify for FFP. The Department will return the federal portion of the improperly claimed payments for services to CMS.

Reason for Change from Prior Estimate:

This is a new audit settlement.

Methodology:

1. The audit identified California Medicaid beneficiaries with aid codes that do not qualify for FFP.
2. The Department will return \$14,471,000 FFP to CMS.

Funding:

State Only General Fund (4260-101-0001)

CDDS DENTAL SERVICES

REGULAR POLICY CHANGE NUMBER: 181
 IMPLEMENTATION DATE: 2/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1629

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$11,430,000	\$11,430,000
- STATE FUNDS	\$11,430,000	\$11,430,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,430,000	\$11,430,000
STATE FUNDS	\$11,430,000	\$11,430,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

Interagency Agreement 10-87244

Interdependent Policy Changes:

Not Applicable

Background:

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

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

Reason for Change from Prior Estimate:

No material change.

Methodology:

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

Funding:

Reimbursement GF (4260-610-0995)

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 182
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1526

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$11,418,000	\$11,418,000
- STATE FUNDS	\$5,709,000	\$5,709,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,418,000	\$11,418,000
STATE FUNDS	\$5,709,000	\$5,709,000
FEDERAL FUNDS	\$5,709,000	\$5,709,000

DESCRIPTION

Purpose:

This policy change estimates the federal financial participation for the increased administrative expenses related to the active treatment and transportation services provided to beneficiaries residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).

Authority:

Interagency Agreement (IA)

Interdependent Policy Changes:

Not Applicable

Background:

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

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

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

Reason for Change from Prior Estimate:

There is no change.

Methodology:

1. The following estimates have been provided by CDDS.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 182

FY 2012-13 (In Thousands)

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

FY 2013-14 (In Thousands)

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

Funding:

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

NONCONTRACT HOSP INPATIENT COST SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 183
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1340

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$4,037,000	\$2,348,000
- STATE FUNDS	\$2,018,500	\$1,174,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,037,000	\$2,348,000
STATE FUNDS	\$2,018,500	\$1,174,000
FEDERAL FUNDS	\$2,018,500	\$1,174,000

DESCRIPTION

Purpose:

This policy change estimates the noncontract hospital inpatient cost settlements.

Authority:

Welfare & Institutions Code 14170

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

The changes are due to updated expenditures.

Methodology:

Based upon payments made through September 2012, non-contract hospital inpatient cost settlements are estimated to total **\$4,037,000** for FY 2012-13 and **\$2,348,000** for FY 2013-14.

Funding:

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

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 186
 IMPLEMENTATION DATE: 4/1998
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 111

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,082,000	\$1,766,000
- STATE FUNDS	-\$9,273,500	-\$9,274,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,082,000	\$1,766,000
STATE FUNDS	-\$9,273,500	-\$9,274,000
FEDERAL FUNDS	\$11,355,500	\$11,040,000

DESCRIPTION

Purpose:

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

Authority:

Public Law 93-638

Interdependent Policy Changes:

Not Applicable

Background:

The Department implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and the Centers for Medicare and Medicaid Services (CMS) on April 21, 1998. The agreement permits the Department to be reimbursed at 100% FFP 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.

The per visit rate payable to the Indian Health Clinics is adjusted annually through changes posted in the *Federal Register*. These rates are set by IHS with the concurrence of the Federal Office of Management and Budget and are based on cost reports compiled by IHS.

Reason for Change from Prior Estimate:

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

Methodology:

1. Currently, there are 49 Indian health clinics participating in Medi-Cal.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 186

2. In fiscal year (FY) 2011-12, the Department spent \$18,547,000.
3. The Department projects a total of \$19,935,000 will be spent on services provided by Indian Health Clinics in FY 2012-13 and FY 2013-14.

\$19,935,000 - \$18,547,000 = \$1,388,000
4. Recent changes posted in the Federal Register, Volume 77, Number 109, June 6, 2012 and corrected in Volume 77, Number 118, June 19, 2012, updated the per visit rate payable to Indian Health Clinics. As a result, effective calendar year 2012, the per visit rate payable to Indian Health Clinics has changed to \$316 from \$294, an increase of \$22.
5. The FY 2012-13 budget includes an additional \$694,000 due to the increased rate for the period of January 2012 through June 2012. The annual rate increase for the additional \$22 is \$1,388,000.
6. The FY 2013-14 budget includes an additional \$379,000 due to the anticipated rate increase to \$320 from \$316 for the period of January 2013 through June 2013. The annual rate increase for the additional \$14 is \$758,000.

(In Thousands)	FY 2012-13	FY 2013-14
CY 2012 rate increase	\$1,388	\$1,388
CY 2013 rate increase	\$0	\$252
Retro Jan –June 2012 rate increase	\$694	\$0
Retro Jan –June 2013 rate increase	\$0	\$126
Total rate increase	\$2,082	\$1,766
FY 2010-11 Base expenditures	\$18,547	\$18,547
Total expenditures	\$20,629	\$20,314

Funding: (In Thousands)

FY 2012-13:		TF	GF	FFP
Title XIX 50/50 FFP	4260-101-0001/0890	(\$18,547)	(\$9,274)	(\$9,274)
Title XIX FFP	4260-101-0890	\$20,629		\$20,629
Net Impact		\$2,082	(\$9,274)	\$11,356*
FY 2013-14		TF	GF	FFP
Title XIX 50/50 FFP	4260-101-0001/0890	(\$18,547)	(\$9,274)	(\$9,274)
Title XIX FFP	4260-101-0890	\$20,314		\$20,314
Net Impact		\$1,766	(\$9,274)	\$11,040

*Totals may differ due to rounding.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 188
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1087

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The CTPS/Proposition 99 funds are allocated to aid in the funding of the *Orthopaedic Hospital* settlement and other outpatient payments for FY 2012-13 and FY 2013-14. The *Orthopaedic Hospital* settlement increased hospital outpatient rates by a total of 43.44% between 2001 and 2004.

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

Reason for Change from Prior Estimate:

There is no change.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 188

Methodology:**FY 2012-13**

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

FY 2013-14

Hospital Services Account	\$58,946,000
Physicians' Services Account	\$105,000
Unallocated Account	<u>\$23,570,000</u>
Total CTPS/Prop. 99	\$82,621,000
GF	<u>-\$82,621,000</u>
Net Impact	\$0

Funding:

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

CLPP FUNDS

REGULAR POLICY CHANGE NUMBER: 189
 IMPLEMENTATION DATE: 7/2005
 ANALYST: Yumie Park
 FISCAL REFERENCE NUMBER: 1633

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

Health & Safety Code 105305,105310,124075

Interdependent Policy Changes:

Not Applicable

Background:

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

- Full-scope beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal Program, or
- Pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program.

