

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

REGULAR POLICY CHANGES

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



EDMUND G. BROWN JR.
Governor
State of California

Diana Dooley
Secretary
California Health and Human Services Agency

Toby Douglas
Director
Department of Health Care Services

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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	\$621,370,000	\$645,619,000
- STATE FUNDS	\$155,479,900	\$161,547,900
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$621,370,000	\$645,619,000
STATE FUNDS	\$155,479,900	\$161,547,900
FEDERAL FUNDS	\$465,890,100	\$484,071,100

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 expanded under the Family PACT program to provide contraceptive services to more persons in need of such services with incomes under 200% of Federal Poverty Level. The Centers for Medicare & Medicaid Services (CMS) approved Section 1115 demonstration project waiver, effective December 1, 1999.

On March 24, 2011, CMS approved a State Plan Amendment (SPA), 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:

Later data actuals were higher than projected.

Methodology:

1. Use linear regressions on actual data from March 2010 to February 2013 for users, units per user, and dollars per unit.

FAMILY PACT PROGRAM

REGULAR POLICY CHANGE NUMBER: 1

2. Family planning services and testing for sexually transmitted infections (STIs) are eligible for 90% FFP.
3. The treatment of STIs and other family planning companion services are eligible for Title XIX 50/50 FFP.
4. The treatment of other medical conditions; including inpatient care for complications from family planning services are not eligible for FFP.
5. 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	\$90,479,000	\$22,640,000	\$97,374,000	\$22,365,000
Other Medical	\$373,284,000	\$93,404,000	\$379,198,000	\$94,884,000
County Outpatient	\$3,426,000	\$857,000	\$3,534,000	\$884,000
Community Outpatient	\$4,448,000	\$1,113,000	\$4,600,000	\$1,151,000
Pharmacy	\$149,733,000	\$37,466,000	\$160,913,000	\$40,264,000
Total	\$621,370,000	\$155,480,000	\$645,619,000	\$161,548,000

Funding:

(In Thousands)

FY 2012-13:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$38,325	\$19,163	\$19,162
State GF	4260-101-0001	\$86,681	\$86,681	\$0
Family Planning 90/10 GF	4260-101-0001/0890	\$496,364	\$49,636	\$446,728
Total		\$621,370	\$155,480	\$465,890

FY 2013-14:

		TF	GF	FF
Title XIX 50/50 FFP	4260-101-0001/0890	\$39,821	\$19,911	\$19,910
State GF	4260-101-0001	\$90,064	\$90,064	\$0
Family Planning 90/10 GF	4260-101-0001/0890	\$515,734	\$51,573	\$464,161
Total		\$645,619	\$161,548	\$484,071

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	\$248,513,000	\$1,103,252,000
- STATE FUNDS	\$86,979,550	\$386,138,200
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$248,513,000	\$1,103,252,000
STATE FUNDS	\$86,979,550	\$386,138,200
FEDERAL FUNDS	\$161,533,450	\$717,113,800

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 HFP to Medi-Cal
 OA 2 CCS Case Management
 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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

Effective January 1, 2013, HFP subscribers began a transition into Medi-Cal through a phase-in methodology. 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.

TRANSITION OF HFP TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 2

Reason for Change from Prior Estimate:

In the November Estimate, Los Angeles and San Diego were scheduled to participate in Phase 1C transitioning in April. Now due to delays, they are scheduled to transition in May. Additionally, Managed Care capitation rates were updated and premium discounts were added.

Methodology:

1. Effective January 1, 2013, 871,027 HFP subscribers began transitioning to Medi-Cal through a phase-in methodology. 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 Transition of HFP subscribers into the Medi-Cal program will occur in four separate phases. The first phase will be split into four phases transitioning January 1, 2013, March 1, 2013, April 1, 2013, and May 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 on August 1, 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 \$96.00. 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. The Department will provide premium exemptions for children ages 0-1 years old, Alaska Natives, and American Indians regardless of income levels. In addition, the Department will offer 25% discounts for those subscribers who sign up for monthly electronic fund transfer (EFT), and those who pay three or more months in advance. Premiums are estimated to total \$14,261,000 in FY 2012-13 and \$51,370,000 in FY 2013-14.
6. Of the 871,027 subscribers, there are an estimated 6,309 CCS-HFP eligibles that will shift to CCS-Medi-Cal in FY 2012-13, and 23,531 in FY 2013-14. The cost for these eligibles is currently budgeted in the Family Health Estimate. CCS-HFP is funded with 65% FFP, 21% GF, and 14% 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 \$957,000 in FY 2012-13 and \$26,739,000 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 \$7,640,000 TF (\$2,674,000 GF) in FY 2012-13 and \$15,601,000 TF (\$5,460,000 GF) in FY 2013-14 for benefit costs that were part of the Bridge to HFP policy change.

TRANSITION OF HFP TO MEDI-CAL

REGULAR POLICY CHANGE NUMBER: 2

(In Thousands)			County
FY 2012-13	TF	GF	Reimbursement*
Other Services	\$248,100	\$86,835	
CCS	\$7,034	\$1,505	\$957
Bridge to HFP	\$7,640	\$2,674	
Benefits Total	\$262,774	\$91,014	\$957
Premiums	-\$14,261	-\$4,991	
Net	\$248,513	\$86,023	\$957

(In Thousands)			County
FY 2013-14	TF	GF	Reimbursement*
Other Services	\$943,553	\$330,243	
CCS	\$195,468	\$41,675	\$26,739
Bridge to HFP	\$15,601	\$5,460	
Benefits Total	\$1,154,622	\$377,378	\$26,739
Premiums	-\$51,370	-\$17,980	
Net	\$1,103,252	\$359,398	\$26,739

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	\$139,452,000	\$142,761,000
- STATE FUNDS	\$61,524,150	\$62,727,800
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$139,452,000	\$142,761,000
STATE FUNDS	\$61,524,150	\$62,727,800
FEDERAL FUNDS	\$77,927,850	\$80,033,200

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:

There is no material change.

Methodology:

1. There were 10,556 FFS and 2,751 managed care eligibles as of November 2012 (total of 13,307). 2,643 of the FFS eligibles were eligible for State-Only services.

BREAST AND CERVICAL CANCER TREATMENT

REGULAR POLICY CHANGE NUMBER: 3

2. 595 of the FFS eligibles were in Accelerated Enrollment as of November 2012.
3. Assume the State will pay Medicare and other health coverage premiums for an average of 372 beneficiaries monthly in FY 2012-13 and FY 2013-14. Assume an average monthly premium cost per beneficiary of \$254.41.

FY 2012-13: 372 x \$254.41 x 12 months = \$1,136,000* TF (\$1,136,000 GF) *Rounded
 FY 2013-14: 372 x \$254.41 x 12 months = \$1,136,000* TF (\$1,136,000 GF) *Rounded

4. FFS costs are estimated as follows:

(In Thousands)	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
Full Scope Costs	\$119,889	\$41,961	\$123,128	\$43,095
State-Only Costs				
Services	\$18,427	\$18,427	\$18,497	\$18,497
Premiums	\$1,136	\$1,136	\$1,136	\$1,136
Total	\$139,452	\$61,524	\$142,761	\$62,728

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:

(In Thousands)

FY 2012-13:		GF	FF	TF
General Fund	4260-101-0001	\$19,563	\$0	\$19,563
Title XIX 35/65 FFP	4260-101-0001/0890	\$41,961	\$77,928	\$119,889
Total		\$61,524	\$77,928	\$139,452
FY 2013-14:		GF	FF	TF
General Fund	4260-101-0001	\$19,633	\$0	\$19,633
Title XIX 35/65 FFP	4260-101-0001/0890	\$43,095	\$80,033	\$123,128
Total		\$62,728	\$80,033	\$142,761

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 4
 IMPLEMENTATION DATE: 7/2008
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 8

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$15,200,000	\$15,022,000
- STATE FUNDS	\$5,320,000	\$5,257,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,200,000	\$15,022,000
STATE FUNDS	\$5,320,000	\$5,257,700
FEDERAL FUNDS	\$9,880,000	\$9,764,300

DESCRIPTION

Purpose:

This policy change estimates the cost of providing pre-enrollment (PE) into the Healthy Families Program (HFP) or the Targeted Low Income Children's Program (TLICP) 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 on 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 part of the Medically Indigent Children aid category, which is incorporated in the base estimate.

Effective January 2013, HFP subscribers began transitioning into Medi-Cal's TLICP through a phase-in methodology. All children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal. DHCS will continue to receive enhanced Title XXI funding for these children.

Reason for Change from Prior Estimate:

The per-member-per-month (PMPM) costs increased for both the HFP PE and Medi-Cal PE and the estimated caseload for aid code 8X decreased in both FY 2012-13 and FY 2013-14. The PMPM for HFP PE increased from \$200.10 to \$222.71 and the PMPM for Medi-Cal PE increased from \$200.07 to \$216.29.

CHDP GATEWAY - PREENROLLMENT

REGULAR POLICY CHANGE NUMBER: 4

Methodology:

1. Based on November 2011 through October 2012 eligible data there will be 549,920 children (35,529 HFP, 33,693 Transition of HFP to Medi-Cal, 447,743 Medi-Cal and 32,952 CHDP State-Only) in FY 2012-13 and 540,414 children (69,455 HFP, 440,376 Medi-Cal and 30,583 CHDP State-Only) in FY 2013-14 who will be screened through the Gateway.
2. Based on February 2012 through January 2013 cost data and November 2011 through October 2012 eligible data, the PMPM cost for HFP PE is \$222.71.
3. Based on February 2012 through January 2013 cost data and November 2011 through October 2012 eligible data, the PMPM cost for Medi-Cal PE is \$216.29.
4. The estimated FY 2012-13 and FY 2013-14 HFP and Medi-Cal PE costs are as follows:

FY 2012-13:	Avg. Mo. Eligibles	TF	GF
HFP PE (Aid Code 8X)	5,922	\$7,913,000	\$2,770,000
Transition of HFP to Medi-Cal PE (Aid Code 8X)*	5,616	\$7,287,000	\$2,550,000
		\$15,200,000	\$5,320,000
Medi-Cal PE (Aid Code 8W)	37,312	\$96,842,000	\$48,421,000
Total		\$112,042,000	\$53,741,000
FY 2013-14:	Avg. Mo. Eligibles	TF	GF
Medi-Cal PE (Aid Code 8X)	5,788	\$15,022,000	\$5,258,000
Medi-Cal PE (Aid Code 8W)	36,698	\$95,249,000	\$47,625,000
Total		\$110,271,000	\$52,883,000

**Due to the Transition 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 Transition of HFP to Medi-Cal PE.*

Funding:

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

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	\$4,289,000	\$21,669,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$4,289,000	\$21,669,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$4,289,000	\$21,669,000

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 or part of the County Compassionate Release Program, 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 an inmate is part of the County Compassionate Release Program, 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

MEDI-CAL INPATIENT HOSP. COSTS - ADULT INMATES

REGULAR POLICY CHANGE NUMBER: 5

order to claim Title XIX FFP.

Reason for Change from Prior Estimate:

The Department cannot process county reimbursements until July 2013 because of delays in establishing new aid codes and a claiming process.

Methodology:

1. Implementation of coverage for the State inmates began April 2012. Implementation of coverage for county inmates began 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. Based on fee-for-service (FFS) cost data the average per-member-per-month (PMPM) cost for an inpatient admission is \$9,173 for aged, \$11,677 for disabled, \$7,947 for LTC eligibles, and \$10,585 for under 21.
4. Based on FFS delivery cost data the average PMPM cost per event is \$6,450 for cesarean delivery and \$4,142 for a vaginal delivery. Based on birth events data 33% of the annual birth events will be for cesarean deliveries and 67% will be for vaginal deliveries. The average birth event cost is \$4,904.
5. It is assumed the Department will process 375 applications per month for State inmates with verified citizenship.
6. Assume 96 percent of the monthly applicants will become eligible for Medi-Cal or LIHP.

375 monthly applications x 96% = 360 eligible State inmates

7. 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

8. State inmate inpatient costs are estimated to be \$8,228,000 (\$4,114,000 GF) in FY 2012-13 and FY 2013-14.

FY 2012-13 & FY 2013-14						TF	FF	
Aged	54	x	12	x	\$9,173	=	\$5,944,000	\$2,972,000
Disabled	11	x	12	x	\$11,677	=	\$1,541,000	\$770,500
Pregnancy Event	4	x	12	x	\$4,904	=	\$235,000	\$117,500
Under 21	4	x	12	x	\$10,585	=	\$508,000	\$254,000
Total							\$8,228,000	\$4,114,000

MEDI-CAL INPATIENT HOSP. COSTS - ADULT INMATES

REGULAR POLICY CHANGE NUMBER: 5

9. It is assumed the Department will process 170 Medi-Cal applications per month for county inmates with verified citizenship.
10. 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	<u>FY 2012-13</u>				-	<u>FY 2013-14</u>				
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

11. Implementation of the County inmate inpatient program began January 1, 2013; however, the claims will not be reimbursed until July 1, 2013. County inmate inpatient costs are estimated to be \$27,758,000 TF (\$9,253,000 TF + \$18,505,000 TF) in FY 2013-14.

FY 2012-13 (paid in FY 13/14)

						<u>TF</u>	<u>FF</u>	
Aged	127	x	6	x	\$9,173	=	\$6,990,000	\$3,495,000
Disabled	17	x	6	x	\$11,677	=	\$1,191,000	\$595,500
Pregnancy Event	17	x	6	x	\$4,904	=	\$500,000	\$250,000
Under 21	9	x	6	x	\$10,585	=	\$572,000	\$286,000
Total							\$9,253,000	\$4,626,500

FY 2013-14

						<u>TF</u>	<u>FF</u>	
Aged	127	x	12	x	\$9,173	=	\$13,980,000	\$6,990,000
Disabled	17	x	12	x	\$11,677	=	\$2,382,000	\$1,191,000
Pregnancy Event	17	x	12	x	\$4,904	=	\$1,000,000	\$500,000
Under 21	9	x	12	x	\$10,585	=	\$1,143,000	\$571,500
Total							\$18,505,000	\$9,252,500

Total FY 2013-14**\$27,758,000 \$13,879,000**

12. In FY 2012-13 and FY 2013-14, it is assumed the Department will process 25 applications annually for State Medical Parolees with verified citizenship. It is assumed these eligibles will receive long term care (LTC) services for six months of continuous coverage.
13. State Medical Parolees inpatient costs are estimated to be:

FY 2012-13

LTC Eligible Months		PMPM		<u>TF</u>	<u>FF</u>
44	x	\$7,947	=	\$350,000	\$175,000

FY 2013-14

LTC Eligible Months		PMPM		<u>TF</u>	<u>FF</u>
150	x	\$7,947	=	\$1,192,000	\$596,000

14. 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 long term care (LTC)

MEDI-CAL INPATIENT HOSP. COSTS - ADULT INMATES

REGULAR POLICY CHANGE NUMBER: 5

services for six months of continuous coverage.

15. Implementation of the County Compassionate Release Program began January 1, 2013; however, the claims will not be reimbursed until July 1, 2013. Total estimated costs for FY 2013-14 are:

FY 2013-14

LTC Eligible Months	PMPM		<u>TF</u>	<u>FF</u>
775	x	\$7,947	=	\$6,159,000 \$3,079,500

16. Total estimated Medi-Cal Inpatient Hospital Costs for Adult Inmates in FY 2012-13 and FY 2013-14 are:

(In Thousands)

Summary:

	FY 2012-13		FY 2013-14	
	<u>TF</u>	<u>FF</u>	<u>TF</u>	<u>FF</u>
Medical Parole	\$350	\$175	\$1,192	\$596
Compassionate Release Program	\$0	\$0	\$6,159	\$3,079.5
State Inmates	\$8,228	\$4,114	\$8,228	\$4,114
County Inmates	\$0	\$0	\$27,758	\$13,879
Total	\$8,578	\$4,289	\$43,337	\$21,668.5

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	\$7,646,000	\$0
- STATE FUNDS	\$2,676,100	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,646,000	\$0
STATE FUNDS	\$2,676,100	\$0
FEDERAL FUNDS	\$4,969,900	\$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, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology, which reduces the need for the bridge from Medi-Cal to the HFP.

Reason for Change from Prior Estimate:

Caseload decreased by 3.1%. However, the fee-for-service (FFS) per-member-per-month (PMPM) costs for aid code 7X increased from \$49.25 to \$60.83, and the managed care PMPM carve-out increased from \$22.51 to \$26.22.

Methodology:

1. Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal. Estimated FY 2012-13 costs in this policy change are based on July 1, 2012 through December 31, 2012. Estimated

BRIDGE TO HFP

REGULAR POLICY CHANGE NUMBER: 6

bridge costs from January 1, 2013 through June 30, 2013 are included in the Transition of HFP to Medi-Cal benefits policy change.

2. Based on current Medi-Cal data, it is estimated 62,266 children will receive the one-month bridge (aid code 7X) from July 2012 through December 2012. The average monthly number of beneficiaries will be 10,378.
3. Of the 62,266 children, it is estimated that 14,258 are in fee-for-service (FFS), and 48,008 are in managed care.
4. Based on 2012 cost data and eligible data from October 2011 through September 2012, the FFS PMPM cost for aid code 7X is \$60.83. The total FFS expenditures for aid code 7X will be \$867,000.

FY 2012-13: \$60.83 PMPM x 14,258 = \$867,000

5. Based on 2012 cost data and eligible data from October 2011 through September 2012, the average monthly managed care carve-out cost for aid code 7X is \$26.22. The total managed care carve-out expenditures for aid code 7X will be \$1,259,000.

FY 2012-13: \$26.22 Carve-Out x 48,008 = \$1,259,000

6. The total managed care capitation cost for aid code 7X from July 2012 through December 2012 will be \$5,520,000.
7. The total managed care cost for aid code 7X will be \$6,779,000.

FY 2012-13: \$1,259,000 Carve-Out + \$5,520,000 Capitation = \$6,779,000

8. Total expenditures for aid code 7X are estimated to be \$7,646,000.

FY 2012-13: \$867,000 + \$6,779,000 = \$7,646,000 TF (\$2,676,000 GF)

Funding:

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

REFUGEES

REGULAR POLICY CHANGE NUMBER: 7
 IMPLEMENTATION DATE: 7/1980
 ANALYST: Dee Britton
 FISCAL REFERENCE NUMBER: 14

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$5,154,000	\$5,199,000
- STATE FUNDS	\$5,154,000	\$5,199,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$5,154,000	\$5,199,000
STATE FUNDS	\$5,154,000	\$5,199,000
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:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

REFUGEES

REGULAR POLICY CHANGE NUMBER: 7

Methodology:

Total refugee expenditures to be reimbursed by CDPH are estimated to be \$5,154,000 in FY 2012-13 and \$5,199,000 in FY 2013-14.

Funding:

Reimbursements (4260-610-0995)

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 8
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1755

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$625,000	\$6,932,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$625,000	\$6,932,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$625,000	\$6,932,000

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:

Even though the county juvenile inmate program was implemented in January 2013, the Department cannot process reimbursements until July 2013.

Methodology:

1. Implementation of coverage began 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. Based on fee-for-service (FFS) cost data the average cost for a general acute care inpatient admission is \$10,585 and \$6,297 for an inpatient psychiatric admission for those under 21 years old.
4. It is assumed the Department will process 29 applications per month for State inmates and 88 applications per month for county inmates with verified citizenship.
5. Of the estimated monthly applications, it is assumed 80% are for psychiatric services and 20% are for inpatient services.

(Rounded)

State Inmates**FY 2012-13 & FY 2013-14**

Psychiatric Services	29	x	80%	=	23
Inpatient Services	29	x	20%	=	6

(Rounded)

County Inmates**FY 2012-13 & FY 2013-14**

Psychiatric Services	88	x	80%	=	70
Inpatient Services	88	x	20%	=	18

6. State juvenile inmates costs are estimated to be \$1,250,000 TF (\$625,000 GF) in FY 2012-13 and \$2,500,000 TF (\$1,250,000 GF) in FY 2013-14.

<u>FY 2012-13</u>						<u>TF</u>	<u>FF</u>	
Psychiatric Services	23	x	6	x	\$6,297	=	\$869,000	\$434,500
Inpatient Services	6	x	6	x	\$10,585	=	\$381,000	\$190,500
Total							\$1,250,000	\$625,000

<u>FY 2013-14</u>							<u>TF</u>	<u>FF</u>
Psychiatric Services	23	x	12	x	\$6,297	=	\$1,738,000	\$869,000
Inpatient Services	6	x	12	x	\$10,585	=	\$762,000	\$381,000
Total							\$2,500,000	\$1,250,000

7. Implementation of the County juvenile inmate program began January 1, 2013; however, the claims will not be reimbursed until July 1, 2013. County juvenile inmate costs are estimated to be \$11,363,000 TF (\$3,788,000 TF + \$7,575,000 TF) in FY 2013-14.

<u>FY 2012-13</u> (paid in FY 13/14)							<u>TF</u>	<u>FF</u>
Psychiatric Services	70	x	6	x	\$6,297	=	\$2,645,000	\$1,322,500
Inpatient Services	18	x	6	x	\$10,585	=	\$1,143,000	\$571,500
Total							\$3,788,000	\$1,894,000

MEDI-CAL INPATIENT HOSP. COSTS - JUVENILE INMATES

REGULAR POLICY CHANGE NUMBER: 8

FY 2013-14					TF	FF	
Psychiatric Services	70	x	12	x	\$6,297 =	\$5,289,000	\$2,644,500
Inpatient Services	18	x	12	x	\$10,585 =	\$2,286,000	\$1,143,000
Total						<u>\$7,575,000</u>	<u>\$3,787,500</u>
FY 2013-14 Total						\$11,363,000	\$5,681,500

8. Total estimated costs for Medi-Cal Inpatient Hospital and Psychiatric Services for Juvenile Inmates in FY 2012-13 and FY 2013-14 are:

(Rounded)	FY 2012-13		FY 2013-14	
Summary	TF	FF	TF	FF
State Inmates	\$1,250,000	\$625,000	\$2,500,000	\$1,250,000
County Inmates	\$0	\$0	\$11,363,000	\$5,681,500
Total	\$1,250,000	\$625,000	\$13,863,000	\$6,931,500

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	\$700,000	\$540,000
- STATE FUNDS	\$350,000	\$270,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$700,000	\$540,000
STATE FUNDS	\$350,000	\$270,000
FEDERAL FUNDS	\$350,000	\$270,000

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

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

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. Additionally, the new screening process was implemented, and all applications submitted to SPE are sent to county eligibility workers for a Medi-Cal determination.

Reason for Change from Prior Estimate:

Eligibles and expenditure data for aid code 3N and 8E were updated to include August through December 2012.

Methodology:

1. Assume that MRMIB will notify approximately 268,192 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 19,578 responses.
4. Assume that 33% of the responses will qualify for 2 months of accelerated enrollment at a per-member-per-month (PMPM) cost of \$71.55.

$$19,578 \text{ responses} * 33\% \text{ qualify for AE} * 2 \text{ months} * \$71.55 \text{ PMPM} = \$925,000$$

5. Due to payment lag factors, only \$623,000 of the \$925,000 accelerated enrollment costs will be paid in FY 2012-13. The remaining \$302,000 is estimated to be paid in FY 2013-14.
6. It is estimated there will be additional accelerated enrollment costs in the amount of \$10,000 in FY 2012-13 and \$4,000 in FY 2013-14. Total accelerated enrollment costs are estimated to be \$633,000 in FY 2012-13 and \$306,000 in FY 2013-14.
7. Assume that of the respondents, 30% will provide the necessary documentation to make a determination of Medi-Cal 1931(b) eligibility and only 2% will be found eligible.
8. Assume that the average benefits PMPM cost is \$162.89.

$$19,578 \text{ responses} * 30\% \text{ provide documentation} * 2\% \text{ found eligible} * \$162.89 \text{ PMPM} * 12 \text{ months} = \$230,000 \text{ annual ongoing cost}$$

9. It is estimated there will be additional ongoing costs in the amount of \$4,000. Total annual ongoing costs are estimated to be \$234,000.
10. It is estimated only \$67,000 of the \$234,000 annual ongoing costs will occur in FY 2012-13.
11. Applying partial year phase-in adjustments and appropriate payment lags, the costs are:

	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
Accelerated Enrollment	\$633,000	\$316,500	\$306,000	\$153,000
Ongoing Benefits	\$67,000	\$33,500	\$234,000	\$117,000
Total	\$700,000	\$350,000	\$540,000	\$270,000

MCHA VS. DHCS AND MRMIB

REGULAR POLICY CHANGE NUMBER: 9

Funding:

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

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 11
 IMPLEMENTATION DATE: 8/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1558

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,309,000	\$2,320,000
- STATE FUNDS	\$1,548,500	\$1,560,000
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 costs of changes made to the 250% Working Disabled Program (WDP).

Authority:

AB 1269 (Chapter 282, Statutes of 2009)

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 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 11

3. Allows beneficiaries to remain eligible for Medi-Cal up to 26 weeks while unemployed, provided premiums continue to be paid.
4. Allows the monthly premium calculation to be based on five percent of an individual's countable income.

However, under the Patient Protection and Affordable Care Act (PPACA) of 2010, Maintenance of Effort (MOE) requirements are imposed upon states until January 1, 2014. These requirements prevent states from implementing more restrictive Medicaid eligibility policies, procedures or methodologies 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 (323 versus 211 annual growth). Base trends already include the impact of this policy change. Therefore, it is shown as 100% in the base and will not be included in the next Estimate.

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 November 2011 through October 2012 eligible data, there are 730 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 3.7% monthly or 27 beneficiaries per month (rounded). It is assumed there will be an additional increase of 323 eligibles per year to the WDP.
7. The full increase in eligibles will be phased-in over 12 months.
8. The fee-for-service (FFS) per member per month (PMPM) cost per eligible for aid code 6G is \$270.94 and the average monthly managed care cost is \$594.48 (\$503.55 cap rate and \$85.18 for carve-out PMPM cost). The monthly dental capitation rate is \$5.74.
9. The monthly premium for the Medicare Part B is \$99.90 in 2012 and \$104.90 in 2013. The monthly premium for the Medicare Part D is \$102.76 in 2012, \$103.70 in 2013 and an estimated \$98.68 in 2014.

250% WORKING DISABLED PROGRAM CHANGES

REGULAR POLICY CHANGE NUMBER: 11

FY 2012-13	TF	GF
FFS	\$645,000	\$322,500
Managed Care	\$853,000	\$426,500
Medicare Part B	\$388,000	\$388,000
Medicare Part D	\$401,000	\$401,000
Dental	\$22,000	\$11,000
Total	\$2,309,000	\$1,549,000

FY 2013-14	TF	GF
FFS	\$645,000	\$322,500
Managed Care	\$853,000	\$426,500
Medicare Part B	\$407,000	\$407,000
Medicare Part D	\$393,000	\$393,000
Dental	\$22,000	\$11,000
Total	\$2,320,000	\$1,560,000

Funding:

FY 2012-13:		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	\$760,500	\$760,500	\$1,521,000
GF	4260-101-0001	\$788,000	\$ 0	\$788,000

FY 2013-14:		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	\$760,000	\$760,000	\$1,520,000
GF	4260-101-0001	\$800,000	\$ 0	\$800,000

LOMELI V. SHEWRY

REGULAR POLICY CHANGE NUMBER: 12
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Ryan Witz
 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	100.00 %	100.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost of 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:

The estimated reimbursement costs from this policy change are assumed to be in the FFS base trends. This is the final estimate in which this policy change will be included.

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

Funding:

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

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13
 IMPLEMENTATION DATE: 1/2011
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1371

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$9,072,100	-\$9,072,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$9,072,100	-\$9,072,100
FEDERAL FUNDS	\$9,072,100	\$9,072,100

DESCRIPTION

Purpose:

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

Authority:

Children's Health Insurance Program Reauthorization Act (CHIPRA)

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 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that federal financial participation (FFP) is available for immigrants 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. Immigrants who are not Qualified Aliens are eligible for state funded full-scope Medi-Cal if they have a satisfactory immigration status. FFP is only available for eligible immigrants and Qualified Aliens under the five year bar 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 and specified lawfully present immigrants who are children or pregnant women regardless of their date of entry into the US. Effective April 1, 2009, the Department began claiming FFP for Qualified Alien pregnant women and children. In FY 2012-13, the Department expects to implement full-scope coverage for lawfully present pregnant women and children.

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

Reason for Change from Prior Estimate:

There is no material change.

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 this estimate is consistent for both FY 2012-13 and FY 2013-14.

3. Children

Based upon quarterly claiming reports for 2012, 37.11% 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:

$\$9,787,000 \times 37.11\% \text{ non-emergency} = \$3,632,000$ (0 to 18 year olds)

$\$1,055,000 \times 37.11\% \text{ non-emergency} = \$391,000$ (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 14,594 for 19 and 20 year olds.

The average capitation for the NQA children and pregnant women is assumed to be \$114.01 PMPM.

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

$171,628 \text{ eligible months} \times \$114.01 \text{ PMPM} \times 37.11\% \text{ non-emergency} = \$7,262,000$ (0 to 18 year olds)

$14,594 \text{ eligible months} \times \$114.01 \text{ PMPM} \times 37.11\% \text{ non-emergency} = \$617,000$ (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 managed care carve-outs for pregnant women are \$34,926,000.

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

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

CHIPRA - M/C FOR CHILDREN & PREGNANT WOMEN

REGULAR POLICY CHANGE NUMBER: 13

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 \$114.01 PMPM.

Non-pregnancy services = 86,471 eligible months x \$114.01 PMPM x 6.64% = \$655,000

	<u>Title XIX (50/50)</u>	<u>Title XXI (65/35)</u>
Children (0-18)		
FFS	\$0	\$3,632,000
Managed Care	\$0	\$7,262,000
Children (19-20)		
FFS	\$391,000	\$0
Managed Care	\$617,000	\$0
Pregnant Women		
FFS	\$2,319,000	\$0
Managed Care	\$655,000	\$0
Total (rounded)	<u>\$3,982,000</u>	<u>\$10,894,000</u>
GF	\$1,991,000	\$3,812,900
FFP	\$1,991,000	\$7,081,100

5. Total FFP of \$9,072,000 offsets the General Fund cost of providing services to these eligibles.

Funding:

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

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

NEW QUALIFIED ALIENS

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

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$68,386,000	\$68,153,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$68,386,000	\$68,153,000
FEDERAL FUNDS	-\$68,386,000	-\$68,153,000

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:

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

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 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

There is no material change.

Methodology:

1. Based on actual expenditure reports for the fee-for-service (FFS) nonemergency services costs of NQAs from January 2006 through December 2012, current year and budget year costs were projected.

NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 14

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.
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.
5. The estimated FFP Repayment in FY 2012-13 and FY 2013-14:

(In Thousands)	FY 2012-13	FY 2013-14
FFS	\$114,671	\$114,280
Managed Care	\$22,101	\$22,026
Total	\$136,772	\$136,306
FFP Repayment	\$68,386	\$68,153

Funding:

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

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 15
 IMPLEMENTATION DATE: 12/1998
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 13

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$52,791,000	-\$54,200,850
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$52,791,000	-\$54,200,850
FEDERAL FUNDS	\$52,791,000	\$54,200,850

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 (HFP).

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. HFP subscribers will be transitioned into Medi-Cal 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 estimated total managed care capitation for aid codes 8P and 8R increased from \$220,680,000 to \$264,835,000 in FY 2012-13 and \$227,234,000 to \$272,700,000 in FY 2013-14.

RESOURCE DISREGARD - % PROGRAM CHILDREN

REGULAR POLICY CHANGE NUMBER: 15

Methodology:

1. Aid codes (8N, 8P, 8R, and 8T) that identify children eligible for Medi-Cal due to disregarding assets were implemented in December 1998.
2. Average monthly fee-for-service (FFS) eligibles, which are included in the base, are estimated to be 53,684 in FY 2012-13 and 54,857 in FY 2013-14. It is assumed total FFS expenditures will be \$30,661,000 in FY 2012-13 and \$31,331,000 in FY 2013-14.
3. Average monthly Managed Care eligibles, which are budgeted in the managed care model policy changes, are estimated to be 176,712 in FY 2012-13 and 179,413 in FY 2013-14. It is assumed total Managed Care expenditures will be \$321,279,000 in FY 2012-13 and \$330,008,000 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:

(In Thousands)

FY 2012-13		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	(\$175,970)	(\$175,970)	(\$351,940)
Title XXI 65/35 FFP	4260-113-0001/0890	\$123,179	\$228,761	\$351,940
Net Impact		(\$52,791)	\$52,791	\$0
FY 2013-14		GF	FF	TF
Title XIX 50/50 FFP	4260-101-0001/0890	(\$180,669)	(\$180,669)	(\$361,339)
Title XXI 65/35 FFP	4260-113-0001/0890	\$126,469	\$234,870	\$361,339
Net Impact		(\$54,201)	\$54,201	\$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	-\$5,317,000	-\$6,634,000
- STATE FUNDS	-\$2,658,500	-\$3,317,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	96.14 %	92.86 %
APPLIED TO BASE		
TOTAL FUNDS	-\$205,200	-\$473,700
STATE FUNDS	-\$102,620	-\$236,830
FEDERAL FUNDS	-\$102,620	-\$236,830

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

PARIS-FEDERAL**REGULAR POLICY CHANGE NUMBER: 16**

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 statewide beginning January 1, 2014.

Reason for Change from Prior Estimate:

The Department expects to implement PARIS-Federal statewide beginning January 1, 2014. The estimated savings for both FY 2012-13 and FY 2013-14 has increased; however, due to the increase of the percent in base, the budgeted savings in this policy change has decreased.

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 219 managed care and 54 FFS beneficiaries will be discontinued from Medi-Cal in FY 2012-13.
3. Based on quarterly reports for August 2012 through May 2013, it is estimated 350 managed care and 86 FFS beneficiaries will be discontinued from Medi-Cal in FY 2013-14.
4. Total managed care savings is estimated to be \$1,008,000 TF in FY 2012-13, and \$1,257,000 TF in FY 2013-14. Total FFS savings is estimated to be \$4,309,000 TF in FY 2012-13 and \$5,377,000 TF in FY 2013-14.
5. In FY 2012-13, it is estimated that 96.14% of the managed care and FFS savings is captured in the base trends. In FY 2013-14, it is estimated that 92.86% 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	(\$1,008,000)	96.14%	(\$969,000)
FFS Savings	(\$4,309,000)	96.14%	(\$4,143,000)
Total	(\$5,317,000)		(\$5,112,000)
FY 2013-14	Total Savings	% in Base	Savings in Base
Managed Care Savings	(\$1,257,000)	92.86%	(\$1,167,000)
FFS Savings	(\$5,377,000)	92.86%	(\$4,993,000)
Total	(\$6,634,000)		(\$6,160,000)

6. Total estimated savings not in the base trends:

FY 2012-13	TF	GF
Managed Care Savings	(\$39,000)	(\$19,500)
FFS Savings	(\$166,000)	(\$83,000)
Total	(\$205,000)	(\$102,500)
FY 2013-14	TF	GF
Managed Care Savings	(\$90,000)	(\$45,000)
FFS Savings	(\$384,000)	(\$192,000)
Total	(\$474,000)	(\$237,000)

Funding:

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

PARIS-VETERANS

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	-\$1,355,000	-\$1,769,000
- STATE FUNDS	-\$677,500	-\$884,500
PAYMENT LAG	0.9317	0.9487
% REFLECTED IN BASE	28.96 %	35.64 %
APPLIED TO BASE		
TOTAL FUNDS	-\$896,800	-\$1,080,100
STATE FUNDS	-\$448,420	-\$540,060
FEDERAL FUNDS	-\$448,420	-\$540,060

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:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

There is no material change.

Methodology:

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

PARIS-VETERANS

REGULAR POLICY CHANGE NUMBER: 17

2. Savings for PARIS-Veterans is for eligibles in managed care and fee-for-service (FFS).
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 PMPM basis will be \$144.35 in FY 2012-13 and \$138.41 in FY 2013-14.

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	-\$14,840,000	-\$22,339,000
- STATE FUNDS	-\$7,420,000	-\$11,169,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	94.95 %	90.54 %
APPLIED TO BASE		
TOTAL FUNDS	-\$749,400	-\$2,113,300
STATE FUNDS	-\$374,710	-\$1,056,630
FEDERAL FUNDS	-\$374,710	-\$1,056,640

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

PARIS-INTERSTATE

REGULAR POLICY CHANGE NUMBER: 18

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 statewide beginning January 1, 2014.

Reason for Change from Prior Estimate:

The Department expects to implement PARIS-Interstate statewide beginning January 1, 2014. The estimated savings for both FY 2012-13 and FY 2013-14 is consistent with the November estimate; however, due to the increase of the percent in base, the budgeted savings in this policy change has decreased.

Methodology:

- 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).
- Based on prior quarterly reports of PARIS-Interstate matches, it is estimated that 3,920 managed care beneficiaries will be discontinued from Medi-Cal in FY 2012-13, and 6,767 in FY 2013-14.
- Total managed care savings is estimated to be \$14,840,000 TF in FY 2012-13, and \$22,339,000 TF in FY 2013-14.
- In FY 2012-13, it is estimated that 94.95% of the managed care savings is captured in the base trends. In FY 2013-14, it is estimated that 90.54% of the managed care savings is captured in the base trends.

FY 2012-13	TF	% in Base	Savings in Base
Managed Care Savings	(\$14,840,000)	94.95%	(\$14,090,000)
FY 2013-14	TF	% in Base	Savings in Base
Managed Care Savings	(\$22,339,000)	90.54%	(\$20,226,000)

- Total estimated savings not in the base trends:

FY 2012-13	TF	GF
Total Savings	(\$750,000)	(\$375,000)
FY 2013-14	TF	GF
Total Savings	(\$2,113,000)	(\$1,056,500)

Funding:

Title XIX 50/50 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	-\$24,013,000
- STATE FUNDS	\$0	-\$12,006,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$24,013,000
STATE FUNDS	\$0	-\$12,006,500
FEDERAL FUNDS	\$0	-\$12,006,500

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 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, 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.

PRIVATE DSH REPLACEMENT PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 19

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.

Reason for Change from Prior Estimate:

The change is due to an increase in the estimated DSH allotment. The nationwide ACA reduction for DSH 2013-14 is estimated from the FY 2012-13 DSH allotment while the prior estimate used the FY 2011-12 DSH allotment.

Methodology:

1. The nationwide ACA reduction of DSH allotment equates to a 4.34% 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 \$26.19 million, a reduction from \$528.03 million to \$501.84 million.
3. Assume 11/12 of the FY 2013-14 ACA DSH replacement reduction (**\$24.013 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	-\$70,421,000
- STATE FUNDS	\$0	-\$24,691,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$70,421,000
STATE FUNDS	\$0	-\$24,691,500
FEDERAL FUNDS	\$0	-\$45,729,500

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 4.34% 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 & Medicaid Services (CMS).

Reason for Change from Prior Estimate:

The change is due to an increase in the estimated DSH allotment. The nationwide ACA reduction for DSH 2013-14 is estimated from the FY 2012-13 DSH allotment while the prior estimate used the FY 2011-12 DSH allotment.