The state share of cost for the lead testing component is partly funded by the CLPP Fund. The lead testing expenditures are in Medi-Cal's Fee-for-Service (FFS) base trends and the Managed Care capitation rate. This policy change adjusts the CLPP funding.

The CLPP Fund receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products, and collected by the Board of Equalization.

Reason for Change from Prior Estimate:

The Department's interagency agreement (IA) with the Department of Public Health (DPH) allows for the reimbursement of \$130,000 to the Medi-Cal program. The Department is budgeting the IA amount rather than claiming prior year expenditures.

CLPP FUNDS**REGULAR POLICY CHANGE NUMBER: 189****Methodology:**

1. Funding for Medi-Cal and CHDP Gateway is at 50% State Funds.
2. In FY 2010-11, \$1,490,000 was incurred on Medi-Cal FFS blood lead tests. The Department estimates FY 2012-13 and FY 2013-14 FFS blood tests will remain the same as in FY 2010-11.
3. The Department will claim \$130,000 from the CLPP Fund, as provided in the IA with DPH.
4. The current IA with DPH expires at the end of FY 2012-13. It is assumed that the IA will be extended for another three years, and the funding for FY 2013-14 will remain at \$130,000.

	<u>CLPP Funds</u>
Total FY 2012-13	\$130,000
Total FY 2013-14	\$130,000

Funding:

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

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 190
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1621

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

SB 335 (Chapter 286, Statutes of 2011)
 AB 1467 (Chapter 23, Statutes of 2012)
 SB 920 (Chapter 452, Statutes of 2012)

Interdependent Policy Changes:

PC 203 Hospital QAF Program Changes

Background:

SB 335 establishes a hospital QAF program for the period beginning July 1, 2011 to December 31, 2013. The Centers for Medicare and Medicaid Services (CMS) approved the extension of the hospital QAF program on June 22, 2012.

AB 1467 (Chapter 23, Statutes of 2012) increases the amount of QAF allocated for children's health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Eliminating grant payments to DPHs in FY 2013-14, and
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14.

The grant and managed care supplemental payments are budgeted in the Hospital QAF – Hospital Payments policy change.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 190

Reason for Change from Prior Estimate:

- Implementation date changed from June 2012 to April 2013 because of delay in the expected federal approval, and
- AB 1467 changed the funding distribution.

Methodology:

1. On an accrual basis, annual funds for children's health care coverage are:

(in Thousands)

	Children's Health Care Coverage
FY 2011-12	\$340,000
FY 2012-13	\$537,000
FY 2013-14	\$310,000
Total	\$1,187,000

2. On a cash basis, the estimated receipts of funds for children's health care coverage are:

(In Thousands)	TF	GF	Hosp. QA Rev Fund
FY 2011-12	\$0	(\$340,000)	\$340,000
FY 2012-13	\$0	(\$402,750)	\$402,750
FY 2012-13 Total	\$0	(\$742,750)	\$742,750
FY 2012-13	\$0	(\$134,250)	\$134,250
FY 2013-14	\$0	(\$310,000)	\$310,000
FY 2013-14 Total	\$0	(\$444,250)	\$444,250

Funding:

Title XIX GF (4260-101-0001)

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

FIRST 5 CALIFORNIA FUNDING

REGULAR POLICY CHANGE NUMBER: 191
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1581

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

AB 1464 (Chapter 21, Statutes of 2012)

AB 1497 (Chapter 29, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

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

Reason for Change from Prior Estimate:

There is no change.

Methodology:

FY 2012-13	
Reimbursement	\$40,000,000
General Fund	(\$40,000,000)
Net	\$0

Funding:

100% State GF (4260-101-0001)

Reimbursement (4260-610-0995)

TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 192
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1654

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

SB 1008 (Chapter 33, Statutes of 2012)
 SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:

Not applicable.

Background:

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal, and persons eligible for Medi-Cal only. The Department will transition care for dual eligibles, partial dual eligibles and Medi-Cal only eligibles who receive LTC institutional services, IHSS and other Home and Community-Based Services (HCBS) to manage care health plans beginning September 1, 2013.

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

TRANSFER OF IHSS COSTS TO DHCS**REGULAR POLICY CHANGE NUMBER: 192**

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

Reason for Change from Prior Estimate:

The implementation date changed from March 2013 to September 2013.

Methodology:

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

(In Thousands) FY 2013-14	TF	GF	FFP	Reim- bursement
Medicare Shared Savings	(\$62,931)	(\$62,931)	\$0	\$0
Managed Care Payments:				
Non HCBS	\$2,361,355	\$1,180,678	\$1,180,677	\$0
HCBS	\$1,030,825	\$485,812	\$545,013	\$0
Total	\$3,392,180	\$1,666,490	\$1,725,690	\$0
FFS Savings:				
Non HCBS	(\$2,026,691)	(\$1,013,346)	(\$1,013,345)	\$0
HCBS	(\$8,863)	(\$4,431)	(\$4,432)	\$0
Defer Mgd. Care Payment	(\$639,662)	(\$319,831)	(\$319,831)	\$0
Total	(\$2,675,216)	(\$1,337,608)	(\$1,337,608)	\$0
IHSS FFS Savings (In the Base)	(\$522,931)	\$0	(\$522,931)	\$0
Delay 1 Checkwrite (In the Base)	\$49,086	\$24,543	\$24,543	\$0
Transfer of IHSS Costs to DHCS	\$0	(\$463,731)	\$0	\$463,731
Transfer of IHSS Costs to CDSS	\$1,021,648	\$0	\$0	\$1,021,648
Other Administration Costs	\$5,172	\$2,543	\$2,630	\$0
Total of CCI PCs including pass through	\$1,207,008	(\$170,695)	(\$107,677)	\$1,485,379
IHSS Funding (CCI-IHSS Funding Adjustment)	\$0	(\$1,049)	\$1,049	\$0
Grand Total	\$1,207,008	(\$171,744)	(\$106,628)	\$1,485,379

TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 192

Funding:

100% Reimbursement (4260-610-0995)

General Fund (4260-101-0001)

OPERATIONAL FLEXIBILITIES

REGULAR POLICY CHANGE NUMBER: 193
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1702

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,105,000	-\$2,210,000
- STATE FUNDS	-\$552,500	-\$1,105,000
PAYMENT LAG	0.7100	0.9950
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$784,600	-\$2,199,000
STATE FUNDS	-\$392,280	-\$1,099,480
FEDERAL FUNDS	-\$392,280	-\$1,099,480

DESCRIPTION

Purpose:

This policy change estimates the savings achieved through the operational flexibilities.