DISPROPORTIONATE SHARE HOSPITAL REDUCTION

REGULAR POLICY CHANGE NUMBER: 20

Methodology:

1. California's DSH allotment for FY 2013-14 is estimated to be \$1.151 billion.
2. Assuming the national reduction percentage of 4.34 will be applied to California, the DSH allotment will be reduced by \$50 million in FY 2013-14.
3. The FY 2013-14 DSH allotment after the reduction is estimated to be \$1.101 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 \$46 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	(\$70,421)	(\$458)	(\$45,729)	(\$24,234)

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: 1/2014
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1742

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	-\$73,000
- STATE FUNDS	\$0	-\$36,500
PAYMENT LAG	1.0000	0.5960
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$43,500
STATE FUNDS	\$0	-\$21,750
FEDERAL FUNDS	\$0	-\$21,750

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. The contract is expected to be approved in April 2013.

Reason for Change from Prior Estimate:

The change is due to a delay in contract approval.

Methodology:

1. Assume \$500,000 in annual overpayment savings is identified starting in FY 2013-14.
2. Savings will be phased in over 12 months beginning January 2014. Until the phase in is complete, assume \$3,472 in monthly savings starting January 2014 and an additional \$3,472 each month thereafter.
3. Budgeted amounts are preliminary until actual data becomes available.

RECOVERY AUDIT CONTRACTOR SAVINGS

REGULAR POLICY CHANGE NUMBER: 21

	<u>TF</u>	<u>GF</u>	<u>FF</u>
FY 2012-13	\$0	\$0	\$0
FY 2013-14	(\$73,000)	(\$36,500)	(\$36,500)

Funding:

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

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 22
 IMPLEMENTATION DATE: 5/2013
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1476

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$554,045,000	\$259,483,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$554,045,000	\$259,483,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$554,045,000	\$259,483,000

DESCRIPTION

Purpose:

This policy change estimates the federal match to the California Department of Developmental Services (CDDS) 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 09-86388

Interdependent Policy Changes:

Not Applicable

Background:

The Department submitted a 1915(i) HCBS state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) in December 2009. The SPA proposes inclusion of certain services provided by the state's Regional Center (RC) network of nonprofit providers to persons with developmental disabilities. RC consumers who received or currently receive certain services will continue to be eligible for these services even though their institutional level of care requirements for the HCBS waiver for persons with developmental disabilities are not met. Services covered under this SPA include: habilitation, respite care, personal care services, homemaker services, and home health aide services. The SPA was approved on April 25, 2013, 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 proposes to restore reimbursement for the eliminated services rendered in FY 2011-12 and forward, enabling persons with developmental disabilities access to these benefits.

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

ADDITIONAL HCBS FOR REGIONAL CENTER CLIENTS

REGULAR POLICY CHANGE NUMBER: 22

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.

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:

The following estimates were provided by the CDSS.

(In Thousands)	Total Funds	CDDS GF	FFP	ARRA
FY 2012-13	\$1,002,678	\$448,633	\$501,339	\$52,706
FY 2013-14	\$513,591	\$254,108	\$256,796	\$2,687

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	\$141,569,000	\$142,840,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$141,569,000	\$142,840,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$141,569,000	\$142,840,000

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:

There is no material 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 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.
- 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 Interim Payments	\$138,744	\$139	\$138,883
FY 2006-07 Reconciliation	\$2,686	0	\$2,686
FY 2012-13 Total	\$141,430	\$139	\$141,569
FY 2013-14 Interim Payments	\$139,840	0	\$139,840
FY 2007-08 Reconciliation	\$3,000	0	\$3,000
FY 2013-14 Total	\$142,840	0	\$142,840

Funding:

Title XIX FFP (4260-101-0890)

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 24
 IMPLEMENTATION DATE: 7/1984
 ANALYST: Davonna McClendon
 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
 Welfare & Institutions Code 14132.275
 Welfare & Institutions Code 14186
 SB 1008 (Chapter 33, Statutes of 2012)

Interdependent Policy Changes:

Not Applicable

Background:

The MSSP provides a comprehensive array of social and health services to persons 65 or older who are determined to be "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 1915(c) home and community-based services (HCBS) waiver for up to 16,335 participants 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 eligibles) and seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only. Beginning January 1, 2014, the Department will mandatorily enroll dual eligibles and SPDs into managed care for their Medi-Cal benefits. Those benefits include institutional LTSS, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS) and MSSP. Under CCI, managed care capitation will include MSSP services.

MULTIPURPOSE SENIOR SERVICES PROGRAM-CDA

REGULAR POLICY CHANGE NUMBER: 24

Beginning January 1, 2014, in the counties participating in CCI and Cal MediConnect, 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.

Reason for Change from Prior Estimate:

There is no change.

Methodology:

(In Thousands)	TF	Reimbursement from CDA	FFP
FY 2012-13	\$ 40,464	\$ 20,232	\$ 20,232
FY 2013-14	\$ 40,464	\$ 20,232	\$ 20,232

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: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1228

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$49,720,000	\$32,651,000
- STATE FUNDS	\$1,758,000	\$3,968,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$49,720,000	\$32,651,000
STATE FUNDS	\$1,758,000	\$3,968,000
FEDERAL FUNDS	\$47,962,000	\$28,683,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

PC 38 California Community Transitions Savings
 PC 26 CCT Fund Transfer to CDSS and CDDS

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 requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into qualified residences and with support of Medi-Cal HCBS.

Participants are enrolled in the demonstration for a maximum of 12 months, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2012 through June 30, 2013 are 670 individuals and 738 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 beneficiaries expected to transition into CCT is included in this policy change. The cost of transitioning, providing

CALIFORNIA COMMUNITY TRANSITIONS COSTS

REGULAR POLICY CHANGE NUMBER: 25

HCBS, and the supplemental federal funding that is associated with provided CCT services to these beneficiaries is budgeted in the CCT Fund Transfer to CDSS and CDDS policy change.

Reason for Change from Prior Estimate:

Current year costs increased due to payment of outstanding claims from prior fiscal years, while budget year costs decreased due to a decline in estimated CCT participants.

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. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.
2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of \$8,566 annually; reimbursed at 75% MFP and 25% GF.
3. Assume pre-transitions that are unsuccessful for non-DD beneficiaries cost \$1,750 annually in FY 2012-13 and \$1,838 annually in FY 2013-14; reimbursed at 100% MFP.
4. Assume non-DD beneficiaries, upon transitioning into CCT, cost \$42,584 annually in FY 2012-13 and \$44,713 annually in FY 2013-14; reimbursed at 75% MFP and 25% GF.
5. Assume DD beneficiaries who participate in CCT have a one-time cost of \$64,587 for pre-transition demonstration services; reimbursed at 75% MFP and 25% GF.
6. Assume DD beneficiaries, upon transitioning into CCT, cost \$67,388 in FY 2012-13 and \$70,757 in FY 2013-14 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.
7. 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.
8. Assume CDDS will request FFP for CCT services provided to DD beneficiaries for FY 2010-11 and FY 2011-12 in FY 2012-13.
9. 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	(\$13,165)	(\$6,583)	(\$23,880)	(\$11,940)
Lagged costs	\$20,756	\$1,759	\$32,651	\$3,968
CDDS prior year costs	\$28,964	\$0	\$0	\$0
Net	\$36,555	(\$4,824)	\$8,771	(\$7,972)

Funding:

100% Title XIX General Fund (4260-101-0001)
MFP Federal Grant (4260-106-0890)

CCT FUND TRANSFER TO CDSS AND CDDS

REGULAR POLICY CHANGE NUMBER: 26
 IMPLEMENTATION DATE: 10/2011
 ANALYST: Davonna McClendon
 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 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.

CCT FUND TRANSFER TO CDSS AND CDDS**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: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1754

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$743,000	\$7,328,000
- STATE FUNDS	\$371,500	\$3,664,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$743,000	\$7,328,000
STATE FUNDS	\$371,500	\$3,664,000
FEDERAL FUNDS	\$371,500	\$3,664,000

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 requires health facilities administering mammograms to women 40 years of age 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:

The change is due to updated managed care expenditures.

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: 373,930
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% = 157,051
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% = 78,526
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 = \$3,875,000
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 \$274,000 annually.

FY 2012-13	TF	GF	FFP
FFS (lagged)	\$674,000	\$337,000	\$337,000
Managed Care	\$69,000	\$34,500	\$34,500
Total FY 2012-13	\$743,000	\$371,500	\$371,500
FY 2013-14	TF	GF	FFP
FFS (lagged)	\$7,054,000	\$3,527,000	\$3,527,000
Managed Care	\$274,000	\$137,000	\$137,000
Total FY 2013-14	\$7,328,000	\$3,664,000	\$3,664,000

Funding:

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

SF COMMUNITY-LIVING SUPPORT BENEFIT WAIVER

REGULAR POLICY CHANGE NUMBER: 28
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1436

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$44,000	\$337,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$44,000	\$337,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$44,000	\$337,000

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)
 1915(c) Home and Community Based Services Waiver (CA.0855)

Interdependent Policy Changes:

Not Applicable

Background:

The Department is working with the San Francisco Department of Public Health, under the authority of a 1915(c) Home and Community Based Services (HCBS) Waiver to serve Medi-Cal beneficiaries who are:

- 21 years of age and older,
- reside in the City or County of San Francisco,
- and who would otherwise live in nursing facilities or be rendered homeless.

CMS approved the waiver for a five year period beginning July 1, 2012 through June 30, 2017.

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:

The estimated costs have been reduced due to a lack of space in approved residential facilities available to house SF CLSB Waiver 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 began in August 2012. Target enrollment for the period of July 1, 2012 through June 30, 2013 has been reduced to 18 individuals and 42 individuals for July 1, 2013 through June 30, 2014.
2. The enrollment will be phased in throughout the year. Total member months in FY 2012-13 will be 97, and 272 in FY 2013-14. Due to a four-month payment lag, only 37 member months will be paid in FY 2012-13. The remaining 60 member months will be paid in FY 2013-14, along with 216 member months for FY 2013-14.
3. 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.
4. 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.
5. 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 CCT PARTICIPANTS

REGULAR POLICY CHANGE NUMBER: 29
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1550

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$186,000	\$170,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$186,000	\$170,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$186,000	\$170,000

DESCRIPTION

Purpose:

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

Authority:

Affordable Care Act (P.L. 111-148), Section 2403
 Deficit Reduction Act of 2005 (P.L. 109-171), Section 6071
 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 CCT participants in receipt of MFP grant funds. QoL surveys are given within specified timeframes and follow a specific methodology. CCT provider agencies, which are Medi-Cal Home and Community Based Services (HCBS) enrolled providers, conduct QoL surveys designed for the following situations:

1. Baseline QoL-Conducted within 30-days 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 costs have decreased in FY 2012-13 and FY 2013-14 due to a decrease in CCT caseload.

QUALITY OF LIFE SURVEYS FOR CCT PARTICIPANTS

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 509 in FY 2012-13 and 738 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 approximately two years after they have been living in community settings.
4. Assume the Department reimburses \$100 to Medi-Cal providers per completed survey for survey administration.
5. In FY 2012-13, assume the California Department of Developmental Services (CDDS), a survey administrator, will bill the Department for 574 surveys which were completed in FYs 2010-11 and 2011-12.

509 x \$100 = \$50,900 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

FY 2012-13 Estimated Costs: \$186,000 TF (rounded)

738 x \$100 = \$73,800 Baseline
509 x \$100 = \$50,900 First follow up
448 x \$100 = \$44,800 Second follow up

FY 2013-14 Estimated Costs: \$170,000 TF (rounded)

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 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:

There is no change.

Methodology:

1. Reimbursement to beneficiaries began 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	-\$11,382,300	-\$3,794,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$11,382,300	-\$3,794,100
FEDERAL FUNDS	\$11,382,300	\$3,794,100

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:

Revised based on mammograms not eligible for FFP under FPACT.

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% FFP, 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 \$444,000 GF, for a total cost of \$4,413,000 GF.

(In Thousands)		
Total Cost	=	New FFP
\$3,969 x 90%	=	\$3,572
\$444 x 50%	=	\$222
<u>\$4,413</u>		<u>\$3,794</u>

4. With enhanced funding, costs for these services and supplies will be \$3,794,000 FFP and \$619,000 GF for a GF savings of \$3,794,000 annually.
5. FY 2010-11 and FY 2011-12 savings of \$7,588,000 have been shifted to FY 2012-13. As a result, total GF savings for FY 2012-13 are \$11,382,000.

(In Thousands)		
FY 2012-13	GF	FFP
FY 2010-11	(\$3,794)	\$3,794
FY 2011-12	(\$3,794)	\$3,794
FY 2012-13	(\$3,794)	\$3,794
FY 2012-13 Savings	(\$11,382)	\$11,382
FY 2013-14 Savings	(\$3,794)	\$3,794

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	\$204,873,000	\$281,754,000
- STATE FUNDS	\$102,436,500	\$140,877,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$204,873,000	\$281,754,000
STATE FUNDS	\$102,436,500	\$140,877,000
FEDERAL FUNDS	\$102,436,500	\$140,877,000

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:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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 established the 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:

This estimate was revised to include costs for Fair Hearings, increased Enhanced Case Management services and updated CBAS utilization. The FFS savings are now captured in the base estimate data, and consequently not budgeted in this policy change.

ADHC TRANSITION-BENEFITS

REGULAR POLICY CHANGE NUMBER: 32

Methodology:

Transition costs include:

CBAS—Effective April 1, 2012, this 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 (including COHS – Ventura) began covering CBAS October 1, 2012. The estimated CBAS average monthly managed care caseload is 23,000. In addition, CBAS users that are exempt from enrolling in managed care plans are expected to stay in FFS.

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 was not eligible for CBAS, the Department has contracted with APS, Inc., to provide care coordination and case management for community-based services. These costs are in the ADHC-Transition – Administration policy and are shown here for information only.

Fair Hearings—For beneficiaries found ineligible for CBAS during their assessment process, fair hearings were conducted. These costs are incurred by the Department for Fair Hearing outcomes and penalties. 2,359 fair hearings have been conducted as of March 2013, of which, 1,206 were found eligible for CBAS, 251 were found ineligible for CBAS and 856 withdrew from the fair hearing process.

ADHC TRANSITION-BENEFITS

REGULAR POLICY CHANGE NUMBER: 32

(In Thousands)	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
Managed Care CBAS Costs	\$228,352	\$114,176	\$281,754	\$140,877
Managed Care Payment Deferral	(\$23,479)	(\$11,740)	\$0	\$0
Net CBAS Benefits Cost	\$204,873	\$102,436	\$281,754	\$140,877
Lagged FFS ADHC/CBAS Savings (in the FFS base)	(\$213,840)	(\$106,920)	(\$332,771)	(\$166,385)
HCO (included in FI Estimate)	\$447	\$223	\$0	\$0
Other Administration Cost FFS Assessment & Care Coordination	\$2,230	\$1,115	\$656	\$328
Fair Hearing Costs	\$4,160	\$2,080	\$0	\$0
Net Other Administration Cost	\$6,390	\$3,195	\$656	\$328
Total All Costs	(\$2,130)	(\$1,066)	(\$50,361)	(\$25,180)

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

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$87,550,450	-\$89,878,100
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$87,550,450	-\$89,878,100
FEDERAL FUNDS	\$87,550,450	\$89,878,100

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 \$127,665,000 in FY 2012-13 and \$131,290,000 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:	$\$127,665,000 \times .65 =$	\$82,982,000 FFP
FY 2013-14:	$\$131,290,000 \times .65 =$	\$85,338,000 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 \$7,028,000 for FY 2012-13 and \$6,984,000 for FY 2013-14.

FY 2012-13:	\$7,028,000 x .65 SCHIP FFP =	\$4,568,000 FFP
FY 2013-14:	\$6,984,000 x .65 SCHIP FFP =	\$4,540,000 FFP

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

FY 2012-13 Savings:	\$82,982,000 + \$4,568,000 =	\$87,550,000
FY 2013-14 Savings:	\$85,338,000 + \$4,540,000 =	\$89,878,000

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	-\$1,434,000	-\$1,434,000
- STATE FUNDS	-\$717,000	-\$717,000
PAYMENT LAG	0.9593	1.0000
% REFLECTED IN BASE	20.46 %	22.10 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,094,200	-\$1,117,100
STATE FUNDS	-\$547,090	-\$558,540
FEDERAL FUNDS	-\$547,090	-\$558,540

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 & 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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

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

Methodology:

1. Assume savings will begin July 1, 2012.
2. Actual annual hearing aid expenditures for FY 2010-11 were \$22,329,000 for 25,868 unduplicated users.

HEARING AID CAP

REGULAR POLICY CHANGE NUMBER: 34

3. Of the annual hearing aid expenditures amount, \$1,751,000 were associated with beneficiaries residing in long-term care and pregnant women, and \$2,132,000 were associated with beneficiaries under 21 years of age.
 $\$1,751,000 + \$2,132,000 = \$3,883,000$
4. Expenditures subject to cap are: $\$22,329,000 - \$3,883,000 = \$18,446,000$
5. Based on paid claims for hearing aids for dates of service between July 1, 2010 and June 30, 2011, total FFS hearing aids expenditures below the \$1,510 cap were \$9,956,000 for 14,720 beneficiaries.
6. Based on paid claims for hearing aids for dates of service between July 1, 2010 and June 30, 2011, an average of \$1,582 is spent annually per beneficiary at and above the \$1,510 expenditure cap.
7. There are 5,365 adult users above the \$1,510 Cap. The allowable costs for these users is \$8,101,000.

(Dollar In Thousands)	Users	Expenditures
Total unduplicated users	25,868	\$22,329
LTC, children, & pregnant women	5,783	\$3,883
Expenditures subject to cap	20,085	\$18,446
Below the \$1,510 cap for adults	14,720	\$9,956
Above the \$1,510 cap for adults	5,365	\$8,490

(Dollar In Thousands)	TF	GF	FFP
Annual FFS Expenditures	(\$22,329)	(\$11,164)	(\$11,165)
LTC, children, & pregnant women	\$3,883	\$1,941	\$1,942
Expenditures Subject to Cap	(\$18,446)	(\$9,223)	(\$9,223)
FFS Expenditures < \$1,510 cap	\$9,956	\$4,978	\$4,978
FFS Expenditures > \$1,510 cap	(\$8,490)	(\$4,245)	(\$4,245)
Allowable costs for > the \$1,510 cap	\$8,101	\$4,050	\$4,051
Annual FFS savings due to cap	(\$389)	(\$194)	(\$195)
Annual Managed Care savings due to cap	(\$1,045)	(\$522)	(\$523)
Total Annual Savings	(\$1,434)	(\$717)	(\$717)

FY 2012-13

FFS	(\$389)	(\$194)	(\$195)
Managed Care	(\$1,045)	(\$522)	(\$523)
Total FY 2012-13	(\$1,434)	(\$717)	(\$717)

FY 2013-14

FFS	(\$389)	(\$194)	(\$194)
Managed Care	(\$1,045)	(\$522)	(\$522)
Total FY 2013-14	(\$1,434)	(\$717)	(\$717)

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: Erickson Chow
 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	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 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:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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)

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 37
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1519

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$22,933,000
- STATE FUNDS	\$0	-\$11,466,500
PAYMENT LAG	1.0000	0.8356
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$19,162,800
STATE FUNDS	\$0	-\$9,581,410
FEDERAL FUNDS	\$0	-\$9,581,410

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 & 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 January 1, 2013 to July 1, 2013 because of delay in expected federal approval and implementing necessary system changes.

Methodology:

- Savings will begin on July 1, 2013.
- 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.
- In CY 2009, the average cost per visit is \$114.66.