Authority:

AB 1497 (Chapter 29, Statutes 2012)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1497 included \$20 million total fund (TF) in savings related to the Department implementing Medi-Cal processes through operational flexibilities. Related trailer bill was not enacted. Without the trailer bill, the Department is unable to achieve the full \$20 million in savings.

However, the Department has identified one operational flexibility to date. It is implementing a change to the hearing aid methodology that is consistent with the intent of the 2011 budget action on operational flexibilities. The hearing aid reimbursement methodology currently reimburses providers the lesser of:

- The maximum allowable amount established by the Department,
- The "one-unit wholesale cost" plus the markup established by the Department,
- The billed amount, and
- The rates established by the Department's contracting program.

The "one-unit wholesale cost" is defined as the unit price or the single unit price as identified in the manufacturer's wholesale catalog not including rebates, discounts, taxes, or any other factors.

The Department will change the definition of "one-unit wholesale cost" to be the cost that is less discounts, rebates, or other reductions in price, and not including taxes. This amended definition will allow the Department to take into account the actual cost that a provider incurred for hearing aids when determining the reimbursement amount.

OPERATIONAL FLEXIBILITIES**REGULAR POLICY CHANGE NUMBER: 193**

The Department released a provider bulletin and a notice in the California Regulatory Notice Register on December 14, 2012, informing providers of the implementation of an amendment to the reimbursement policy for hearing aids, effective for dates of service on or after January 15, 2013.

Reason for Change from Prior Estimate:

Related trailer bill language was not approved. The Department is achieving some of the savings by revising the hearing aid methodology.

Methodology:

1. Assume savings will begin January 15, 2013.
2. Assume the average discount per claim is \$351.
3. Assume the total annual hearing aid claims are 13,963 and 45.1% of the total claims has discounts or rebates.
4. Annual hearing aid savings: $\$351 \times 13,963 \times 45.1\% = \$2,210,000$

	<u>TF</u>	<u>GF</u>
FY 2012-13	(\$1,105,000)	(\$552,500)
FY 2013-14	(\$2,210,000)	(\$1,105,000)

Funding:

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

FI COST CONTAINMENT PROJECTS

REGULAR POLICY CHANGE NUMBER: 194
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Taryn Gerald
 FISCAL REFERENCE NUMBER: 124

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,520,000	\$0
- STATE FUNDS	-\$760,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,520,000	\$0
STATE FUNDS	-\$760,000	\$0
FEDERAL FUNDS	-\$760,000	\$0

DESCRIPTION

Purpose:

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

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

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

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

Reason for Change from Prior Estimate:

There is no material change.

Methodology:

<u>Project Number</u>	<u>Savings Begin</u>	<u>Title</u>	<u>FY 2012-13 Savings</u>
07-17	Dec 12	Pharmacy Duplicates	\$1,520,000

Funding:

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

OVERPAYMENTS - INTEREST RATE CHANGE

REGULAR POLICY CHANGE NUMBER: 195
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Taryn Gerald
 FISCAL REFERENCE NUMBER: 1636

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,556,000	-\$3,112,000
- STATE FUNDS	-\$1,556,000	-\$3,112,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,556,000	-\$3,112,000
STATE FUNDS	-\$1,556,000	-\$3,112,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

The Department assesses interest on account receivables over 90 days old, for overpayments made to Medi-Cal providers, at a rate equal to the monthly average received on investments in the Surplus Money Investment Fund (SMIF). The current SMIF rate is 0.361%.

AB 1467 authorizes the Department to update the interest rate to the California Constitution or the SMIF rate, whichever is higher.

Reason for Change from Prior Estimate:

As a result of the rate change, the Department anticipates receiving increased revenue.

Methodology:

1. The current SMIF rate is 7.00%. The 20 year average SMIF rate is 2.75%. The difference between the new rate and current rate is 4.25% annually. The monthly rate is 0.35%.

$$7.00\% - 2.75\% = 4.25\% \div 12 = 0.35\%$$

2. The average monthly outstanding accounts receivable is \$82,325,000. In FY 2012-13, assume 50% of this balance is carried over from prior fiscal years; which will not be impacted by the interest rate change. The remaining 50% will accrue interest at the new interest rate. In FY 2013-14, assume the full balance will accrue interest at the new rate.

OVERPAYMENTS - INTEREST RATE CHANGE

REGULAR POLICY CHANGE NUMBER: 195

FY 2012-13: $\$82,325,000 \times 50\% \times 0.35\% = \$144,069$ FY 2013-14: $\$82,325,000 \times 0.35\% = \$288,813$

3. Assume 10% of the interest is based on refunds to providers. This amount is deducted from the savings.

FY 2012-13: $\$144,069 \times 10\% = \$14,407$ $\$144,069 - \$14,407 = \$129,662$ FY 2013-14: $\$288,813 \times 10\% = \$28,814$ $\$288,813 - \$28,814 = \$259,324$

4. The savings are:

FY 2012-13: $\$129,662 \times 12 = \$1,556,000$ **FY 2013-14: $\$259,314 \times 12 = \$3,112,000$** **Funding:**

Title XIX General Fund (4260-101-0001)

MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER: 196
 IMPLEMENTATION DATE: 3/2012
 ANALYST: Taryn Gerald
 FISCAL REFERENCE NUMBER: 1587

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$4,000,000	-\$4,000,000
- STATE FUNDS	-\$3,800,000	-\$3,800,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,000,000	-\$4,000,000
STATE FUNDS	-\$3,800,000	-\$3,800,000
FEDERAL FUNDS	-\$200,000	-\$200,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14124.90
 Social Security Act 1634

Interdependent Policy Changes:

OA 35 Medicare Buy-In Quality Review Project

Background:

On October 1, 2010, the Department entered into a three-year contract with the University of Massachusetts (UMASS) to identify potential overpayments to CMS or Medicare providers related to the Medicare Buy-In process for Medicare/Medi-Cal dual eligibles. UMASS will assist the Department in auditing the invoices received from CMS to pay the Medicare premiums. On May 17, 2012, the Department of General Services approved extending the agreement to June 30, 2015.

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

Reason for Change from Prior Estimate:

The change is due to a re-evaluation of the estimated overpayments and UMASS finding overpayments.