PHYSICIAN AND CLINIC SEVEN VISIT SOFT CAP

REGULAR POLICY CHANGE NUMBER: 37

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)

(Dollar In Thousands)

Annual Savings:	TF	GF
FFS	_____ (\$22,933)	_____ (\$11,466)
FY 2012-13 Savings:	TF	GF
FFS	_____ (\$0)	_____ (\$0)
FY 2013-14 Savings:	TF	GF
FFS	_____ (\$22,933)	_____ (\$11,466)

Funding:

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

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 38
 IMPLEMENTATION DATE: 12/2008
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1222

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$13,165,000	-\$23,880,000
- STATE FUNDS	-\$6,582,500	-\$11,940,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$13,165,000	-\$23,880,000
STATE FUNDS	-\$6,582,500	-\$11,940,000
FEDERAL FUNDS	-\$6,582,500	-\$11,940,000

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
 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 requires the Department to develop and implement strategies to assist Medi-Cal eligible individuals, who have continuously resided in health care facilities for three months or longer, transition into qualified residences and with support of Medi-Cal HCBS.

Participants are enrolled in the demonstration for a maximum of 12 months, but can also receive up to six months of pre-transition services. CCT transitions began December 1, 2008. Target transitions for the period of July 1, 2012 through June 30, 2013 are 670 individuals and 738 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 beneficiaries expected to transition into CCT is included in this policy change. The cost of transitioning, providing

CALIFORNIA COMMUNITY TRANSITIONS SAVINGS

REGULAR POLICY CHANGE NUMBER: 38

HCBS, and the supplemental federal funding that is associated with provided CCT services to these beneficiaries is budgeted in the CCT Fund Transfer to CDSS and CDDS policy change.

Reason for Change from Prior Estimate:

Current year costs increased due to payment of outstanding claims from prior fiscal years, while budget year costs decreased due to a decline in estimated CCT participants.

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. The savings from moving participants from NF-Bs to the waiver are 50% FFP and 50% GF.
2. Assume 100% of non-DD CCT participants will receive pre-transition demonstration services for up to six months at a cost of \$8,566 annually; reimbursed at 75% MFP and 25% GF.
3. Assume pre-transitions that are unsuccessful for non-DD beneficiaries cost \$1,750 annually in FY 2012-13 and \$1,838 annually in FY 2013-14; reimbursed at 100% MFP.
4. Assume non-DD beneficiaries, upon transitioning into CCT, cost \$42,584 annually in FY 2012-13 and \$44,713 annually in FY 2013-14; reimbursed at 75% MFP and 25% GF.
5. Assume DD beneficiaries who participate in CCT have a one-time cost of \$64,587 for pre-transition demonstration services; reimbursed at 75% MFP and 25% GF.
6. Assume DD beneficiaries, upon transitioning into CCT, cost \$67,388 in FY 2012-13 and \$70,757 in FY 2013-14 upon transitioning into CCT; reimbursed at 75% MFP and 25% GF.
7. 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.
8. Assume CDDS will request FFP for CCT services provided to DD beneficiaries for FY 2010-11 and FY 2011-12 in FY 2012-13.
9. 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	(\$13,165)	(\$6,583)	(\$23,880)	(\$11,940)
Lagged costs	\$20,756	\$1,759	\$32,651	\$3,968
CDDS prior year costs	\$28,964	\$0	\$0	\$0
Net	\$36,555	(\$4,824)	\$8,771	(\$7,972)

Funding:

100% Title XIX General Fund (4260-101-0001)
MFP Federal Grant (4260-106-0890)

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 39
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1524

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$33,707,000
- STATE FUNDS	\$0	-\$16,853,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$33,707,000
STATE FUNDS	\$0	-\$16,853,500
FEDERAL FUNDS	\$0	-\$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)
 AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

Implementation date changed from January 1, 2013 to July 1, 2013 because of delay in expected federal approval and implementing necessary system.

Methodology:

1. It is assumed that the copayment will be implemented July 1, 2013.

COPAYMENT FOR NON-EMERGENCY ER VISITS

REGULAR POLICY CHANGE NUMBER: 39

2. The managed care savings are estimated to be **\$33,707,000 TF (\$16,853,500 GF)** annually.

Funding:

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

FEDERAL DRUG REBATE CHANGE

REGULAR POLICY CHANGE NUMBER: 41
 IMPLEMENTATION DATE: 10/2010
 ANALYST: Erickson Chow
 FISCAL REFERENCE NUMBER: 1559

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$116,057,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$116,057,000	\$0
FEDERAL FUNDS	-\$116,057,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost related to the retroactive rebate adjustments collected by the Centers for Medicare & Medicaid Services (CMS).

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 was 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 was completed. The Department completed the reconciliation process in January 2013.

Reason for Change from Prior Estimate:

The Department paid the rebate payment in three payments in FY 2012-13. The new estimate was created from actual accounting records.

Methodology:

1. CMS sent the Department an estimated quarterly rebate offset amount (EQROA) to be remitted to the federal government. The EQROA was reconciled with the total quarterly rebate offset amount

FEDERAL DRUG REBATE CHANGE**REGULAR POLICY CHANGE NUMBER: 41**

(QROA) when the Department received 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. Assume that, beginning with the October 2011 payment, CMS has collected 100% of the estimated additional amount due.
4. The Department paid approximately \$23 million in September 2012, \$3 million in October 2012, and \$90 million in January 2013 for the final reconciliation of prior payments that included a discount factor.
5. 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.

September 2012 Payment	\$ 2,802,000
October 2012 Payment	\$ 23,178,000
January 2013 Payment	\$ 90,077,000
General Fund Cost	\$116,057,000
Federal Fund Offset	<u>(\$116,057,000)</u>
Net Impact	\$ 0

Funding:

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

KALYDECO FOR TREATMENT OF CYSTIC FIBROSIS

REGULAR POLICY CHANGE NUMBER: 42
 IMPLEMENTATION DATE: 2/2012
 ANALYST: Erickson Chow
 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	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 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: Erickson Chow
 FISCAL REFERENCE NUMBER: 108

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$2,026,000	\$1,912,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$2,026,000	\$1,912,000
FEDERAL FUNDS	-\$2,026,000	-\$1,912,000

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 from July 2012 to December 2012.

Methodology:

1. The Department reimburses CMS quarterly for ongoing non-FFP drugs purchased. Based on data from July 2004 to December 2012, the FFP actual total costs were compared to the base amount which created a percentage used to calculate the estimate.

NON FFP DRUGS
REGULAR POLICY CHANGE NUMBER: 43

(In Thousands)

	Non-FFP Drug Exp.	Est. FFP Repayment
FY 2012-13	\$4,052	\$2,026
FY 2013-14	\$3,824	\$1,912

Funding:

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

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

BCCTP DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 44
 IMPLEMENTATION DATE: 1/2010
 ANALYST: Erickson Chow
 FISCAL REFERENCE NUMBER: 1433

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$16,000,000	-\$16,000,000
- STATE FUNDS	-\$5,600,000	-\$5,600,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$16,000,000	-\$16,000,000
STATE FUNDS	-\$5,600,000	-\$5,600,000
FEDERAL FUNDS	-\$10,400,000	-\$10,400,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & 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. It is estimated that \$16 million in rebates will be collected for FY 2012 – 13 and FY 2013-14.

Funding:

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

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 45
 IMPLEMENTATION DATE: 10/2006
 ANALYST: Erickson Chow
 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 & 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:

There is no change.

Methodology:

1. The current medical supply diabetic testing products contract were renegotiated and the new contract is effective January 1, 2013.
2. Based on actual rebate data for the last three quarters, the average quarterly collection is \$6,492,000.

MEDICAL SUPPLY REBATES

REGULAR POLICY CHANGE NUMBER: 45

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.

FY 2012-13:

$(\$6,492,000 \times 2 \text{ qtrs.} = \$ 12,984,000) + (\$4,869,000 \times 2 \text{ qtrs.} = \$9,738,000) = \mathbf{\$22,722,000}$

FY 2013-14:

$\$4,869,000 \times 4 \text{ qtrs.} = \mathbf{\$19,476,000}$

CASH BASIS	<u>Medical Supply Rebates</u>
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: Erickson Chow
 FISCAL REFERENCE NUMBER: 1434

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$10,789,000	-\$15,157,000
- STATE FUNDS	-\$5,394,500	-\$7,578,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$10,789,000	-\$15,157,000
STATE FUNDS	-\$5,394,500	-\$7,578,500
FEDERAL FUNDS	-\$5,394,500	-\$7,578,500

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 & 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), established 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 pharmacy rate of reimbursement is further defined as the lower of: AWP minus 17%, federal upper limit (FUL) or maximum allowable ingredient cost (MAIC). The new methodology was implemented in November 2012.

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:

Implementation of the new methodology will yield predictable savings only for those claims paid under the old methodology of AWP minus 5%. Prospective savings is unpredictable due to the nature and

PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 46

fluctuation in Medicaid quarterly rates, average wholesale price and expected federal implementation of new FULs. The original estimate was projected using historical data, but did not take into account that there would be increases in the AWP. Over time, these increases raised the base reimbursement rate resulting in reduced savings compared to the original estimate.

Also, As fee-for-service beneficiaries migrated into managed care, drug utilization in fee-for-service (FFS) reduced significantly.

Methodology:

1. The new methodology began in September 2012 effective for claims from September 1, 2012 and forward.
2. Assume implementation will be retroactive to September 2011.
3. The amount and timing for the retroactive recoupment for services from September 1, 2012 to September 31, 2012 are assumed to be \$19,000,000 beginning September 2013 and collected over a 24 month period.

FY 2012-13: $\$19,000,000 \div 24 \text{ months} \times 10 \text{ months} + \$7,917,000$

FY 2013-14: $\$19,000,000 \div 24 \text{ months} \times 12 \text{ months} + \$9,500,000$

4. Assume that ongoing savings will be $\$19,000,000 \times 12/13 = \$17,538,000$ annually.

5. Total savings are estimated to be:

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
Retro Savings	(\$7,917,000)	(\$9,500,000)
Ongoing Savings (lagged)	(\$13,981,000)	(\$18,696,000)
Total	<u>(\$21,898,000)</u>	<u>(\$28,196,000)</u>

6. Because the ongoing changed began in September 2012, the impact of this part of the savings is already partially reflected in the base estimate. The impact of this policy change, excluding the amount already included in the base estimate is:

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
Retro Savings	(\$7,917,000)	(\$9,500,000)
Ongoing Savings (lagged)	(\$2,872,000)	(\$5,657,000)
Total	<u>(\$10,789,000)</u>	<u>(\$15,157,000)</u>

Funding:

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

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 47
 IMPLEMENTATION DATE: 12/1999
 ANALYST: Erickson Chow
 FISCAL REFERENCE NUMBER: 51

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$70,090,000	-\$73,946,000
- STATE FUNDS	-\$9,170,600	-\$9,675,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$70,090,000	-\$73,946,000
STATE FUNDS	-\$9,170,600	-\$9,675,000
FEDERAL FUNDS	-\$60,919,400	-\$64,271,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & 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 from July 2008 to December 2012.

Methodology:

1. The regular Federal Medical Assistance Percentage (FMAP) percentage is applied to 6.93% of the FPACT rebates to account for the purchase of non-family planning drugs, and the family planning percentage (90% FFP) is applied to 93.07% of the FPACT rebates.

FAMILY PACT DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 47

2. We use recent actual data from July 2008 to December 2012 to project rebates.

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		(\$73,946)	
	<u>TF</u>	<u>50% FFP</u>	<u>90% FFP</u>
FY 2012-13	(\$70,090)	(\$5,404)	(\$64,686)
FY 2013-14	(\$73,946)	(\$5,701)	(\$68,245)

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: Erickson Chow
 FISCAL REFERENCE NUMBER: 1182

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$135,000,000	-\$135,000,000
- STATE FUNDS	-\$67,433,600	-\$67,433,600
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$135,000,000	-\$135,000,000
STATE FUNDS	-\$67,433,600	-\$67,433,600
FEDERAL FUNDS	-\$67,566,400	-\$67,566,400

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 & 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.

AGED AND DISPUTED DRUG REBATES**REGULAR POLICY CHANGE NUMBER: 48****Methodology:**

Between July 1, 2012 and April 24, 2013 the Department collected \$114,000,000 in aged and disputed rebates. The \$135,000,000 estimate covers actual rebates collected and the estimate for the remainder of the fiscal year.

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: Erickson Chow
 FISCAL REFERENCE NUMBER: 54

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$144,201,000	-\$152,549,000
- STATE FUNDS	-\$71,985,700	-\$76,153,300
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$144,201,000	-\$152,549,000
STATE FUNDS	-\$71,985,700	-\$76,153,300
FEDERAL FUNDS	-\$72,215,300	-\$76,395,700

DESCRIPTION

Purpose:

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

Authority:

Welfare & 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 from September 2012 to January 2013.

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.

STATE SUPPLEMENTAL DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 49

4. Family planning drugs account for 0.221% of rebates and are funded with 90% federal funds and 10% General Fund.

(In Thousands)	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
Title XIX 50/50 FFP	(\$143,914)	(\$71,957)	(\$152,246)	(\$76,123)
Title XIX 10/90 FFP	(\$287)	(\$29)	(\$303)	(\$30)
Total	(\$144,201)	(\$71,986)	(\$152,549)	(\$76,153)

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: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1449

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$227,441,000	\$0
- STATE FUNDS	-\$227,441,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$227,441,000	\$0
STATE FUNDS	-\$227,441,000	\$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:

(In Thousands)	FY 2012-13
	<u>Settlement Payments</u>
A-Med Pharmacy	\$ 73
Amgen	\$ 1,154
Amgen 2	\$ 644
Amgen/Kurnik	\$ 463
Bio-Med	\$ 2,261
Bioscrip	\$ 122
Boehringer Ingelheim Pharmaceuticals, Inc.	\$ 820
Dava Pharmaceuticals, Inc	\$ 72
GlaxoSmithKline, LLC	\$ 22,222
HealthPoint	\$ 39
Integrated Nephrology Network (INN)	\$ 103
KV Pharmaceuticals, Inc.	\$ 61
Maxim	\$ 4,225
McKesson	\$ 22,361
Merck (Vioxx)	\$ 19,124
Pacific Health Corporation	\$ 674
Par	\$ 229
Seacliff Diagnostics	\$ 124
Senior Care Action Network	\$ 152,288
Serono	\$ 367
Victory Pharma	\$ 1
Walgreen's Pharmacy	\$ 14
Total GF Savings	\$ 227,441

Funding:

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

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 51
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Erickson Chow
 FISCAL REFERENCE NUMBER: 1585

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$353,399,000	-\$348,403,000
- STATE FUNDS	-\$176,699,500	-\$174,201,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$353,399,000	-\$348,403,000
STATE FUNDS	-\$176,699,500	-\$174,201,500
FEDERAL FUNDS	-\$176,699,500	-\$174,201,500

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:

Based on new data, rebate collections during FY 2013-14 are higher than previously estimated. The current estimate uses this data to project the remaining months of FY 2012-13 and a revised estimated for FY 2013-14.

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 80% of invoiced amounts beginning in FY 2013-14.
3. Assume rebates will be collected beginning in April 2013.

MANAGED CARE DRUG REBATES

REGULAR POLICY CHANGE NUMBER: 51

4. The Department received \$294,499,484 for ten months of FY 2012-13. Assuming that this trend continues, we take the average per month and multiply it by 12 to project the remaining portion of FY 2012-13. This equals to \$353,399,381.
5. Based on data from FY 2012-13, there will be about \$80,497,000 in invoices remaining. It is expected that we will receive 80% of these total invoices which equals \$64,382,238 for FY 2013-14.
6. The total invoice for FY 2013-14 is expected to be \$355,006,222. With an 80% collection rate, it is expected we will receive \$284,004,978
7. Assume the Department will collect 80% 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.

(In Thousands)

Invoiced to Date	\$ 433,896
Estimated % of Total to be Invoiced	÷ 55%
Total to be Invoiced	<u>\$ 788,902</u>
Additional Invoicing (\$788,902 x 45%)	\$ 355,006

FY 2012-13

Collected First 10 Months:	\$ 294,499
Inflate to 12 Months (\$294,499 x 12/10)	<u>\$ 353,399</u>
FY 2012-13 Total	\$ 353,399

FY 2013-14

FY 2012-13 Invoiced but Uncollected	\$ 80,497
Assumed Collection Rate	<u>80%</u>
To be Collected	\$ 64,398

Additional Invoicing	\$ 355,006
Assumed Collection Rate	<u>80%</u>
To be Collected	\$ 284,005

To be Collected from FY 2012-13	\$ 64,398
To be Collected from FY 2013-14	<u>\$ 284,005</u>
Total	\$ 348,403

FY 2013-14 Total **\$ 348,403****Funding:**

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

FEDERAL DRUG REBATE PROGRAM

REGULAR POLICY CHANGE NUMBER: 52
 IMPLEMENTATION DATE: 7/1990
 ANALYST: Erickson Chow
 FISCAL REFERENCE NUMBER: 55

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,264,651,000	-\$1,258,766,000
- STATE FUNDS	-\$575,319,500	-\$572,381,400
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,264,651,000	-\$1,258,766,000
STATE FUNDS	-\$575,319,500	-\$572,381,400
FEDERAL FUNDS	-\$689,331,500	-\$686,384,600

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 from September 2012 to January 2013.

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.

(In Thousands)	FY 2012-13		FY 2013-14	
	TF	GF	TF	GF
Title XIX 50/50 FFP	(\$1,150,136)	(\$575,068)	(\$1,144,262)	(\$572,131)
Title XIX 10/90 FFP	(\$2,515)	(\$252)	(\$2,504)	(\$250)
Title XIX FFP	(\$112,000)	(\$0)	(\$112,000)	(\$0)
Total	(\$1,264,651)	(\$575,320)	(\$1,258,766)	(\$572,381)

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: 5/2013
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1724

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	-\$1,627,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$1,627,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	-\$1,627,000

DESCRIPTION

Purpose:

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

Authority:

Welfare & Institutions Code 14021.5 (c)(e); 14021.51; 14021.6 (d)(e)(f); 14021.9 (c); and 14105 (a)
 Title 22, California Code of Regulations, Section 51516.1 (a)
 AB 106 (Chapter 32, Statutes of 2011) Section 14021.31 (a)

Interdependent Policy Changes:

Not Applicable

Background:

Annually, the Department adjusts the DMC rates based on the cumulative growth in the Implicit Price (CIP) Deflator for the Costs of Goods and Services to Governmental Agencies reported by the Department of Finance. 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:

CIP deflator changed.

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

Methodology:

1. The CIP deflator used in calculating the FY 2013-14 DMC rate is 8.7%. This is comprised of:

- 2.4% for the change from FY 2009-10 to FY 2010-11,
- 2.8% for the change from FY 2010-11 to FY 2011-12,
- 1.6% for the change from FY 2011-12 to FY 2012-13, and
- 1.9% for the change from FY 2012-13 to FY 2013-14.

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	8.7%	\$12.33	\$11.49	\$11.49
NTP-Individual	\$13.30	8.7%	\$14.46	\$15.42	\$14.46
NTP- Group	\$3.14	8.7%	\$3.41	\$3.27	\$3.27
DCR	\$61.05	8.7%	\$66.36	\$62.15	\$62.15
Naltrexone	\$19.07	8.7%	\$20.73	\$19.07	\$19.07
ODF-Individual	\$66.53	8.7%	\$72.32	\$77.10	\$72.32
ODF-Group	\$28.27	8.7%	\$30.73	\$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	8.7%	\$13.27	\$12.57	\$12.57
NTP-Individual	\$19.04	8.7%	\$20.70	\$24.08	\$20.70
NTP- Group	\$6.36	8.7%	\$6.91	\$7.41	\$6.91
DCR	\$73.04	8.7%	\$79.39	\$85.32	\$79.39
PR	\$89.90	8.7%	\$97.72	\$110.29	\$97.72
ODF-Individual	\$95.23	8.7%	\$103.52	\$120.38	\$103.52
ODF-Group	\$57.26	8.7%	\$62.24	\$66.65	\$62.24

*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	\$14.46	\$0.22
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	\$72.32	\$1.07
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	\$20.70	\$0.31
NTP- Group	\$6.81	\$6.91	\$0.10
DCR	\$78.23	\$79.39	\$1.16
PR	\$96.28	\$97.72	\$1.44
ODF-Individual	\$101.99	\$103.52	\$1.53
ODF-Group	\$61.33	\$62.24	\$0.91

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 \$4,713,000 TF:

Regular-Services	TF	FFP	County
NTP	(\$2,534,000)	(\$1,266,000)	(\$1,268,000)
DCR	(\$883,000)	(\$441,000)	(\$442,000)
Naltrexone	\$0	\$0	\$0
ODF	(\$1,325,000)	(\$476,000)	(\$849,000)
Perinatal-Services	TF	FFP	County
NTP	(\$7,000)	(\$3,000)	(\$4,000)
DCR	\$10,000	\$5,000	\$5,000
PR	\$6,000	\$3,000	\$3,000
ODF	\$21,000	\$10,000	\$11,000
Total FY 2013-14	(\$4,713,000)	(\$2,169,000)	(\$2,544,000)

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	TF	FFP	County
NTP	(\$1,901,000)	(\$950,000)	(\$951,000)
DCR	(\$662,000)	(\$331,000)	(\$331,000)
Naltrexone	\$0	\$0	\$0
ODF	(\$994,000)	(\$357,000)	(\$637,000)
Total	(\$3,557,000)	(\$1,638,000)	(\$1,919,000)

ANNUAL RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 58

<u>Perinatal-Services</u>	<u>TF</u>	<u>FFP</u>	<u>County</u>
NTP	(\$6,000)	(\$3,000)	(\$3,000)
DCR	\$8,000	\$4,000	\$4,000
PR	\$16,000	\$8,000	\$8,000
ODF	\$4,000	\$2,000	\$2,000
Total	\$22,000	\$11,000	\$11,000
Total FY 2013-14	(\$3,535,000)	(\$1,627,000)	(\$1,908,000)

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	-\$3,259,000	-\$1,859,000
- STATE FUNDS	-\$1,313,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$3,259,000	-\$1,859,000
STATE FUNDS	-\$1,313,000	\$0
FEDERAL FUNDS	-\$1,946,000	-\$1,859,000

DESCRIPTION

Purpose:

This policy change estimates the federal reimbursement funds for cost settlements to counties and contracted providers for payments related to the Drug Medi-Cal (DMC) services.

Authority:

Welfare & Institutions Code 14124.24 (g)(1)
 Title 22, California Code of Regulations 51516.1
 AB 106 (Chapter 32, Statutes of 2011) Section 14021.31 (a)

Interdependent Policy Changes:

Not Applicable

Background:

The 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 charge to the general public for the same or similar services,
- Provider's allowable costs of providing the service, or
- DMC statewide maximum allowance for the service modality.

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

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

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

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

Through FY 2010-11, the local assistance General Fund (GF) for perinatal services were budgeted in the Department of Alcohol and Drug Programs' (ADP) perinatal appropriation item 4200-102-0001. The local assistance GF for non-perinatal services was budgeted in ADP's appropriation item 4200-103-0001. Effective July 1, 2011, the local assistance GF was realigned to counties as County Funds (CF).

Effective July 1, 2012, DMC services transferred from ADP to the Department. The Department budgets the local assistance federal reimbursement funds in appropriation item 4260-101-0890.

Reason for Change from Prior Estimate:

Updated actual expenditure data became available for FY 2009-10.

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	\$83,492,321	\$67,698,602	\$66,284,963
Cost Settlement	\$74,471,389	\$67,696,589	\$65,804,685
Difference	\$9,020,932	\$2,013	\$480,278

PERINATAL EXPENDITURES	FY 2007-08	FY 2008-09	FY 2009-10
Actual Expenditures	\$3,362,373	\$1,917,006	\$1,516,157
Cost Settlement	\$3,156,546	\$1,913,686	\$1,452,385
Difference	\$205,827	\$3,320	\$63,772

	Difference (Regular)	Difference (Perinatal)
	\$9,020,932	\$205,827
	\$2,013	\$3,320
	\$480,278	\$63,772
	\$9,503,223	\$272,919
Divide by the # of FYs	3	3
	\$3,167,741	\$90,973

DRUG MEDI-CAL PROGRAM COST SETTLEMENT

REGULAR POLICY CHANGE NUMBER: 59

4. Savings are estimated to total \$3,259,000 for FY 2012-13 and FY 2013-14. In the FY 2011-12, the General Funds (GF) were replaced by a County Funds (CF).

FY 2010-11

Settlements	TF	GF	FFP-Regular	FFP-ARRA
Regular (Item 103)	(\$3,168,000)	(\$1,276,000)	(\$1,584,000)	(\$308,000)
Perinatal (Item 102)	(\$91,000)	(\$37,000)	(\$45,000)	(\$9,000)
Total for FY 2012-13	(\$3,259,000)	(\$1,313,000)	(\$1,629,000)	(\$317,000)

FY 2011-12

Settlements	TF	FFP	CF
Regular (Item 103)	(\$3,168,000)	(\$1,584,000)	(\$1,584,000)
Perinatal (Item 102)	(\$91,000)	(\$46,000)	(\$45,000)
Total for FY 2013-14	(\$3,259,000)	(\$1,630,000)	(\$1,629,000)

5. In FY 2013-14, the DMC program will utilize enhanced FFP rates for certain Medi-Cal aid codes authorized for DMC use. Since the program can claim the enhanced FFP retroactive two years, the FY 2011-12 cost settlements that will be finalized in FY 2013-14 will include the enhanced FFP rates. The enhanced FFP rates for FY 2013-14 are \$229,000.

Total FY 2013-14: (\$1,630,000) + (\$229,000) = **(\$1,859,000)**

Funding:

Title XIX 100% FFP (4260-101-0890)
 Title XXI 100% FFP (4260-113-0890)
 State Only General Fund (4260-101-0001)

SPECIALTY MENTAL HEALTH SVCS SUPP REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 61
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1458

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$293,819,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$293,819,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$293,819,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

State law allows an eligible public agency receiving reimbursement for SMHS provided to Medi-Cal beneficiaries to receive supplemental reimbursement up to 100% of the allowable costs of providing the services. To receive the supplemental payments, the public agency must certify that they incurred the public expenditures.

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

Reason for Change from Prior Estimate:

The expected CMS approval date shifted from FY 2012-13 to FY 2013-14.

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).

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

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. Assume the FY 2010-11 supplemental payments will increase by 10% from the payment for FY 2009-10.

	(In Thousands)		
	<u>FFP - REGULAR</u>	<u>FFP - ARRA</u>	<u>TOTAL FFP</u>
FY 2008-09 FFP	\$51,463	\$12,079	\$63,542
FY 2009-10 FFP	\$89,172	\$20,484	\$109,656
FY 2010-11 FFP	\$98,089	\$22,532	\$120,621
Total for FY 2013-14	\$238,724	\$55,095	\$293,819

Funding:

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

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 62
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1712

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$23,950,000	\$22,250,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$23,950,000	\$22,250,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$23,950,000	\$22,250,000

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 county 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 receive 65% federal FFP reimbursement for services provided to HFP subscribers and pay for the 35% match with realignment dollars or other local funds.

HEALTHY FAMILIES - SED

REGULAR POLICY CHANGE NUMBER: 62

Effective July 1, 2012, the Department of Mental Health (DMH) functions related to the HFP SED benefit was shifted to the Department.

On January 1, 2013, HFP ceased to enroll new subscribers and began transitioning HFP subscribers into Medi-Cal. The transition will continue through a phase-in methodology that will be completed in calendar year 2013.

Reason for Change from Prior Estimate:

Updated claims data increased expenditures.

Methodology:

1. The costs are developed using 70 months of Short-Doyle/Medi-Cal (SD/MC) approved claims data, excluding disallowed claims. The SD/MC data is current as of March 31, 2013, with dates of service from February 2007 through November 2012.
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. Medicaid Children's Health Insurance Program (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:

	(In Thousands)		
Accrual Estimate	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2010-11	\$27,553	\$17,909	\$9,644
FY 2011-12	\$31,342	\$20,372	\$10,970
FY 2012-13	\$33,409	\$21,716	\$11,693
FY 2013-14	\$34,124	\$22,181	\$11,943

6. On a cash basis for FY 2012-13, the Department will be paying 1% of FY 2010-11 claims, 41% of FY 2011-12 claims, and 71% of FY 2012-13 claims.

	(In Thousands)		
Cash Estimate	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2010-11	\$276	\$179	\$97
FY 2011-12	\$12,850	\$8,353	\$4,498
FY 2012-13	\$23,720	\$15,418	\$8,302
TOTAL FY 2012-13	\$36,846	\$23,950	\$12,897

HEALTHY FAMILIES - SED
REGULAR POLICY CHANGE NUMBER: 62

7. On a cash basis for FY 2013-14, the Department will be paying 1% of FY 2011-12 claims, 29% of FY 2012-13 claims, and 71% of FY 2013-14 claims.

	(In Thousands)		
Cash Estimate	<u>TF</u>	<u>FFP</u>	<u>County</u>
FY 2011-12	\$313	\$204	\$110
FY 2012-13	\$9,689	\$6,298	\$3,391
FY 2013-14	\$24,228	\$15,748	\$8,480
TOTAL FY 2013-14	\$34,230	\$22,250	\$11,981

Funding:

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

KATIE A. V. DIANA BONTA

REGULAR POLICY CHANGE NUMBER: 63
 IMPLEMENTATION DATE: 1/2013
 ANALYST: Raman Pabla
 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 Bontá* lawsuit.

Authority:

Katie A. v. Diana Bontá

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 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program "wraparound" and "therapeutic foster care" (TFC) mental health services under the Specialty Mental Health Services waiver to children in foster care or "at risk" of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service 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 available effective January 1, 2013.

Reason for Change from Prior Estimate:

This is no 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 began January 1, 2013.
4. In FY 2012-13, assume the accrual estimate is 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: Raman Pabla
 FISCAL REFERENCE NUMBER: 1719

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$7,931,000	\$32,731,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,931,000	\$32,731,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$7,931,000	\$32,731,000

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 carve out from Medi-Cal managed care plans any mental health services beyond what a primary care physician can provide within 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 provided by 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.

The first group of children transitioned from HFP to Medi-Cal on January 1, 2013. The remaining groups will transition to Medi-Cal in phases throughout calendar year 2013 and upon CMS approval for each transition phase.

HFP subscribers that transition to the Medi-Cal program are considered Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible and can receive the full array of Medi-Cal specialty mental health services based on medical necessity and their mental health needs.

TRANSITION OF HFP - SMH SERVICES

REGULAR POLICY CHANGE NUMBER: 64

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 began transitioning to Medi-Cal.
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’s SMHS and Adult’s SMHS policy changes.
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	\$19,356	\$12,581	\$6,775
Outpatient	\$9,194	\$5,976	\$3,218
Inpatient	\$3,008	\$1,955	\$1,053
FY 2012-13	\$31,558	\$20,512	\$11,046

	(In Thousands)		
	TF	FFP	County
SED Services	\$26,521	\$17,239	\$9,282
Outpatient	\$37,944	\$24,664	\$13,280
Inpatient	\$12,411	\$8,067	\$4,344
FY 2013-14	\$76,876	\$49,970	\$26,906

Funding:

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

SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT

REGULAR POLICY CHANGE NUMBER: 65
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Raman Pabla
 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 the cost of 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.

Effective July 1, 2012, the Solano County mental health plan terminated its contractual relationship with Partnership Health Plan and assumed responsibility to provide or arrange for the provision of the full array of Medi-Cal specialty mental health services to eligible Medi-Cal beneficiaries, with the exception of Partnership Health Plan enrollees that are Kaiser Permanente members. Partnership Health Plan will continue to capitate payments for Kaiser Permanente specialty mental health services provided to Kaiser Permanente members, pursuant to the terms of a separate agreement between Partnership Health Plan and Kaiser Permanente.

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. Solano County will provide the Department with the portion of its 2011 Realignment funds associated with the capitated amount provided by the Department to Partnership Health Plan for specialty mental health services for Kaiser Permanente members.

Reason for Change from Prior Estimate:

There is no change.

SOLANO COUNTY SMHS REALIGNMENT CARVE-OUT

REGULAR POLICY CHANGE NUMBER: 65

Methodology:

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

	(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: Raman Pabla
 FISCAL REFERENCE NUMBER: 1717

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,000,000	\$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	\$2,000,000	\$3,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$2,000,000	\$3,000,000

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:

Updated data shows additional claims will be paid in FY 2013-14.

Methodology:

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

	TF	FFP	County
FY 2012-13	\$4,000	\$2,000	\$2,000
FY 2013-14	\$6,000	\$3,000	\$3,000

Funding:

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

SPECIALTY MENTAL HEALTH LAWSUITS

REGULAR POLICY CHANGE NUMBER: 67
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Raman Pabla
 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.

Reason for Change from Prior Estimate:

There is no change.

SPECIALTY MENTAL HEALTH LAWSUITS

REGULAR POLICY CHANGE NUMBER: 67

Methodology:

1. The costs are based on approved claims at issue in the lawsuit.
2. All three lawsuits will be paid in FY 2012-13.

Lawsuit	TF	FFP	GF
<i>Hillsides Home for Children</i>	\$ 85,000	\$ 44,000	\$ 41,000
<i>Hathaway-Sycamores Child</i>	\$ 84,000	\$ 43,000	\$ 41,000
<i>Five Acres</i>	\$ 201,000	\$ 104,000	\$ 98,000
Total	\$ 370,000	\$ 191,000	\$180,000

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: Raman Pabla
 FISCAL REFERENCE NUMBER: 1660

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$6,227,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$6,227,000	\$0
FEDERAL FUNDS	-\$6,227,000	\$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 a 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 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. The County submitted its first payment of \$200,000 in August 2012.

Reason for Change from Prior Estimate:

There is no material 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 \$6,227,000 that the Department will make in FY 2012-13, \$6,027,000 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	\$ 586,000	
12/21/2011	\$ 95,000	
3/12/2012	\$3,357,000	
Total:	\$6,227,000	
	(\$200,000)	GF (\$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: Raman Pabla
 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:

PC 70 Reimbursement in IMD Ancillary Services Costs

Background:

Ancillary services provided to Medi-Cal beneficiaries who are ages 22 through 64 residing in IMDs are not eligible for 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 an 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>	<u>FY 2012-13</u>	<u>FY 2013-14</u>
10/01/09 - 09/30/10	\$6,000,000	\$0
10/01/10 - 09/30/11	\$0	\$6,000,000
Total:	\$6,000,000	\$6,000,000

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: Raman Pabla
 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 Institutions for Mental Diseases (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 state or federal reimbursement. 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 whether 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 a system change in MEDS that would prevent inappropriate claiming for ancillary services.

Reason for Change from Prior Estimate:

This is no 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.

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

Funding:

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

CHART REVIEW

REGULAR POLICY CHANGE NUMBER: 71
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1714

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$590,000	-\$580,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$590,000	-\$580,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$590,000	-\$580,000

DESCRIPTION

Purpose:

This policy change estimates the savings from on-site chart reviews of mental health providers.

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 of mental health providers by comparing claims to the corresponding patient chart entries.

Reason for Change from Prior Estimate:

Fiscal estimates have been updated to reflect current chart review data.

Methodology:

1. Chart review recoupment estimates are based on both inpatient and outpatient chart reviews.

	<u>TF</u>	<u>FFP</u>
FY 2012-13	(\$590,000)	(\$590,000)
FY 2013-14	(\$580,000)	(\$580,000)

Funding:

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Raman Pabla
 FISCAL REFERENCE NUMBER: 1713

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$26,634,000	-\$70,714,000
- STATE FUNDS	\$1,151,000	\$39,385,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$26,634,000	-\$70,714,000
STATE FUNDS	\$1,151,000	\$39,385,000
FEDERAL FUNDS	-\$27,785,000	-\$110,099,000

DESCRIPTION

Purpose:

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

Authority:

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

Interdependent Policy Changes:

Not Applicable

Background:

The Department reconciles interim settlements to county cost reports for mental health plans (MHPs) for children, adults, and Healthy Families SMHS. The Department completes interim settlements within two years of the end of the fiscal year. Final settlement is completed within three years of the last amended county cost report the MHPs submit to the Department.

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:

FY 2013-14 expenditures have been updated to include final cost settlements.

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72

Methodology:

1. Interim cost settlements are based upon the difference between each county MHP's filed cost report and the payments they received from the Department.
2. Final cost settlement is based upon the difference between each county MHP'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.

	<u>Underpaid</u>	<u>Overpaid</u>	<u>Net</u>
Interim Settlement (FY 2008-09)			
Children and Adults	\$7,466,000	(\$60,879,000)	(\$53,413,000)
M-CHIP*	\$254,000	(\$1,419,000)	(\$1,165,000)
Healthy Families*	\$1,869,000	(\$2,353,000)	(\$484,000)
Final Settlement (Multi-Years)			
Children and Adults	\$38,014,000	(\$10,152,000)	\$27,862,000
M-CHIP*	\$734,000	\$0	\$734,000
Healthy Families*	\$1,324,000	(\$1,492)	(\$168,000)
Total FY 2012-13	\$49,661,000	(\$76,295,000)	(\$26,634,000)
	<u>Underpaid</u>	<u>Overpaid</u>	<u>Net</u>
Interim Settlements (FY 2009-10)			
Children and Adults	\$50,739,000	(\$80,501,000)	(\$29,761,000)
M-CHIP*	\$2,942,000	(\$2,441,000)	\$501,000
Healthy Families*	\$671,000	(\$4,213,000)	(\$3,542,000)
Interim Settlements (FY 2010-11)			
Children and Adults	\$51,005,000	(\$81,100,000)	(\$30,094,000)
M-CHIP*	\$2,942,000	(\$2,441,000)	\$501,000
Healthy Families*	\$671,000	(\$4,213,000)	(\$3,542,000)
Final Settlement (Multi-Years)			
Children and Adults	\$1,022,000	(\$5,727,000)	(\$4,704,000)
Healthy Families*	\$20,000	(\$93,000)	(\$73,000)
Total FY 2013-14	\$110,013,000	(\$180,729,000)	(\$70,714,000)

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

INTERIM AND FINAL COST SETTLEMENTS - SMHS

REGULAR POLICY CHANGE NUMBER: 72

	<u>TF</u>	<u>GF</u>	<u>FFP</u>
Children and Adults	(\$25,551,000)	\$1,151,000	(\$26,702,000)
M-CHIP*	(\$431,000)	\$0	(\$431,000)
Healthy Families*	(\$652,000)	\$0	(\$652,000)
Total FY 2012-13	(\$26,634,000)	\$1,151,000	(\$27,785,000)
Children and Adults	(\$64,557,000)	\$39,385,000	(\$103,942,000)
M-CHIP*	\$1,001,000	\$0	\$1,001,000
Healthy Families*	(\$7,158,000)	\$0	(\$7,158,000)
Total FY 2013-14	(\$70,714,000)	\$39,385,000	(\$110,099,000)

Funding:

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

Title XXI FFP (4260-113-0890)*

State General Fund (4260-101-0001)

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 73
 IMPLEMENTATION DATE: 7/2011
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1578

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,035,893,000	\$4,770,999,000
- STATE FUNDS	\$26,942,000	\$2,090,531,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,035,893,000	\$4,770,999,000
STATE FUNDS	\$26,942,000	\$2,090,531,000
FEDERAL FUNDS	\$1,008,951,000	\$2,680,468,000

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)

California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (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 eligible individuals with family incomes at or below 133% of Federal Poverty Level. The HCCI will cover those eligible individuals with family incomes above 133% through 200% of Federal Poverty Level. These are statewide county-based elective programs. The LIHP HCCI replaced the HCCI (CI) under the Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid Demonstration. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use the following methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs),
- Intergovernmental Transfers (IGTs) for capitation rates payments, and
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

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 from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and Conditions under the section 1115(a) Bridge to Reform

BTR - LIHP - MCE

REGULAR POLICY CHANGE NUMBER: 73

Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. The CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013. The Department makes payments for dates of services beginning the second quarter of FY 2011-12 based on the new CPE cost claiming protocol.