Methodology:

1. The contractor began auditing invoices in July 2012.
2. Assume recovery of overpayments will begin October 2012.
3. Assume that 90% of recoveries will be from CMS Medicare Premiums and 10% will be from provider overpayments.

MEDICARE BUY-IN QUALITY REVIEW PROJECT

REGULAR POLICY CHANGE NUMBER: 196

4. Based on current Department Medicare and Medi-Cal dual beneficiary data for the months of July and August; it is assumed there will be \$4,000,000 recovered annually.

(In Thousands)

	FY 2012-13			FY 2013-14		
	TF	GF	FFP	TF	GF	FFP
Provider Overpayments	\$400	\$200	\$200	\$400	\$200	\$200
Medicare Premiums *	\$3,600	\$3,600	\$0	\$3,600	\$3,600	\$0
TOTALS	\$4,000	\$3,800	\$200	\$4,000	\$3,800	\$200

Funding:

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

State Only General Fund (4260-101-0001) *

ANTI-FRAUD ACTIVITIES FOR PHARMACY AND PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 197
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1474

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$12,363,000	-\$13,800,000
- STATE FUNDS	-\$6,181,500	-\$6,900,000
PAYMENT LAG	0.5800	0.8890
% REFLECTED IN BASE	31.40 %	29.10 %
APPLIED TO BASE		
TOTAL FUNDS	-\$4,919,000	-\$8,698,200
STATE FUNDS	-\$2,459,500	-\$4,349,080
FEDERAL FUNDS	-\$2,459,500	-\$4,349,080

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code, section 14123.25

Interdependent Policy Change:

Not Applicable

Background:

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

Pharmacy Services Activities

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

Physicians Services Activities

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

Reason for Change from Prior Estimate:

There is no change.

**ANTI-FRAUD ACTIVITIES FOR PHARMACY AND
PHYSICIANS**
REGULAR POLICY CHANGE NUMBER: 197

Methodology:

1. Savings are estimated to be \$13,800,000 annually.
2. Savings will be phased in over 12 months.
3. Budgeted amounts are preliminary until actual data becomes available.

Funding:

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

TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVINGS

REGULAR POLICY CHANGE NUMBER: 198
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1640

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$62,931,000
- STATE FUNDS	\$0	-\$62,931,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$62,931,000
STATE FUNDS	\$0	-\$62,931,000
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

SB 1008 (Chapter 33, Statutes of 2012)
 SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

In coordination with Federal and State government, the Coordinated Care Initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles). By enrolling dual eligibles into coordinated care delivery models, the CCI will align financial incentives, streamline beneficiary-centered care delivery, and rebalance the current health care system away from avoidable institutionalized services.

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

Initially, the CCI will be implemented in eight pilot counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

The CCI will rebalance these incentives around supporting the Dual Eligibles with appropriate medical and social services, thereby achieving savings in Medicare-covered high-cost, institutional and inpatient health care services. The Administration will seek a sharing arrangement with the federal government so that California will receive half of the Medicare savings attributed to this proposal.

TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVINGS

REGULAR POLICY CHANGE NUMBER: 198

Reason for Change from Prior Estimate:

The implementation date changed from March 2013 to September 2013.

Methodology:

1. Assume Dual Eligibles receiving Medicare services under the traditional Fee-for Service (FFS) model will begin enrolling into the CCI on September 1, 2013. Medicare FFS beneficiaries from San Mateo County will enroll at once on September 1, 2013. Medicare FFS beneficiaries from Los Angeles will enroll over 18 months in even increments. Medicare FFS beneficiaries from the other six counties will enroll over 12 months in even increments.
2. Beneficiaries enrolled in a Medicare Advantage plan will enroll at once into CCI on January 1, 2014.
3. Beneficiaries eligible for CCI, but enrolled in a Kaiser Medi-Cal managed care plan, and or a Kaiser Medicare Advantage plan, have been excluded from these estimates.
4. Assume there are an estimated 554,000 beneficiaries in September 2013 who will transition into a managed care plan in the eight pilot counties.
5. Assume shared savings will only result from savings generated in the Medicare program. No Medi-Cal savings are included in this policy change as they are assumed in PC-135 Transitions of Dual Eligibles – Long Term Care.
6. Assume Inpatient Hospital utilization will drop by 15% in FY 2013-14 and 20% annually thereafter.
7. Assume Skilled Nursing Facility utilization will drop by 5% in the FY 2013-14 and 5% annually thereafter. This excludes beneficiaries enrolled in a Long-Term Care aid code.
8. Assume Physician utilization will increase by 4% in FY 2013-14 and 5% annually thereafter.
9. Assume Pharmaceutical utilization will increase by 2% in FY 2013-14 and 2% annually thereafter.
10. Assume the State will share savings 50/50 with the federal government.
11. Assume that the dual eligible participation rate will be 60%.
12. The Patient Protection and Affordable Care Act (ACA) of 2010 included more than \$424 billion in net Medicare spending reductions over a ten-year period, reducing annual payment updates to hospitals and other providers. The impact of these changes was not considered in this analysis.

TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVINGS

REGULAR POLICY CHANGE NUMBER: 198

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

(In Thousands)				
FY 2013-14	<u>TF</u>	<u>GF</u>	<u>FFP</u>	<u>Reim- bursement</u>
Medicare Shared Savings	(\$62,931)	(\$62,931)	\$0	\$0
Managed Care Payments:				
Non HCBS	\$2,361,355	\$1,180,678	\$1,180,677	\$0
HCBS	\$1,030,825	\$485,812	\$545,013	\$0
Total	\$3,392,180	\$1,666,490	\$1,725,690	\$0
FFS Savings:				
Non HCBS	(\$2,026,691)	(\$1,013,346)	(\$1,013,345)	\$0
HCBS	(\$8,863)	(\$4,431)	(\$4,432)	\$0
Defer Mgd. Care Payment	(\$639,662)	(\$319,831)	(\$319,831)	\$0
Total	(\$2,675,216)	(\$1,337,608)	(\$1,337,608)	\$0
IHSS FFS Savings (In the Base)	(\$522,931)	\$0	(\$522,931)	\$0
Delay 1 Checkwrite (In the Base)	\$49,086	\$24,543	\$24,543	\$0
Transfer of IHSS Costs to DHCS	\$0	(\$463,731)	\$0	\$463,731
Transfer of IHSS Costs to CDSS	\$1,021,648	\$0	\$0	\$1,021,648
Other Administration Costs	\$5,172	\$2,543	\$2,630	\$0
Total of CCI PCs including pass through	\$1,207,008	(\$170,695)	(\$107,677)	\$1,485,379
IHSS Funding (CCI-IHSS Funding Adjustment)	\$0	(\$1,049)	\$1,049	\$0
Grand Total	\$1,207,008	(\$171,744)	(\$106,628)	\$1,485,379