The Department submitted the new cost claiming protocol for claims based on capitation rates for health care services provided to only MCE enrollees, and the capitated rate contract amendments to CMS in April 2012. The Department also submitted the letters of Certification of Capitation Rates to CMS in August 2012, for the following eight local LIHPs: Alameda, Los Angeles, Kern, Riverside, San Bernardino, San Francisco, Santa Clara, and San Mateo.

Upon CMS approval of the capitation rate claiming protocol, the capitated rates, and the capitated rate contract amendments, these local LIHPs will receive payments based on approved capitation rates for health care services provided to their MCE population effective retroactively to July 1, 2011. Currently CMS has approved the capitation rates for these local LIHPs, but not approved the capitation rate protocol and the contract amendments.

The local LIHPs with CMS's approval to use the capitation payment mechanism for federal reimbursement of the MCE component of their program will continue to use CPEs to claim for reimbursement of their allowable health care services that are excluded from their capitation rates. The remaining local LIHPs will only use CPEs to claim for federal reimbursement. The MCE program is not subject to a federal funding cap.

Reason for Change from Prior Estimate:

Estimates have been revised based on the CMS approval of the capitation rates and the cost claiming protocol for county-owned FQHCs.

Methodology:

1. The eight local LIHPs with approved capitation rates will continue to use CPEs for claiming federal reimbursement until CMS approves all capitation rate reimbursement documents. Once CMS approves the documents, the prior CPE-based payments retroactive to July 1, 2011 will be reconciled with the new capitation rate payments and the CPEs for excluded services.
2. Assume the capitation rates payments and reconciliation for FY 2011-12 payments to the new capitated rates will occur in FY 2013-14.
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.
4. Local LIHPs with county-owned FQHCs will claim their allowable FQHC costs by using IGTs as the nonfederal share of the payments. That will be retroactively to July 1, 2011 or their LIHP implementation date if later.

BTR - LIHP - MCE
REGULAR POLICY CHANGE NUMBER: 73

The estimated MCE payments on a cash basis are:

(Dollars In Thousands)

FY 2012-13	TF	IGT CAP	IGT-FQHC	FFP	CPE*
2011-12 (CPEs)	\$498,898			\$498,898	\$997,797
2011-12 (IGT-FQHC)	\$53,884		\$26,942	\$26,942	
2012-13 (CPEs)	\$483,111			\$483,111	\$966,223
Total FY 2012-13	\$1,035,893		\$26,942	\$1,008,951	\$1,964,020
FY 2013-14					
2011-12 (IGTs CAP)	\$996,499	\$498,250		\$498,249	
2012-13 (IGTs CAP)	\$1,950,925	\$975,462		\$975,463	
2012-13 (CPEs)	\$185,043			\$185,043	\$370,086
2012-13 (IGTs-FQHC)	\$53,884		\$26,942	\$26,942	
2013-14 (CPEs)	\$404,894			\$404,894	\$817,788
2013-14 (IGTs-FQHC)	\$26,942		\$13,471	\$13,471	
2013-14 (IGTs CAP)	\$1,152,812	\$576,406		\$576,406	
Total FY 2013-14	\$4,770,999	\$2,050,118	\$40,413	\$2,680,468	\$1,187,874

Funding:

LIHP IGT Fund (4260-607-8502)

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

*Not included in TF.

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	\$1,770,785,000	\$1,774,361,000
- STATE FUNDS	\$617,797,000	\$622,248,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,770,785,000	\$1,774,361,000
STATE FUNDS	\$617,797,000	\$622,248,000
FEDERAL FUNDS	\$1,152,988,000	\$1,152,113,000

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 \$1,150,718,000.

- 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 overall increase is due to an increase to the estimated 2012-13 and 2013-14 DSH allotment. NDPH aggregate payments for 2010-11, 2011-12, 2012-13, and 2013-14, however, are estimated to decrease slightly due to hospital data changes. Additionally, the timing of DSH 2010-11 and DSH 2011-12 payments will be split between FY 2012-13 and FY 2013-14.

Methodology:

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

(In Thousands)

FY 2012-13	TF	GF**	FF	IGT*
DSH 2008-09	\$5,182	\$2	\$5,180	\$0
DSH 2009-10	\$1,421	\$376	\$1,045	\$0
DSH 2010-11	\$1,484	\$742	\$742	\$0
DSH 2011-12	\$138,748	\$0	\$91,192	\$47,556
DSH 2012-13	\$1,623,950	\$9,630	\$1,054,829	\$559,491
	\$1,770,785	\$10,750	\$1,152,988	\$607,047
FY 2013-14				
DSH 2010-11	\$1,076	\$538	\$538	\$0
DSH 2011-12	\$1,722	\$861	\$861	\$0
DSH 2012-13	\$147,623	\$871	\$95,889	\$50,863
DSH 2013-14	\$1,623,940	\$9,625	\$1,054,825	\$559,490
	\$1,774,361	\$11,895	\$1,152,113	\$610,353

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	\$1,121,770,000	\$1,435,292,000
- STATE FUNDS	\$560,885,000	\$717,646,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,121,770,000	\$1,435,292,000
STATE FUNDS	\$560,885,000	\$717,646,000
FEDERAL FUNDS	\$560,885,000	\$717,646,000

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:

Updated program expenditures.

Methodology:

1. 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.
2. Any hospitals that did not achieve full funding in March and September as noted above for DY 2011-12 can achieve the remaining funding in March 2013 and September 2013.
3. It is anticipated that hospitals will achieve 95% of the DY 2012-13 funding as noted above by September 2013. The remaining 5% is anticipated to be achieved by March 2014.
4. It is anticipated that hospitals will achieve 55% of the DY 2013-14 funding in the March 2014 payment.
5. DSRIP payments are estimated to be:

(In Thousands)

FY 2012-13	TF	FF	IGT
DY 2011-12	\$381,662	\$190,831	\$190,831
DY 2012-13	\$740,108	\$370,054	\$370,054
	\$1,121,770	\$560,885	\$560,885
FY 2013-14			
DY 2011-12	\$5,400	\$2,700	\$2,700
DY 2012-13	\$659,892	\$329,946	\$329,946
DY 2013-14	\$770,000	\$385,000	\$385,000
	\$1,435,292	\$717,646	\$717,646

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	\$527,640,000	\$546,058,000
- STATE FUNDS	\$263,820,000	\$273,029,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$527,640,000	\$546,058,000
STATE FUNDS	\$263,820,000	\$273,029,000
FEDERAL FUNDS	\$263,820,000	\$273,029,000

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 is due to an increase to the estimated 2012-13 and 2013-14 DSH allotment and the inclusion of 2009-10 payments. The Department anticipates completing the FY 2009-10 overpayment collections necessary to make the FY 2009-10 final payments.

Methodology:

1. 2008-09 payments resulting from data corrections, 2009-10 final payments, and 2010-11 phase one final payments are assumed to be paid in FY 2012-13.
2. SB 90 reduces Medi-Cal DSH replacement payments to private hospitals by \$150 million TF (\$75 million GF) in FY 2011-12.
3. 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 \$12,276,000 TF (\$6,138,000 GF) in FY 2013-14.
4. 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.
5. 11 months of 2012-13 payments are assumed to be paid in FY 2012-13 and one month is assumed to be paid in FY 2013-14. The prorated FY 2012-13 SB 335 reductions 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.
6. 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.

MH/UCD & BTR—PRIVATE HOSPITAL DSH REPLACEMENT

REGULAR POLICY CHANGE NUMBER: 76

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

(In Thousands)			
FY 2012-13	TF	GF	FFP
2008-09	\$208	\$104	\$104
2009-10	\$16,543	\$8,271	\$8,272
2010-11	\$46,108	\$23,054	\$23,054
2012-13	\$484,031	\$242,016	\$242,015
SB 335	(\$19,250)	(\$9,625)	(\$9,625)
Net	\$464,781	\$232,391	\$232,390
Total FY 2012-13	\$527,640	\$263,820	\$263,820
FY 2013-14			
2011-12	\$41,675	\$20,837	\$20,838
SB 90	(\$12,276)	(\$6,138)	(\$6,138)
Net	\$29,399	\$14,699	\$14,700
2012-13	\$44,003	\$22,002	\$22,001
SB 335	(\$1,750)	(\$875)	(\$875)
Net	\$42,253	\$21,127	\$21,126
2013-14	\$484,031	\$242,015	\$242,016
SB 335	(\$9,625)	(\$4,812)	(\$4,813)
Net	\$474,406	\$237,203	\$237,203
Total FY 2013-14	\$546,058	\$273,029	\$273,029

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 claimed 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 in four payments to the DPHs on a quarterly basis. The fourth quarter payment is split into 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 (DY 6)	\$400,000	\$565,422
2011-12 (DY 7)	\$400,000	\$436,000
2012-13 (DY 8)	\$400,000	\$386,000
2013-14 (DY 9)	\$400,000	\$311,000
2014-15 (DY 10)	\$400,000	\$236,000

- 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: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1572

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$314,749,000	\$161,299,000
- STATE FUNDS	\$8,980,000	\$13,470,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$314,749,000	\$161,299,000
STATE FUNDS	\$8,980,000	\$13,470,000
FEDERAL FUNDS	\$305,769,000	\$147,829,000

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)

California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR) (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 (CI). The MCE will cover eligible individuals with family incomes at or below 133% of the Federal Poverty Level (FPL). The HCCI will cover those eligible individuals 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 which was extended until October 31, 2010. AB 342 and AB 1066 authorize the local LIHPs to provide health care services to eligible individuals.

The local LIHPs use two methodologies to obtain federal funding:

- Certified Public Expenditures (CPEs)
- IGTs for county-owned Federally Qualified Health Centers (FQHCs)

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 from November 1, 2010 through September 30, 2011. This protocol is permitted by the Special Terms and Conditions under the section 1115(a) Bridge to Reform Medicaid Demonstration for those local LIHPs which were legacy counties under the CI.

BTR—LOW INCOME HEALTH PROGRAM - HCCI

REGULAR POLICY CHANGE NUMBER: 78

The Centers for Medicare & Medicaid Services (CMS) approved the new cost claiming protocol for claims based on CPEs on August 13, 2012. The CMS also approved the new cost claiming protocol for claims based on IGTs for health care services provided by county-owned FQHCs on February 5, 2013. The Department makes payments for dates of services beginning the second quarter of FY 2011-12 based on the new CPE cost claiming protocol.

The MCE program is not subject to a federal funding cap while HCCI funding is capped at \$360 million total computable (TC) annually for Demonstration Years (DYs) 2010-11, 2011-12, and 2012-13 and \$180 million TC for DY 2013-14. Federal funding will be provided through the Health Care Support Fund (HCSF).

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 IGT-FQHC claiming protocol.

Methodology:

The estimated HCCI payments on a cash basis are:

(Dollars in Thousands)

FY 2012-13

	<u>TF</u>	<u>IGT-FQHC</u>	<u>FFP</u>	<u>CPE*</u>
2010-11 (CPEs)	\$20,494		\$20,494	\$40,989
Rollover 2010-11	\$88,000		\$88,000	\$176,000
2011-12 (CPEs)	\$ 40,941		\$40,941	\$81,883
2011-12 (IGT-FQHC)	\$17,960	\$8,980	\$8,980	
Rollover 2011-12	\$73,000		\$73,000	\$146,000
2012-2013 (CPEs)	\$74,354		\$74,354	\$148,709
Total	\$314,749	\$8,980	\$305,769	\$593,581

FY 2013-14

2012-2013 (CPEs)	\$6,640		\$6,640	\$13,281
2012-13 (IGT-FQHC)	\$17,960	\$8,980	\$8,980	
Rollover 2012-13	\$49,000		\$49,000	\$98,000
2013-14 (IGT-FQHC)	\$8,980	\$4,490	\$4,490	
2013-2014 (CPEs)	\$78,719		\$78,719	\$157,439
Total	\$161,299	\$13,470	\$147,829	\$268,720

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	\$212,122,000	\$339,269,000
- STATE FUNDS	\$106,061,000	\$169,634,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$212,122,000	\$339,269,000
STATE FUNDS	\$106,061,000	\$169,634,500
FEDERAL FUNDS	\$106,061,000	\$169,634,500

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 14166.14

Interdependent Policy Changes:

PC 106 Hospital Stabilization
 PC 231 Private Hospital Supplemental Fund Savings

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 (GF), 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

**MH/UCD & BTR—PRIVATE HOSPITAL SUPPLEMENTAL
PAYMENT**
REGULAR POLICY CHANGE NUMBER: 79

requirements specified in SB 1100, while the remainder will be subject to negotiations with the Office of Selective Provider Contracting Program (OSPCP).

Reason for Change from Prior Estimate:

The changes are due to updated IGTs, interest, and program expenditures. The redirection of \$36.08 million TF (\$18.04 million GF) stabilization to the GF was delayed to FY 2013-14. In addition, the Department will redirect \$23 million GF received pursuant to the American Recovery and Reinvestment Act of 2009 (ARRA) to the GF in FY 2013-14.

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.
2. Interest earned in a fiscal year will be available for distribution in the following fiscal year.
3. IGTs are estimated to total \$9,400,000 in FY 2012-13 and FY 2013-14, generating \$4,700,000 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 OSPCP. 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. Under 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. The Private Hospital Supplemental Fund includes funds received due to increased ARRA FMAP.
9. In FY 2013-14, the Department will redirect \$23,000,000 ARRA funds from the Private Hospital Supplemental Fund to the General Fund. General Fund savings are budgeted in the Private Hospital Supplemental Fund Savings policy change.
10. AB 1467 authorizes the redirection of stabilization funding that has not yet been paid for FY 2005-06 through FY 2009-10 to the General Fund. General Fund savings are budgeted in the Hospital Stabilization policy change.
11. 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	\$135,026,000	\$67,513,000	\$67,513,000
Appropriation (from GF)	\$240,354,000	\$120,177,000	\$120,177,000
FY 2010-11 interest	\$802,000	\$401,000	\$401,000
IGT	\$16,000,000	\$8,000,000	\$8,000,000
Total	\$392,182,000	\$196,091,000	\$196,091,000
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	\$74,678,000	\$37,339,000	\$37,339,000
FY 2012-13			
FY 2011-12 Ending Balance	\$74,678,000	\$37,339,000	\$37,339,000
Appropriation (from GF)	\$236,800,000	\$118,400,000	\$118,400,000
Est. FY 2011-12 interest	\$522,000	\$261,000	\$261,000
Est. 2005-06 Stabilization Transfer	\$3,556,000	\$1,778,000	\$1,778,000
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	\$9,400,000	\$4,700,000	\$4,700,000
Total	\$357,480,000	\$178,740,000	\$178,740,000
Cash Expenditures to Hospitals	\$212,122,000	\$106,061,000	\$106,061,000
SB 335 Reduction	\$35,000,000	\$17,500,000	\$17,500,000
FY 2012-13 Ending Balance	\$110,358,000	\$55,179,000	\$55,179,000
FY 2013-14			
FY 2012-13 Ending Balance	\$110,358,000	\$55,179,000	\$55,179,000
Appropriation (from GF)	\$236,800,000	\$118,400,000	\$118,400,000
Est. FY 2012-13 interest	\$211,000	\$105,500	\$105,500
IGT	\$9,400,000	\$4,700,000	\$4,700,000
Total	\$356,769,000	\$178,384,500	\$178,384,500
Cash Expenditures to Hospitals	\$257,189,000	\$128,594,500	\$128,594,500
Redirect Stabilization Fund to GF	\$36,080,000	\$18,040,000	\$18,040,000
Redirect ARRA to GF	\$46,000,000	\$23,000,000	\$23,000,000
SB 335 Reduction	\$17,500,000	\$8,750,000	\$8,750,000
FY 2013-14 Ending Balance	\$0	\$0	\$0

Funding:

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

LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS FUND

REGULAR POLICY CHANGE NUMBER: 80
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1622

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$40,000,000	\$126,400,000
- STATE FUNDS	\$20,000,000	\$63,200,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$40,000,000	\$126,400,000
STATE FUNDS	\$20,000,000	\$63,200,000
FEDERAL FUNDS	\$20,000,000	\$63,200,000

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)

SB 920 (Hernandez, Statutes of 2012)

California Bridge to Reform (BTR) Section 1115(a) Medicaid Demonstration

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 post stabilization care provided by private hospitals that are outside the LIHP coverage network. 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:

The changes are due to less estimated HQARF transfer.

Methodology:

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

2. LIHPs will provide utilization data for FY 2011-12, and FY 2012-13 to the Department after the fiscal

**LIHP MCE OUT-OF-NETWORK EMERGENCY CARE SVS
FUND
REGULAR POLICY CHANGE NUMBER: 80**

year and will provide FY 2013-14 data after the close of program period. The Department will calculate the payments based on the data and make payments to the LIHPs within 60 days of completing the calculations. The program ends December 31, 2013.

3. Funds from the HQARF will be transferred 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.

(Dollars in Thousands)

FY 2012-13	TF	IGT	LIHP	FFP
2011-12	\$40,000	\$20,000	\$0	\$20,000
FY 2013-14	TF	IGT	LIHP	FFP
2012-13	\$40,000	\$20,000	\$0	\$20,000
2013-14	\$86,400	\$10,000	\$33,200	\$43,200
Total	\$126,400	\$30,000	\$33,200	\$63,200

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	\$80,500,000	\$24,500,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$80,500,000	\$24,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$80,500,000	\$24,500,000

DESCRIPTION**Purpose:**

This policy change estimates the fiscal impact of allocating unspent 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. 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 is due to the shift of DY 2012-13 HCCI rollover amounts to FY 2013-14. The Department will submit a waiver amendment for approval to rollover DY 2012-13 HCCI funding and expects approval in FY 2013-14.

Methodology:

1. The LIHP-HCCI total computable annual limit 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. In FY 2012-13, assume the Department will rollover available funding from DY 2010-11 and DY 2011-12 for a total of \$161 million FFP.
5. In FY 2013-14, assume the Department will rollover available funding from DY 2012-13 for a total of \$49 million FFP.
6. Assume funds will be split 50/50 between the state and DPHs.
7. DPHs will receive \$80.5 million and \$24.5 million in additional funding for uncompensated care costs in FY 2012-13 and FY 2013-14, respectively.

(In Millions)		
FY 2012-13	FFP	GF
HCCI Rollover		
DY 2010-11	(\$88.00)	\$0.00
DY 2011-12	(\$73.00)	\$0.00
Total	(\$161.00)	\$0.00
SNCP-DPHs	\$80.50	\$0.00
SNCP-DSHPs	\$80.50	(\$80.50)
FY 2013-14		
HCCI Rollover		
DY 2012-13	(\$49.00)	\$0.00
SNCP-DPHs	\$24.50	\$0.00
SNCP-DSHPs	\$24.50	(\$24.50)

Funding:

Health Care Support Fund (4260-601-7503)

MH/UCD & BTR—DPH 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	\$80,147,000	\$77,960,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$80,147,000	\$77,960,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$80,147,000	\$77,960,000

DESCRIPTION**Purpose:**

This policy change estimates the payments to Designated Public Hospitals (DPHs) 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)
 Proposed Legislation

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 Medi-Cal uncompensated costs incurred for physician and non-physician practitioner professional services.

AB 1467 changed the Non-Designated Public Hospital (NDPH) reimbursement methodology to a CPE methodology. The Department submitted a SPA to the Centers for Medicare & Medicaid Services (CMS) 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. Because CMS approval has not been received timely, the Department is no longer pursuing the reimbursement change. NDPHs will continue to receive payments through the current methodology and will not be eligible to receive reimbursement for uncompensated costs for physician and non-physician practitioner professional services.

The reimbursement is available only for costs associated with health care services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings.

MH/UCD & BTR—DPH PHYSICIAN & NON-PHYS. COST

REGULAR POLICY CHANGE NUMBER: 82

Each DPH's physician and non-physician costs will be reconciled to the Medi-Cal 2552 cost report for the respective fiscal year end. Payments resulting from the interim or final reconciliation will be based on the hospitals' CPEs and comprised of 100% federal funds.

Reason for Change from Prior Estimate:

NDPHs will not be eligible for reimbursement for these costs.

Methodology:

1. Payments for the DPH June 2012 dates of service claims were made in FY 2012-13. Additionally, in FY 2012-13 and 2013-14, one annual payment will be made for DPHs.
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
Total	\$ 80,147	\$ 80,147
FY 2013-14		
DPH 2013-14	\$ 77,960	\$ 77,960

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	\$67,568,000	\$39,911,000
- STATE FUNDS	\$43,000,000	\$29,154,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$67,568,000	\$39,911,000
STATE FUNDS	\$43,000,000	\$29,154,000
FEDERAL FUNDS	\$24,568,000	\$10,757,000

DESCRIPTION**Purpose:**

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

Authority:

SB 1100 (Chapter 560, Statutes of 2005), Welfare & 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 timing of the DPH and Distressed stabilization payments have been updated. DPH stabilization payments for 2007-08 are anticipated to be paid in FY 2013-14. Distressed stabilization payments for 2007-08, 2008-09, 2009-10 are anticipated to be paid in FY 2013-14.

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 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

MH/UCD—STABILIZATION FUNDING**REGULAR POLICY CHANGE NUMBER: 83**

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		
2005-06		
DPHs*	<u>\$17,655,000</u>	<u>\$17,655,000</u>
Redirect to GF-Private	<u>\$7,022,000</u>	<u>\$3,511,000</u>
2005-06 Total	\$24,677,000	\$21,166,000
2006-07		
DPHs*	\$777,000	\$777,000
Redirect to GF-Private	<u>\$12,714,000</u>	<u>\$6,357,000</u>
2006-07 Total	\$13,491,000	\$7,134,000
2007-08		
Redirect to GF-NDPH	\$1,614,000	\$807,000
2008-09		
Redirect to GF-Private	\$2,586,000	\$1,293,000
2009-10		
Redirect to GF-Private	\$48,980,000	\$24,490,000
Payments to hospitals receiving underpayments	<u>(\$23,780,000)</u>	<u>(\$11,890,000)</u>
2009-10 Total	<u>\$25,200,000</u>	<u>\$12,600,000</u>
Total FY 2012-13	\$67,568,000	\$43,000,000
FY 2013-14		
2007-08		
DPHs*	\$8,924,000	\$8,924,000
Distressed	<u>\$9,350,000</u>	<u>\$4,675,000</u>
2007-08 Total	\$18,274,000	\$13,599,000
2008-09		
DPHs*	\$9,473,000	\$9,473,000
Distressed	<u>\$5,866,000</u>	<u>\$2,933,000</u>
2007-08 Total	\$15,339,000	\$12,406,000
2009-10		
Distressed	<u>\$6,298,000</u>	<u>\$3,149,000</u>
Total FY 2013-14	\$39,911,000	\$29,154,000

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	\$11,657,000	\$159,300,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,657,000	\$159,300,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$11,657,000	\$159,300,000

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 is due to the updated final reconciliation amount for Fiscal Year (FY) 2005-06 and delays to the final reconciliations for FY 2006-07 and FY 2008-09. The final reconciliation for FY 2006-07 will be delayed to FY 2013-14. The final reconciliation for FY 2008-09 will be delayed to FY 2014-15 and no longer included in this estimate.

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 April 2013. When reconciled with the tentative settlement of \$42,891,000, there is an estimated payout of \$11,657,000.
4. The final reconciliation for 2006-07 is expected to be completed by September 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 May 2014 and is estimated to be \$91,900,000. There are no plans to issue a tentative settlement for 2007-08.

(In Thousands)

FY 2012-13

2005-06 Final Reconciliation

FFP\$11,657**FY 2013-14**

2006-07 Final Reconciliation

\$67,400

2007-08 Final Reconciliation

\$91,900

Total

\$159,300**Funding:**

Title XIX FFP (4260-101-0890)

BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR INMATES

REGULAR POLICY CHANGE NUMBER: 86
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1576

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$60,041,000	\$29,503,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$60,041,000	\$29,503,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$60,041,000	\$29,503,000

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 correctional facilities.

Authority:

AB 1628 (Chapter 729, Statutes of 2010)

SB 92 (Chapter 36, Statutes of 2011)

California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

Not Applicable

Background:

The BTR established the LIHP effective November 1, 2010 through December 31, 2013. AB 1628 and SB 92 authorize the Department to claim federal funding for inpatient hospital services for certain inmates of CDCR correctional facilities. The eligible inpatient hospital services are services provided at hospitals that are off the grounds of the correctional facilities for inmates with family incomes at or below 133% of the Federal Poverty Level determined. The Department determines the eligible inmates for either the Medi-Cal program or the LIHP operated by the counties.

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:

The changes are due to updated inpatient costs

Methodology:

1. CDCR/CCHCS began to submit LIHP claims in March 2012.
2. The Department processes LIHP applications and assumes no additional county administrative costs.
3. Assume 19 LIHPs will be implemented by March 2013, and this number of LIHPs will continue through FY 2013-14.
4. Assume the Department will process 375 applications per month. 80% of the applications are LIHP inmate applications.
5. Assume 96% of processed LIHP inmate applications will be approved.

Monthly eligible LIHP inmates are:

$375 \text{ total inmate applications processed} \times 80\% \text{ LIHP} \times 96\% \text{ approval rate} = 288$

6. The average cost per inpatient stay is estimated to be \$19,170.
7. Assume 18.75% of eligible LIHP inmates will receive two inpatient hospital services during a month.

Additional monthly inpatient Stays:

$288 \text{ approved application} \times 18.75\% \text{ patients with 2 inpatient stays} = 54$

Monthly Approved Inpatient Stays:

$288 \text{ monthly approved inpatient stays} + 54 \text{ additional monthly approved inpatient stays} = 342$

8. The annual LIHP inmate inpatient service costs:

$342 \text{ monthly approved inpatient stays} \times \$19,170 \text{ average cost} \times 12 \text{ months} = \$78,674,000 \text{ TF.}$

9. Assume the LIHP will expire December 31, 2013.

10. Assume date of services began July 1, 2011 for two LIHPs, and October 1, 2011 for 17 LIHPs.

Average Monthly Approved Inpatient Stays for Each LIHP:

$342 \text{ monthly} / 19 \text{ LIHP} = 18$

The Estimated FY 2011-12 CPE on an Accrual Basis (Effective July 1, 2011):

$2 \text{ LIHP} \times 18 \text{ Approved applications} \times \$19,170 \text{ average cost} \times 12 \text{ months} = \$8,281,000$

The Estimated FY 2011-12 CPE on an Accrual Basis (Effective October 1, 2011):

$17 \text{ LIHP} \times 18 \text{ Approved applications} \times \$19,170 \text{ average cost} \times 9 \text{ months} = \$52,794,000$

The Estimated FY 2011-12 CPE on an Accrual Basis:

$\$8,281,000 \text{ Effective July} + \$52,794,000 \text{ Effective October} = \$61,076,000$

**BTR — LIHP INPATIENT HOSP. COSTS FOR CDCR
INMATES
REGULAR POLICY CHANGE NUMBER: 86**

11. The estimated federal fund for LIHP inmate inpatient service costs on an accrual basis:

(Dollars In Thousands)	TF	FFP	CPE*
FY 2011-12	\$30,538	\$30,538	\$61,076
FY 2012-13	\$39,337	\$39,337	\$78,674
FY 2013-14	\$19,669	\$19,669	\$39,337

12. The Centers for Medicare and Medicaid Services (CMS) approved the claiming protocols in August 2012. The Department began processing claims at the same time. Assume FY 2011-12 payments will be paid in FY 2012-13.

13. 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.

14. Assume all FY 2013-14 payments will be paid in FY 2013-14.

The estimated payments for inmate inpatient services on a cash basis:

(Dollars In Thousands)	TF	FFP	CPE*
FY 2012-13			
FY 2011-12	\$30,538	\$30,538	\$61,076
FY 2012-13	\$29,503	\$29,503	\$59,006
Total	\$60,041	\$60,041	\$120,082
FY 2013-14			
FY 2012-13	\$9,834	\$9,834	\$19,668
FY 2013-14	\$19,669	\$19,669	\$39,337
Total	\$29,503	\$29,503	\$59,005

Funding:

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

*Not included in Total Fund

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	\$106,342,000	\$130,627,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$106,342,000	\$130,627,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$106,342,000	\$130,627,000

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 & 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:**

The changes are due to updated program expenditures.

Methodology:

1. Total eligible expenditures have been reduced by 17.79% under the MH/UCD and 13.95% under the BTR to adjust for services provided to undocumented persons. The FFP received for CCS and GHPP will be deposited in the Health Care Support Fund, Item 4260-601-7503. These funds are transferred to the Family Health Estimate. The GF savings is reflected in the Family Health Estimate. The GF savings created will be used to support safety net hospitals under the MH/UCD and BTR.
2. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP 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 SNCP federal funds allotment will increase for expenditures incurred from October 1, 2008 to August 31, 2010, resulting in additional \$423.769 million federal funds available in the SNCP. The Department claims these funds using certified public expenditures. This policy change budgets those federal funds that are claimed using CPEs from the CCS and GHPP programs.
3. The Department will conduct the final reconciliations for Demonstration Year (DY) 2009-10 in FY 2012-13 and estimates that the Department will have to repay the federal government \$14.791 million in FY 2012-13. The CCS and GHPP federal reimbursements are reduced by the final reconciliation amounts in this policy change.
4. The final reconciliation for DY 2010-11 is anticipated to be completed in FY 2013-14. The Department estimates to claim an additional \$9.494 million in federal funds in FY 2013-14.

MH/UCD & BTR—CCS AND GHPP

REGULAR POLICY CHANGE NUMBER: 87

The estimated CCS/GHPP federal reimbursements are:

(In Thousands)	CCS	GHPP	Total
FY 2005-06	\$ 15,523	\$ 8,485	\$ 24,008
FY 2006-07	\$ 46,856	\$ 15,300	\$ 62,156
FY 2007-08	\$ 18,000	\$ 8,000	\$ 26,000
FY 2008-09	\$ 20,958	\$ 21,336	\$ 42,294
FY 2009-10	\$ 114,023	\$ 41,073	\$ 155,096
FY 2010-11	\$ 59,959	\$ 25,613	\$ 85,572
FY 2011-12	\$ 102,046	\$ 55,019	\$ 157,065
 (In Thousands)			
FY 2012-13			
DSHP-BTR (DY 2012-13)	\$ 80,305	\$ 40,828	\$ 121,133
DY 2009-10 Final Reconciliation	<u>(\$ 9,853)</u>	<u>(\$ 4,938)</u>	<u>(\$ 14,791)</u>
Total	\$ 70,452	\$ 35,890	\$ 106,342
 FY 2013-14			
DSHP-BTR (DY 2013-14)	\$ 80,305	\$ 40,828	\$ 121,133
DY 2010-11 Final Reconciliation	<u>\$ 6,454</u>	<u>\$ 3,040</u>	<u>\$ 9,494</u>
Total	\$ 86,759	\$ 43,868	\$ 130,627

Funding:

Health Care Support Fund (4260-601-7503)

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 88
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Yao-Hui Yu
 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 HIV/AIDS Treatment Extension Act of 2009 "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

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS**REGULAR POLICY CHANGE NUMBER: 88**

LIHP enrollees diagnosed with HIV, particularly those enrollees who previously received services under 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, and it was approved on October 31, 2012. The Proposal served 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. On November 7, 2012, the Department submitted the proposed new supplements to CMS and they were approved on November 19, 2012.

As of July 1, 2012, 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. Eleven DPHs elected to propose DSRIP plan modifications to incorporate Category 5 HIV Transition projects. Ten DSRIP plan modifications have been approved.

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:

There is no change from prior estimate.

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.

(Dollars in
Thousands)

FY 2012-13
Total

TF	IGT	FFP
<u>\$55,000</u>	<u>\$27,500</u>	<u>\$27,500</u>

FY 2013-14
2012-13
2013-14
Total

TF	IGT	FFP
<u>\$55,000</u>	<u>\$27,500</u>	<u>\$27,500</u>
<u>\$55,000</u>	<u>\$27,500</u>	<u>\$27,500</u>
\$110,000	\$55,000	\$55,000

BTR - LIHP - DSRIP HIV TRANSITION PROJECTS

REGULAR POLICY CHANGE NUMBER: 88

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	\$11,734,000	\$116,992,000
- STATE FUNDS	\$5,867,000	\$58,496,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,734,000	\$116,992,000
STATE FUNDS	\$5,867,000	\$58,496,000
FEDERAL FUNDS	\$5,867,000	\$58,496,000

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:

- Updated expenditure data through February 2013,
- Updated rate increase information, and
- A shift in FY 2012-13 expenditures to FY 2013-14 due to an Erroneous Payment Correction (EPC) in September 2013 for FY 2012-13 dates of service.

Methodology:

1. The DPHs received an interim increase in their interim per diem rates of 5% for dates of service on and after December 1, 2012.

MH/UCD & BTR—DPH INTERIM RATE GROWTH**REGULAR POLICY CHANGE NUMBER: 89**

2. The final interim rates for dates of services in FY 2012-13 are expected to be effective by the end of May 2013. Assume the final increase in the DPH interim rate is 6.37% for FY 2012-13 dates of service.
3. Assume an EPC for claims with dates of service from July 1, 2012 through May 31, 2013 will be processed in September 2013.
4. Assume the DPHs will receive an increase in their interim per diem rates for dates of services on or after July 1, 2013, of 5%.
5. An additional cost of \$11,734,000 is estimated to occur in FY 2012-13.
6. An additional cost of \$116,992,000 is estimated to occur in FY 2013-14.
7. 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	\$38,866,000	\$154,500,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$38,866,000	\$154,500,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$38,866,000	\$154,500,000

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 and 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 is due to the delay of final reconciliations for DY 2007-08 to FY 2013-14.

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	\$38,866	\$154,500

Funding:

Health Care Support Fund (4260-601-7503)

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 92
 IMPLEMENTATION DATE: 9/2007
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1154

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$37,811,000	\$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	\$37,811,000	\$31,467,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$37,811,000	\$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)
 Medi-Cal Hospital/Uninsured Care Section 1115(a) Medicaid 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.

MH/UCD—HEALTH CARE COVERAGE INITIATIVE

REGULAR POLICY CHANGE NUMBER: 92

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 payments to or recovery of FFP payments from affected counties.

Reason for Change from Prior Estimate:

Estimate changes are due to the use of updated data.

Methodology:

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

(Dollars in Thousands)

County/Agency	Annual Allocations
Alameda County Health Care Services Agency	\$ 8,204
Contra Costa County/Contra Costa Health Services	\$ 15,250
County of Orange	\$ 16,872
County of San Diego, Health and Human Services Agency	\$ 13,040
County of Kern, Kern Medical Center	\$ 10,000
Los Angeles County Department of Health Services	\$ 54,000
San Francisco Department of Public Health	\$ 24,370
San Mateo County	\$ 7,564
County of Santa Clara, DBA Santa Clara Valley Health and Hospital System	\$ 20,700
Ventura County Health Care Agency	\$ 10,000
Total	\$180,000

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:

(Dollars in Thousands)

FY 2012-13	TF	FFP	CPE*
2007-08	\$28,297	\$28,297	\$56,594
2008-09	\$4,523	\$4,523	\$9,047
2009-10	\$4,991	\$4,991	\$9,981
Total	\$37,811	\$37,811	\$75,622
FY 2013-14	TF	FFP	CPE*
2007-08	\$30,375	\$30,375	\$60,750
2008-09	\$1,092	\$1,092	\$2,184
Total	\$31,467	\$31,467	\$62,934

Funding:

Health Care Support Fund (4260-601-7503)

*Not included in Total Fund

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	\$66,339,000
- STATE FUNDS	-\$366,443,000	-\$279,331,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$17,150,000	\$66,339,000
STATE FUNDS	-\$366,443,000	-\$279,331,000
FEDERAL FUNDS	\$383,593,000	\$345,670,000

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 03
 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) <ul style="list-style-type: none"> · 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
- the transfer of \$66,339,000 ADAP FFP to the CDPH budget instead of \$17,150,000 in FY 2013-14.

Methodology:

1. The FFP for other departments is offset against General Fund expenses in Item 4260-101-0001. In FY 2012-13, 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. In FY 2013-14, of the \$66,339,000 ADAP FFP available, \$66,339,000 is offset against the CDPH budget.
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

BTR—DESIGNATED STATE HEALTH PROGRAMS**REGULAR POLICY CHANGE NUMBER: 93**

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.

3. In FY 2012-13, for all programs except for UC, CSU, and CCCs, the Department will claim DSHPs for DY 2012-13 on a cash basis. Due to delays the Department will claim for:
 - DY 2010-11 and DY 2011-12 for CMSP in FY 2012-13.
 - DY 2010-11, DY 2011-12, and DY 2012-13 for the UC, CSU, and CCCs in FY 2013-14.
4. In FY 2013-14, on a cash basis, the Department will claim all DSHPs for DY 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
	DY 2012-13	DY 2013-14	FY 2012-13	FY 2013-14
CCS	\$80,305	\$80,305		
GHPP	\$40,828	\$40,828		
MIA-LTC	\$19,103	\$19,103		
BCCTP	\$1,472	\$1,472		
DHCS Total	\$141,708	\$141,708		
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	\$0	\$5,796	\$0	\$5,796
PCTP	\$1,295	\$1,295	\$1,295	\$1,295
OSHPD	\$9,871	\$9,871	\$9,871	\$9,871
Univ. of Calif.	\$2,575	\$2,575	\$0	\$9,743
CSU/Comm. Colleges	\$29,362	\$29,362	\$0	\$109,572
CMSP	\$0	\$0	\$157,238	\$0
Miscellaneous Programs	\$40,659	\$34,863	\$40,659	\$34,863
Total Other Programs	\$258,292	\$258,292	\$383,593	\$345,670
Grand Total	\$400,000	\$400,000	\$383,593	\$345,670

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	\$914,000	\$8,141,000
- STATE FUNDS	\$457,000	\$4,070,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$914,000	\$8,141,000
STATE FUNDS	\$457,000	\$4,070,500
FEDERAL FUNDS	\$457,000	\$4,070,500

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)

Interdependent Policy Changes:

PC 106 Hospital Stabilization

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 (GF) 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).

AB 1467 (Chapter 23, Statutes of 2012) changed the NDPH reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. The Department submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS), but because CMS approval has not been received timely, the Department is no longer pursuing this reimbursement change. NDPHs will continue to receive supplemental payments.