Funding:

100% GF (4260-101-0001)

FQHC/RHC AUDIT STAFFING

REGULAR POLICY CHANGE NUMBER: 199
 IMPLEMENTATION DATE: 1/2012
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1437

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$12,723,000	-\$12,723,000
- STATE FUNDS	-\$6,361,500	-\$6,361,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$12,723,000	-\$12,723,000
STATE FUNDS	-\$6,361,500	-\$6,361,500
FEDERAL FUNDS	-\$6,361,500	-\$6,361,500

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code, section 14170

Interdependent Policy Changes:

Not Applicable

Background:

The Department will redirect three positions to continue audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines. Reconciliation audits consist of reconciling Managed Care, Medicare Crossover and Medicare Advantage plan visits and payments to assure the FQHC/RHC providers were paid an amount equal to their prospective payment system rate. In the past five years, the number of FQHC/RHC providers has increased an average of nine percent annually, while the number of audit staff has remained the same. The redirected positions will generate cost savings for FY 2012-13 and FY 2013-14.

Reason for Change from Prior Estimate:

The number of staff increased from one to three.

Methodology:

1. Assume three trained staff members will be ready to complete 12 reconciliation audits each month beginning July 1, 2012.
2. Based on 2009 reconciliation audit data, each reconciliation audit saves \$29,452. Therefore each redirected staff position saves:

FQHC/RHC AUDIT STAFFING
REGULAR POLICY CHANGE NUMBER: 199

12 audits X \$29,452 = \$353,424 savings per month
\$353,424 X 12 months = \$4,241,088 TF
Therefore 3 FTE's will save \$12,723,264

	<u>TF</u>	<u>GF</u>
FY 2012-13	\$12,723,000	\$6,362,000
FY 2013-14	\$12,723,000	\$6,362,000

Funding:

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

REDUCTION IN IHSS AUTHORIZED HOURS

REGULAR POLICY CHANGE NUMBER: 200
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1745

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	-\$122,499,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$122,499,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	-\$122,499,000

DESCRIPTION

Purpose:

This policy change estimates the savings from implementing a 20% service hour reduction of In-Home Supportive Services (IHSS) in the Personal Care Services Program (PCSP), IHSS Plus Option, and Community First Choice Option (CFCO) recipients.

Authority:

SB 73 (Chapter 34, Statutes of 2011)
 Welfare & Institution Code 12301.7

Interdependent Policy Changes:

Not Applicable

Background:

SB 73 imposed a 20% service hour reduction on IHSS recipients effective January 1, 2012. The reduction became effective when the 2011-12 Budget "Trigger Reductions" became operative. Individuals receiving IHSS hours through a 1915(c) waiver would be exempt. The bill also established an IHSS Care Supplement process. Under this reduction, recipients at risk of out-of-home placement would receive an opportunity for a partial or full restoration of reduced hours through a request for supplemental care. Those recipients determined not to be at risk of out-of-home placement would be able to appeal the determination.

The Department submitted to Centers for Medicare and Medicaid Services (CMS) a state plan amendment (SPA) to implement the 20% IHSS hour reduction. The proposed SPA would be effective April 1, 2013. On December 1, 2011, plaintiffs in *Oster v. Lightbourne* requested a temporary restraining order to prevent defendants from implementing the 20% reduction in authorized IHSS services. The restraining order was issued by the Court. The court order enjoined the Department and the California Department of Social Services (CDSS) from implementing provisions of SB 73. This policy change assumes resolution of the lawsuit by April 1, 2013.

Reason for Change from Prior Estimate:

This is a new policy change.

REDUCTION IN IHSS AUTHORIZED HOURS

REGULAR POLICY CHANGE NUMBER: 200

Methodology:

1. The following estimates have been provided by CDSS on a cash basis.

(In Thousands)

	TF	FFP	CDSS GF	County Match
FY 2013-14	<u>(\$107,998)</u>	<u>(\$122,499)</u>	<u>(\$28,660)</u>	<u>(\$17,925)</u>

Funding:

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

3.6% IHSS REDUCTION

REGULAR POLICY CHANGE NUMBER: 201
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Julie Chan
 FISCAL REFERENCE NUMBER: 1746

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$50,212,000	-\$16,631,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$50,212,000	-\$16,631,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$50,212,000	-\$16,631,000

DESCRIPTION

Purpose:

This policy change estimates the savings associated with reducing the hours of service for In-Home Supportive Services (IHSS) recipients by 3.6%.

Authority:

Welfare & Institutions Code 12301.06
 AB 1612 (Chapter 725, Statutes of 2010)
 SB 1041 (Chapter 47, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

Personal care services are rendered under the administrative direction of the State Department of Social Services (CDSS) for the IHSS program.

The 3.6% reduction of IHSS service hours was implemented February 1, 2011, as a result of Assembly Bill 1612 with a sunset date of June 30, 2012. Subsequently, through SB 1041, the 3.6% reduction was extended for 11 months from August 2012 through June 2013. Recipients may determine which of their services will be impacted by the reduction.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

The estimated savings are provided by CDSS.

Funding:

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

HOSPITAL QAF PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 203
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1695

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$300,000,000	-\$211,500,000
- STATE FUNDS	-\$150,000,000	-\$116,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

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

Authority:

AB 1467 (Chapter 23, Statutes 2012)

Interdependent Policy Changes:

PC 154 Hospital QAF – Hospital Payments
 PC 190 Hospital QAF – Children’s Health Care

Background:

SB 335 (Chapter 286, Statutes of 2011) extended the hospital quality assurance fee (QAF) program from July 1, 2011 through December 31, 2013. The fee generates approximately \$2.8 billion in annual revenue primarily to match federal funds to provide supplemental payments to private hospitals and increase payments to managed care plans so they can increase hospital payments. Some fee revenue is also used to provide grants to public hospitals, fund payments for out-of-network hospitals in county Low-Income Health Programs, and fund children’s health coverage. On June 22, 2012, the Centers for Medicare and Medicaid Services approved the extension of the hospital QAF program.

AB 1467 increases the amount of QAF allocated for children’s health care coverage by:

- Eliminating managed care payments for DPHs in FY 2013-14,
- Eliminating grant payments to DPHs in FY 2013-14, and
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14.

The grants and managed care supplemental payments are budgeted in the Hospital QAF – Hospital Payments policy change.

Reason for Change from Prior Estimate:

There is no change.

HOSPITAL QAF PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 203

Methodology:

1. FY 2012-13 supplemental payments to private hospitals for managed care plans are reduced by \$300 million total funds – 50% fee revenue and 50% federal funds. The \$150 million in fee revenue is redirected to offset General Fund costs for children's health coverage.
2. FY 2013-14 supplemental payments to private hospitals and DPHs for managed care plans are reduced by \$190 million total funds – 50% fee revenue and 50% federal funds. The \$95 million in fee revenue is redirected to offset General Fund costs for children's health coverage.
3. FY 2013-14 direct grants to DPHs are reduced by \$21.5 million total fund – 100% fee revenue. The \$21.5 million in fee revenue is redirected to offset General Fund costs for children's health coverage.

(In Thousands)

FY 2012-13

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

FY 2013-14

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

Funding:

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

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 204
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Betty Lai
 FISCAL REFERENCE NUMBER: 1759

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$90,494,000	\$124,484,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$90,494,000	\$124,484,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$90,494,000	\$124,484,000

DESCRIPTION

Purpose:

This policy change estimates the elimination of the state maximum rates for Medi-Cal specialty mental health services.

Authority

Assembly Bill 1297 (Chapter 651, Statutes of 2011)

Interdependent Policy Changes:

Not Applicable

Background:

The Welfare and Institution Code, section 5720 and 5724, limited reimbursement of specialty mental health services to the state maximum rates. The state maximum rate is a schedule of maximum allowances (SMA) for specialty mental health services. AB 1297 amended W&I Code, section 5720 and 5724 to change the manner in which specialty mental health services are reimbursed. AB 1297 requires the Department to reimburse mental health plans based upon the lower of their certified public expenditures or the federal upper payment limit. The federal upper payment limit will be equal to the aggregate allowable cost or customary charge for all specialty mental health services provided by the mental health plan and its network of providers. These changes to the reimbursement methodology will result in an increase of federal reimbursement to mental health plans for specialty mental health services.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The costs are developed using FY 2009-10 final filed cost reports received from each county.
2. The costs in excess of the SMA that was no reimbursed in the past but are eligible for reimbursement under AB 1297, is budgeted in this policy change.

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 204

3. Assume each year, there will be an increase of 10% from the payment for FY 2009-10, which is the most recent fiscal year for which cost reports are available.
4. The accrual estimates are:

(In Thousands)				
FY 2012-13	TF	FFP	M-CHIP	County
Children	\$129,552	\$63,016	\$2,288	\$64,248
Adults	\$104,440	\$52,220	\$0	\$52,220
Total	\$233,992	\$115,236	\$2,288	\$116,468

(In Thousands)				
FY 2013-14	TF	FFP	M-CHIP	County
Children	\$139,517	\$67,863	\$2,464	\$69,190
Adults	\$112,474	\$56,237	\$0	\$56,237
Total	\$251,991	\$124,100	\$2,464	\$125,427

5. On a cash basis for FY 2012-13, the Department will be paying 77% of FY 2012-13 claims. On a cash basis for FY 2013-14, the Department will be paying 23% of FY 2012-13 claims and 77% of FY 2013-14 claims.

(In Thousands)				
FY 2012-13	TF	FFP	M-CHIP*	County
Children	\$99,755	\$48,522	\$1,762	\$49,471
Adults	\$80,419	\$40,210	\$0	\$40,209
Total	\$180,174	\$88,732	\$1,762	\$89,680

(In Thousands)				
FY 2013-14	TF	FFP	M-CHIP*	County Match
Children	\$137,225	\$66,749	\$2,423	\$68,053
Adults	\$110,626	\$55,312	\$0	\$55,313
Total	\$247,851	\$122,061	\$2,423	\$123,366

Funding:

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

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

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 205
 IMPLEMENTATION DATE: 6/2014
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1760

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the funding for health care coverage for children in the Medi-Cal program due to extension of a quality assurance fee (QAF) for hospitals from January 1, 2014 to December 31, 2016.

Authority:

Proposed Legislation

Interdependent Policy Changes:

Not Applicable

Background:

SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

The Department proposes to extend the Hospital QAF program from January 1, 2014 through December 31, 2016.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The current Hospital QAF program will end on December 31, 2013. Assume a 36-month extension for the Hospital QAF program beginning January 1, 2014 through December 31, 2016.
2. The estimated funds for children's health care coverage for the period of January 1, 2014 through June 30, 2014 are \$310 million TF (\$310 million GF).

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 205

(In Thousands)	<u>TF</u>	<u>GF</u>	<u>Hosp. QA Rev Fund</u>
FY 2013-14	\$0	(\$310,000)	\$310,000

Funding:

Title XIX GF (4260-101-0001)

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

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 206
 IMPLEMENTATION DATE: 6/2014
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1761

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$2,577,306,000
- STATE FUNDS	\$0	\$1,304,053,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$2,577,306,000
STATE FUNDS	\$0	\$1,304,053,000
FEDERAL FUNDS	\$0	\$1,273,253,000

DESCRIPTION

Purpose:

This policy change estimates the payments hospitals will receive from the extension of quality assurance fee (QAF) program.

Authority:

Proposed Legislation

Interdependent Policy Changes:

Not Applicable

Background:

SB 335 (Chapter 286, Statutes of 2011) establishes the Hospital QAF program from July 1, 2011 through December 31, 2013, which provides additional funding to hospitals and for children's health care. The fee revenue is primarily used to match federal funds to provide supplemental payments to private hospitals, increased payments to managed care plans, and direct grants to public hospitals.

The Department proposes to extend the Hospital QAF program from January 1, 2014 through December 31, 2016.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The current Hospital QAF program will end on December 31, 2013. Assume a 36-month extension for the Hospital QAF program beginning January 1, 2014 through December 31, 2016.
2. In FY 2013-14, the estimated six-month payments (January 1, 2014 through June 30, 2014) to the hospitals are:

	<u>TF</u>	<u>SF(HQARF)</u>	<u>FF</u>
FY 2013-14	\$2,577,306,000	\$1,304,053,000	\$1,273,253,000

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 206

Funding:

Hospital Quality Assurance Revenue Fund (4260-611-3158)
Title XIX FFP (4260-101-0890)

EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 207
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1652

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$364,348,000	\$484,718,000
- STATE FUNDS	\$182,174,000	\$242,359,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$364,348,000	\$484,718,000
STATE FUNDS	\$182,174,000	\$242,359,000
FEDERAL FUNDS	\$182,174,000	\$242,359,000

DESCRIPTION

Purpose:

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

Authority:

Proposed Legislation

Interdependent Policy Changes:

PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 209 Extend Gross Premium Tax

Background:

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

Reason for Change from Prior Estimate:

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

Methodology:

1. The gross premium tax proceeds are required to be used to offset the capitation rate development process and payments made to the State that result directly from the imposition of the gross premium tax.

**EXTEND GROSS PREMIUM TAX - INCR. CAPITATION
RATES**
REGULAR POLICY CHANGE NUMBER: 207

2. Capitation rate increases due to the gross premium tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from the Gross Premium Tax Fund (Fund 3156) on a quarterly basis. The reimbursement is budgeted in the Extend Gross Premium Tax – Funding Adjustment policy change.

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

(In Thousands)	<u>Gross Premium Tax</u>	<u>FFP</u>	<u>TF</u>
FY 2012-13	\$182,174	\$182,174	\$364,348
FY 2013-14	\$242,359	\$242,359	\$484,718

Funding:

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

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 208
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1655

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the transfer of funds from the Gross Premium Tax Fund to the General Fund for FY 2012-13 and FY 2013-14 as a result of a proposal to eliminate the Gross Premium Tax sunset date.

Authority:

Proposed Legislation

Interdependent Policy Changes:

PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 209 Extend Gross Premium Tax

Background:

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

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

Reason for Change from Prior Estimate:

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

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 208

Methodology:

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

	<u>GF</u>	<u>Gross Premium Tax</u>	<u>TF</u>
FY 2012-13	\$ (136,631,000)	\$ 136,631,000	\$ 0
FY 2013-14	\$ (227,211,000)	\$ 227,211,000	\$ 0

Funding:

100% State GF (4260-101-0001)

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

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 209
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1647

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the transfer of funds collected from the Gross Premium Tax Fund to the General Fund (GF) to be retained by the Department beginning July 1, 2013.

Authority:

Proposed Legislation

Background:

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

Reason for Change from Prior Estimate:

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

Methodology:

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

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 209

4. The amount shown in this policy change does not include \$136,631,000 for the Healthy Families Program in FY 2012-13.

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

	<u>GF</u>	<u>Gross Premium Tax</u>	<u>TF</u>
FY 2013-14	\$ (227,211,000)	\$ 227,211,000	\$ 0

Funding:

100% State GF (4260-101-0001)

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

STABLE ENROLLMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 212
 IMPLEMENTATION DATE: 10/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1606

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$2,000,000
- STATE FUNDS	\$0	-\$1,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$2,000,000
STATE FUNDS	\$0	-\$1,000,000
FEDERAL FUNDS	\$0	-\$1,000,000

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact of implementing a stable enrollment plan for Medi-Cal managed care beneficiaries, excluding seniors and persons with disabilities (SPDs).

Authority:

Proposed Legislation

Background:

Currently, managed care enrollees may change plans on a monthly basis. This policy fosters frequent changes throughout the year which adversely affect continuity of care. The Department is proposing legislation to change the managed care enrollment policy to allow non-SPD enrollees in Two-Plan and Geographic Managed Care counties to change plans on an annual basis. This change is consistent with the policy in most large group health plans such as CalPERS. New beneficiaries will have 90 days from their initial enrollment date to select or change their managed care plan. On an annual basis, existing members will be provided a 60-day period to change plans.

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

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume the initial open enrollment period will be implemented October 1, 2013. In October and November 2013, existing plan members may elect to change their plan. Any plan changes will be effective January 1, 2014. Thereafter, plan members will have a 60-day period each year to change plans. New beneficiaries will continue to have 90 days from their initial enrollment date to select or change their managed care plan.
2. During October through December 2013, routine plan changes will not be allowed.

STABLE ENROLLMENT PROGRAM**REGULAR POLICY CHANGE NUMBER: 212**

3. It is assumed that most health assessments will no longer be required when an existing beneficiary changes plans. The new plan will rely on the initial health assessment of the previous plan. The average cost of an assessment is \$68.00.

4. Of the estimated 164,400 beneficiaries changing plans each year, it is assumed 85% will no longer require a health assessment and the remaining 15% will still require an additional assessment.

164,400 assessments x 85% x \$68.00 = \$9,502,000 TF (\$4,751,500 GF) annual savings
 \$9,502,000 x .75 (October to June) = \$7,127,000 (\$3,563,500 GF) FY 2013-14 savings

5. Upon implementation, an initial notification will be mailed to approximately 3,200,000 beneficiaries informing them of their open enrollment period. There will be two additional mailings. The net increase in total mailing and related costs will be \$4,464,000 in FY 2013-14. Annual costs are expected to be lower but are indeterminate at this time.

6. Currently, the average annual cost of mailing information packets to beneficiaries who are changing plans is \$510,000. It is assumed that approximately 164,400 will change plans. Of these, 50%, or 82,200 beneficiaries, will request an information packet so they can change plans by mail, at a cost of \$5.10 per packet. The remaining 50% will change plans, at no cost, by phone.

82,195 information packets x \$5.10 = \$419,000 projected mailing cost
 \$510,000 current cost - \$419,000 projected cost = \$91,000 (\$45,500 GF) net annual savings for mailings
 \$91,000 x .75 (October to June) = \$68,000 (\$34,000 GF) savings in FY 2013-14

7. Assume there will be an additional one-time cost of \$731,000 (\$365,500 GF) in FY 2013-14 for system modifications.

FY 2013-14:	TF	GF
Health Assessment Savings	(\$7,127,000)	(\$3,563,500)
Net Mailing Costs	\$4,464,000	\$2,232,000
Information Packet Savings	(\$68,000)	(\$34,000)
System Cost	\$731,000	\$365,500
Total	(\$2,000,000)	(\$1,000,000)

Funding:

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

MANAGED CARE EFFICIENCIES

REGULAR POLICY CHANGE NUMBER: 213
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1765

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$269,282,000
- STATE FUNDS	\$0	-\$134,641,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$269,282,000
STATE FUNDS	\$0	-\$134,641,000
FEDERAL FUNDS	\$0	-\$134,641,000

DESCRIPTION

Purpose:

This policy change estimates the savings due to incorporation of efficiency adjustments into the managed care plan rates.

Authority:

Not Applicable

Background:

The Department continues to seek efficiencies in the provision of services in the Medi-Cal program in order to reduce costs and improve outcomes. Instituting efficiency adjustments in the managed care rate development provides the appropriate financial incentives to health plans to seek efficiencies and avoid unnecessary costs.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

This policy is based on the Department's projections of efficiencies potentially achievable in reducing cost and improving outcomes in our Medi-Cal managed care plans.

Funding:

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

TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 214
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1766

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$3,392,180,000
- STATE FUNDS	\$0	\$1,666,490,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$3,392,180,000
STATE FUNDS	\$0	\$1,666,490,000
FEDERAL FUNDS	\$0	\$1,725,690,000

DESCRIPTION

Purpose:

This policy changes estimates the capitation payments for dual eligible (beneficiaries on Medi-Cal and Medicare) and Medi-Cal only beneficiaries transitioning from fee-for-service into Medi-Cal managed care health plans for their Medi-Cal Long Term Care (LTC) institutional and community-based services and supports benefits.

Authority:

SB 1008 (Chapter 33, Statutes of 2012)

SB 1036 (Chapter 45, Statutes of 2012)

Interdependent Policy Changes:

PC 113 Transfer of IHSS Costs to CDSS

PC 135 Transition of Dual Eligibles-Long Term Care

PC 192 Transfer of IHSS Costs to DHCS

PC 208 Extend Gross Premium Tax

PC 207 Extend Gross Premium Tax – Incr. Capitation Rates

PC 209 Extend Gross Premium Tax – Funding Adjustment

Background:

In coordination with Federal and State government, the Coordinated Care initiative (CCI) will provide the benefits of coordinated care models to persons eligible for both Medicare and Medi-Cal (dual eligibles) and for Medi-Cal only. By enrolling these eligibles into coordinated care delivery models, the CCI will align financial incentives, streamline beneficiary-centered care delivery, and rebalance the current health care system away from avoidable institutionalized services.

The CCI will mandatorily enroll dual and Medi-Cal only eligibles into managed care for their Medi-Cal benefits. Those benefits include LTC institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) services, and other Home and Community-Based Services (HCBS). Savings will be generated from a reduction in inpatient and LTC institutional services.

**TRANSITION OF DUAL ELIGIBLES-MANAGED CARE
PAYMENTS**
REGULAR POLICY CHANGE NUMBER: 214

Initially, the CCI will be implemented in eight pilot counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Methodology:

1. Assume Dual Eligibles and Medi-Cal Only eligible populations receiving Medicare services under the traditional Fee-for-Service (FFS) model will begin enrolling into the CCI on September 1, 2013. Medicare FFS beneficiaries from San Mateo County will enroll at once on September 1, 2013. Medicare FFS beneficiaries from Los Angeles County will enroll over 18 months in even increments. Medicare FFS beneficiaries from the other six counties will enroll over 12 months in even increments.
2. Beneficiaries enrolled in a Medicare Advantage plan will all enroll into the CCI on January 1, 2014.
3. Assume there are an estimated 1,010,000 beneficiaries in September 2013 who will be phased into a managed care plan in the eight pilot counties.
4. Assume Inpatient Care will be reduced by 10.9% in FY 2013-14. Assume it will be reduced by 11% annually thereafter.
5. Assume LTC institutional services will be reduced by 4.2% in FY 2013-14. Assume it will be reduced by 10.9% annually thereafter.
6. Assume IHSS, CBAS, and other HCBS will be increased by 3.5% in FY 2013-14. Assume it will be increased by 2.8% annually thereafter.
7. Assume MSSP services will remain the same.

**TRANSITION OF DUAL ELIGIBLES-MANAGED CARE
PAYMENTS**
REGULAR POLICY CHANGE NUMBER: 214

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

(In Thousands)

FY 2013-14	TF	GF	FFP	Reim- bursement
Medicare Shared Savings	(\$62,931)	(\$62,931)	\$0	\$0
Managed Care Payments:				
Non HCBS	\$2,361,355	\$1,180,678	\$1,180,677	\$0
HCBS	\$1,030,825	\$485,812	\$545,013	\$0
Total	\$3,392,180	\$1,666,490	\$1,725,690	\$0
FFS Savings:				
Non HCBS	(\$2,026,691)	(\$1,013,346)	(\$1,013,345)	\$0
HCBS	(\$8,863)	(\$4,431)	(\$4,432)	\$0
Defer Mgd. Care Payment	(\$639,662)	(\$319,831)	(\$319,831)	\$0
Total	(\$2,675,216)	(\$1,337,608)	(\$1,337,608)	\$0
IHSS FFS Savings (In the Base)	(\$522,931)	\$0	(\$522,931)	\$0
Delay 1 Checkwrite (In the Base)	\$49,086	\$24,543	\$24,543	\$0
Transfer of IHSS Costs to DHCS	\$0	(\$463,731)	\$0	\$463,731
Transfer of IHSS Costs to CDSS	\$1,021,648	\$0	\$0	\$1,021,648
Other Administration Costs	\$5,172	\$2,543	\$2,630	\$0
Total of CCI PCs including pass through	\$1,207,008	(\$170,695)	(\$107,677)	\$1,485,379
IHSS Funding (CCI-IHSS Funding Adjustment)	\$0	(\$1,049)	\$1,049	\$0
Grand Total	\$1,207,008	(\$171,744)	(\$106,628)	\$1,485,379

Funding:

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

CCI-IHSS FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 215
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1767

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	-\$1,049,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	-\$1,049,000
FEDERAL FUNDS	\$0	\$1,049,000

DESCRIPTION

Purpose:

This policy change adjusts funding for additional In-Home Supportive Services (IHSS) provided to Coordinated Care Initiative (CCI) eligibles through managed care plans.

Authority:

Welfare & Institutions Code 14132.956
 Affordable Care Act (ACA) 2401

Interdependent Policy Changes:

Not Applicable

Background:

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

The State Plan Amendment (SPA) was approved on August 31, 2012 with an effective date of December 1, 2011.

As shown in the Community First Choice Option policy change, CFCO will generate new federal funds and will create General Fund savings to the Department of Social Services and counties who provide matching funds. The higher federal funding will also affect additional IHSS services to CCI eligibles authorized by managed care plans.

CCI-IHSS FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 215

Reason for Change from Prior Estimate:

New policy change.

Methodology:

FY 2013-14	TF	GF	FFP
	\$0	(\$1,049,000)	\$1,049,000

Funding:

Title XIX 100% General Fund (4260-101-0001)

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