MH/UCD & BTR—NDPH SUPPLEMENTAL PAYMENT

REGULAR POLICY CHANGE NUMBER: 94

Reason for Change from Prior Estimate:

The change is due to updated appropriation amounts and program expenditures. In addition, the redirection of supplemental payments to the GF will no longer occur and the redirection of \$538,000 TF (\$269,000 GF) stabilization to the GF was delayed to FY 2013-14.

Methodology:

1. The State Funds (SF) item includes the annual General Fund 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:

	<u>TF</u>	<u>SF</u>	<u>FFP</u>
FY 2012-13			
FY 2011-12 Ending Balance	\$898,000	\$449,000	\$449,000
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	\$1,452,000	\$726,000	\$726,000
Cash Expenditures in FY 2012-13	\$914,000	\$457,000	\$457,000
FY 2012-13 Ending Balance	\$538,000	\$269,000	\$269,000
FY 2013-14			
FY 2012-13 Ending Balance	\$538,000	\$269,000	\$269,000
Appropriation (GF)	\$7,600,000	\$3,800,000	\$3,800,000
Est. FY 2012-13 Interest Earned	\$3,000	\$1,500	\$1,500
Total Funds Available	\$8,141,000	\$4,070,500	\$4,070,500
Cash Expenditures in FY 2013-14	\$7,603,000	\$3,801,500	\$3,801,500
Redirect Stabilization Fund to GF	\$538,000	\$269,000	\$269,000
FY 2013-14 Ending Balance	\$0	\$0	\$0

Funding:

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

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:

There is no change.

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:

	TF	SF	FFP
FY 2011-12			
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	-\$19,694,000	-\$19,518,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$19,694,000	-\$19,518,000
FEDERAL FUNDS	\$19,694,000	\$19,518,000

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:

The changes are due to updated program expenditures.

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 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 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 Demonstration Year (DY) 2009-10 in FY 2012-13 and estimates to claim an additional \$591,000 in federal funds in FY 2012-13.
4. The final reconciliation for DY 2010-11 is anticipated to be completed in FY 2013-14. The Department estimates to claim an additional \$415,000 in federal funds in FY 2013-14.

The MIA-LTC federal reimbursements are:

(In Thousands)	FFP
FY 2005-06	\$ 12,834
FY 2006-07	\$ 7,328
FY 2007-08	\$ 14,743
FY 2008-09	\$ 23,160
FY 2009-10	\$ 28,147
FY 2010-11	\$ 11,386
FY 2011-12	\$ 33,737

(In Thousands)	
FY 2012-13	
DSHP-BTR (DY 2012-13)	\$ 19,103
DY 2009-10 Final Reconciliation	\$ 591
Total	\$ 19,694

FY 2013-14	
DSHP-BTR (DY 2013-14)	\$ 19,103
DY 2010-11 Final Reconciliation	\$ 415
Total	\$ 19,518

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	-\$1,496,000	-\$1,423,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$1,496,000	-\$1,423,000
FEDERAL FUNDS	\$1,496,000	\$1,423,000

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 & 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:

The changes are due to updated program expenditures.

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 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 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 Demonstration Year (DY) 2009-10 in FY 2012-13 and estimates to claim an additional \$24,000 in federal funds in FY 2012-13.
4. The final reconciliation for DY 2010-11 is anticipated to be completed in FY 2013-14. The Department estimates to have to repay the federal government \$49,000 in FY 2013-14. The BCCTP federal reimbursements are reduced by the final reconciliation amounts in this policy change.

The BCCTP federal reimbursements are:

(In Thousands)	FFP
FY 2005-06	\$ 591
FY 2006-07	\$ 291
FY 2007-08	\$ -
FY 2008-09	\$ 1,211
FY 2009-10	\$ 2,137
FY 2010-11	\$ 1,095
FY 2011-12	\$ 2,439

(In Thousands)	
FY 2012-13	
DSHP-BTR (DY 2012-13)	\$ 1,472
DY 2009-10 Final Reconciliation	\$ 24
Total	\$ 1,496

FY 2013-14	
DSHP-BTR (DY 2013-14)	\$ 1,472
DY 2010-11 Final Reconciliation	(\$ 49)
Total	\$ 1,423

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	-\$474,942,500	-\$560,037,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$474,942,500	-\$560,037,000
FEDERAL FUNDS	\$474,942,500	\$560,037,000

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 SPCP 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 expenditure data through February 2013.

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 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 due to ARRA on a date-of-service basis. In FY 2012-13 the increase due to ARRA is assumed to be \$46,189,000, on a cash basis.
- The funding adjustment is estimated at:

(In Thousands)	<u>Expenditures</u>	<u>GF to FF shift</u>
FY 2012-13	\$ 949,885	\$ 474,942
FY 2013-14	\$ 1,120,074	\$ 560,037

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 & 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:**

The changes are due to updated program expenditures.

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 Program (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 Quality Assurance Fee (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 Demonstration Year (DY) 2009-10 in FY 2012-13 and estimates that the Department will have to repay the federal government \$14.176 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:

(In Thousands)	FFP
	FY 2012-13
CCS	(\$9,853)
GHPP	(\$4,938)
MIA LTC	\$591
BCCTP	\$24
Grand Total	(\$14,176)

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	-\$80,500,000	-\$24,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$80,500,000	-\$24,500,000
FEDERAL FUNDS	\$80,500,000	\$24,500,000

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact of allocating unspent 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. 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 is due to the shift of DY 2012-13 HCCI rollover amounts to FY 2013-14. The Department will submit a waiver amendment for approval to rollover DY 2012-13 HCCI funding and expects approval in FY 2013-14.

Methodology:

1. The LIHP-HCCI total computable annual limit 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. In FY 2012-13, assume the Department will rollover available funding from DY 2010-11 and DY 2011-12 for a total of \$161 million FFP.
5. In FY 2013-14, assume the Department will rollover available funding from DY 2012-13 for a total of \$49 million FFP.
6. Assume funds will be split 50/50 between the state and DPHs.
7. General Fund savings of \$80.5 million and \$24.5 million is expected in FY 2012-13 and FY 2013-14, respectively.

(In Millions)		
FY 2012-13	FFP	GF
HCCI Rollover		
DY 2010-11	(\$88.00)	\$0.00
DY 2011-12	(\$73.00)	\$0.00
Total	(\$161.00)	\$0.00
 SNCP-DPHs	 \$80.50	 \$0.00
SNCP-DSHPs	\$80.50	(\$80.50)
 FY 2013-14		
HCCI Rollover		
DY 2012-13	(\$49.00)	\$0.00
 SNCP-DPHs	 \$24.50	 \$0.00
SNCP-DSHPs	\$24.50	(\$24.50)

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	-\$140,628,000
- STATE FUNDS	\$0	-\$70,314,000
PAYMENT LAG	1.0000	0.8286
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$116,524,400
STATE FUNDS	\$0	-\$58,262,180
FEDERAL FUNDS	\$0	-\$58,262,180

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 Non-Designated Public Hospitals (NDPHs) and freezing rates at the July 1, 2013 level.

Authority:

SB 853 (Chapter 717, Statutes 2010), Welfare & Institutions Code 14105.28

Interdependent Policy Changes:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

Currently, private hospitals and NDPHs 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 hospitals, Medi-Cal reimburses FFS inpatient services with cost-based interim per-diem rates.

Under the current payment system, these 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 private hospitals 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.

DRG - INPATIENT HOSPITAL PAYMENT METHODOLOGY

REGULAR POLICY CHANGE NUMBER: 101

AB 1467 (Chapter 23, Statutes of 2012) changed the NDPH reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. The Department submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS), but because CMS approval has not been received timely, the Department is no longer pursuing this reimbursement change. NDPHs will continue to receive payments under the current methodology through December 31, 2013. These hospitals will transition to a DRG payment system on January 1, 2014.

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 July 1, 2013 level will directly impact managed care capitation rates.

Reason for Change from Prior Estimate:

The change is due to updated data which indicates FY 2013-14 expenditures under the current methodology will be \$3,057,677,000 TF instead of \$3,217,878,000 TF and DRG expenditures will be \$2,956,833,000 TF instead of \$3,115,067,000 TF.

Methodology:

1. Assume the DRG payment methodology will be implemented on July 1, 2013 for private hospitals.
2. Assume the DRG payment methodology will be implemented on January 1, 2014 for NDPHs and savings will be insignificant.
3. 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 private hospital expenditures under the current methodology are estimated to be \$3,057,677,000 TF.
4. FY 2013-14 FFS payments for private hospitals under the DRG payment system that will be frozen at the July 1, 2013 level are estimated to be \$2,956,833,000 TF.
5. Based on private hospital data, annual FFS savings are estimated to be:

$$\$3,057,677,000 - \$2,956,833,000 = \$100,844,000 \text{ TF } (\$50,422,000 \text{ GF}) \text{ FFS Savings}$$
6. 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	(100,844)	(50,422)
Managed Care	(39,784)	(19,892)
Total savings	(140,628)	(70,314)

Funding:

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

MH/UCD—FEDERAL FLEX. & STABILIZATION-SNCP

REGULAR POLICY CHANGE NUMBER: 103
 IMPLEMENTATION DATE: 7/2010
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1459

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	-\$10,557,000	-\$28,925,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	-\$10,557,000	-\$28,925,000
FEDERAL FUNDS	\$10,557,000	\$28,925,000

DESCRIPTION**Purpose:**

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

Authority:

Welfare & 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 & 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:

The changes are due to updated program expenditures.

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.

3. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP 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 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 (EAPC, CMSP, & ADAP)	\$10,557	\$10,557
FY 2013-14		
CMHS	\$28,925	\$28,925

Funding:

GF (4260-101-0001)

Health Care Support Fund (4260-601-7503)

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	-\$49,136,000	-\$36,618,000
- STATE FUNDS	-\$24,568,000	-\$18,309,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$49,136,000	-\$36,618,000
STATE FUNDS	-\$24,568,000	-\$18,309,000
FEDERAL FUNDS	-\$24,568,000	-\$18,309,000

DESCRIPTION

Purpose:

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

Authority:

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 and FY 2013-14. 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:

Delay hospital stabilization savings of \$36.618 million TF (\$18.309 million GF) to FY 2013-14.

Methodology:

1. A total of \$49.136 million TF (\$24.568 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.
2. A total of \$36.618 million TF (\$18.309 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 2013-14.

The estimated GF savings are:

(In Thousands)		TF	GF
FY 2012-13			
FY 2005-06	Private	(\$7,022)	(\$3,511)
FY 2006-07	Private	(\$12,714)	(\$6,357)
FY 2007-08	NDPH	(\$1,614)	(\$807)
FY 2008-09	Private	(\$2,586)	(\$1,293)
FY 2009-10	Private	(\$25,200)	(\$12,600)
	Total:	(\$49,136)	(\$24,568)
 FY 2013-14			
FY 2005-06	Private	(\$3,556)	(\$1,778)
FY 2006-07	Private	(\$6,432)	(\$3,216)
FY 2007-08	NDPH	(\$538)	(\$269)
FY 2008-09	Private	(\$1,308)	(\$654)
FY 2009-10	Private	(\$24,784)	(\$12,392)
	Total:	(\$36,618)	(\$18,309)

Funding:

Title XIX 50/50 FFP (4260-101-0001/0890)
 NDPH Supplemental Fund (4260-601-3096)
 Private Hospital Supplemental Fund (4260-601-3097)

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	-\$161,000,000	-\$49,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$161,000,000	-\$49,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$161,000,000	-\$49,000,000

DESCRIPTION

Purpose:

This policy change estimates the fiscal impact of allocating unspent 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. 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 is due to the shift of DY 2012-13 HCCI rollover amounts to FY 2013-14. The Department will submit a waiver amendment for approval to rollover DY 2012-13 HCCI funding and expects approval in FY 2013-14.

Methodology:

1. The LIHP-HCCI total computable annual limit 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. In FY 2012-13, assume the Department will rollover available funding from DY 2010-11 and DY 2011-12 for a total of \$161 million FFP.
5. In FY 2013-14, assume the Department will rollover available funding from DY 2012-13 for a total of \$49 million FFP.
6. 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
Total	(\$161.00)	\$0.00
SNCP-DPHs	\$80.50	\$0.00
SNCP-DSHPs	\$80.50	(\$80.50)
 FY 2013-14		
HCCI Rollover		
DY 2012-13	(\$49.00)	\$0.00
SNCP-DPHs	\$24.50	\$0.00
SNCP-DSHPs	\$24.50	(\$24.50)

Funding:

Health Care Support Fund (4260-601-7503)

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 111
 IMPLEMENTATION DATE: 5/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1588

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$391,994,000	\$678,988,000
- STATE FUNDS	\$195,997,000	\$339,494,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$391,994,000	\$678,988,000
STATE FUNDS	\$195,997,000	\$339,494,000
FEDERAL FUNDS	\$195,997,000	\$339,494,000

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

Reason for Change from Prior Estimate:

The prior estimate was based upon preliminary data. Final amounts have now been determined.

MANAGED CARE PUBLIC HOSPITAL IGTS

REGULAR POLICY CHANGE NUMBER: 111

Methodology:

The SPD enrollment transition occurred over a period of time beginning June 1, 2011. The initial IGT was estimated to be \$152.9 million for the period June 1, 2011 through June 30, 2012, which is assumed to be transferred in FY 2012-13 after CMS approval. A portion of the FY 2012-13 is \$43.1 million and expected to be paid in FY 2012-13. The remaining FY 2012-13 IGT is \$141.8 million and is expected to be paid in FY 2013-14. The FY 2013-14 IGT is \$339.4 million and is expected to be paid in FY 2013-14.

(In Thousands)	IGT	FFP	TF
FY 2012-13			
FY 2011-12	\$152,939	\$152,939	\$317,222
FY 2012-13	\$43,058	\$43,058	\$86,115
Total	\$195,997	\$195,997	\$391,994
 FY 2013-14			
FY 2012-13	\$141,862	\$141,862	\$283,724
FY 2013-14	\$197,632	\$197,632	\$395,264
Total	\$339,494	\$339,494	\$678,988

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	\$529,151,000	\$500,119,000
- STATE FUNDS	\$236,083,000	\$245,938,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$529,151,000	\$500,119,000
STATE FUNDS	\$236,083,000	\$245,938,000
FEDERAL FUNDS	\$293,068,000	\$254,181,000

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, Mendocino, and Ventura Counties are expected to be effective retroactive to 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 reinstitute 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 Gross Premium Tax policy change.

Capitation rate increases due to the gross premium tax are initially paid from the General Fund. The General Fund is then reimbursed in arrears through a funding adjustment from the gross premium tax fund on a quarterly basis. The reimbursement is budgeted in the Funding Adjustment of Gross Premium Tax to General Fund policy change.

(In Thousands)**FY 2012-13**

	IGT*	Regular FFP	ARRA FFP	T21 FFP	Total FFP	TF
Total	\$236,083	\$252,474	\$23,450	\$17,143	\$293,068	\$529,151

FY 2013-14

	IGT*	Regular FFP	T21 FFP	Total FFP	TF
Total	\$245,938	\$236,322	\$17,859	\$254,181	\$500,119

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: 1/2014
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1653

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$503,439,000
- STATE FUNDS	\$0	\$503,439,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$503,439,000
STATE FUNDS	\$0	\$503,439,000
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 January 1, 2014.

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 September 2013 to January 2014.

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	\$0	\$0	\$0	\$0
Managed Care Payments:				
Non HCBS	\$1,110,274	\$555,137	\$555,137	\$0
HCBS	\$556,006	\$262,900	\$293,106	\$0
Existing Mgd. Care duals	-\$1,142	-\$571	-\$571	\$0
Total	\$1,665,138	\$817,466	\$847,672	\$0
FFS Savings:				
Non HCBS	-\$712,506	-\$356,253	-\$356,253	\$0
HCBS	-\$2,624	-\$1,312	-\$1,312	\$0
Defer Mgd. Care Payment	-\$437,828	-\$218,914	-\$218,914	\$0
Total	-\$1,152,958	-\$576,479	-\$576,479	\$0
IHSS FFS Savings (In the Base)	-\$243,099	\$0	-\$243,099	\$0
Delay 1 Checkwrite (In the Base)	\$39,641	\$19,820	\$19,820	\$0
Transfer of IHSS Costs to DHCS	\$0	-\$242,189	\$0	\$242,189
Transfer of IHSS Costs to CDSS	\$503,439	\$0	\$0	\$503,439
Other Administration Costs	\$5,172	\$2,543	\$2,629	\$0
Total of CCI PCs including pass through	\$817,332	\$21,161	\$50,543	\$745,628

Funding:

100% Reimbursement (4260-610-0995)

RETRO MC RATE ADJUSTMENTS FOR FY 2011-12

REGULAR POLICY CHANGE NUMBER: 114
 IMPLEMENTATION DATE: 5/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1750

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$297,163,000	\$0
- STATE FUNDS	\$148,581,500	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$297,163,000	\$0
STATE FUNDS	\$148,581,500	\$0
FEDERAL FUNDS	\$148,581,500	\$0

DESCRIPTION

Purpose:

This policy change estimates managed care capitation rate increases for FY 2011-12.

Authority:

Welfare & Institutions Code, section 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:

Retroactive rate adjustments are due to the rate redeterminations for the Rate Year 2011-12 for Two Plan, COHS, and GMC. Capitation rate increases for FY 2011-12 will be paid in FY 2012-13.

Reason for Change from Prior Estimate:

The previous estimate was based upon estimated rate increases. This estimate reflects final rate redeterminations.

Methodology:

- The Department determined the difference between what was calculated to be paid for FY 2011-12 and what was actually paid for FY 2011-12. This difference will be paid in FY 2012-13.

(In Thousands)

FY 2012-13	<u>FF</u>	<u>GF</u>	<u>TF</u>
Two Plan	\$131,061	\$131,062	\$262,123
COHS	\$4,479	\$4,479	\$8,958
GMC	\$13,041	\$13,041	\$26,082
Total	\$148,581	\$148,582	\$297,163

RETRO MC RATE ADJUSTMENTS FOR FY 2011-12

REGULAR POLICY CHANGE NUMBER: 114

Funding:

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

MANAGED CARE COST-BASED REIMBURSEMENT CLINICS

REGULAR POLICY CHANGE NUMBER: 116
 IMPLEMENTATION DATE: 5/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1618

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$89,761,000	\$174,700,000
- STATE FUNDS	\$44,880,500	\$87,350,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$89,761,000	\$174,700,000
STATE FUNDS	\$44,880,500	\$87,350,000
FEDERAL FUNDS	\$44,880,500	\$87,350,000

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 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 account for the CBRCs rates that will not be received and approved until FY 2012-13. Payments will not be made until approval is received from the Centers for Medicare and Medicaid Services (CMS). It is expected that the FY 2011-12 costs will be paid in FY 2013-14. FY 2012-13 costs are expected to be paid in FY 2013-14.

MANAGED CARE COST-BASED REIMBURSEMENT CLINICS

REGULAR POLICY CHANGE NUMBER: 116

Methodology:

1. Assume managed care payments will be retroactive to July 1, 2011.
2. Rate Year 2010-11 and Rate Year 2011-12 retroactive costs of \$89,761,000 will be paid in FY 2012-13.
3. Rate Year 2012-13 costs of \$99,700,000 for the period of October 1, 2012, to September 30, 2013, will be paid in FY 2013-14.
4. Rate Year 2013-14 costs of \$75,000,000 for the period of October 1, 2013, to June 30, 2014, will be paid in FY 2013-14.
5. While the transition of these costs from FFS to managed care is effective July 1, 2011, the adjustment to the managed care plan payments will not begin until FY 2012-13 when CMS approval is anticipated.
6. Managed care payments will begin in May 2013. Retroactive payments for July 2011 through September 2012 will also be paid in May 2013.
7. The FFS savings which began in July 2011 are fully reflected in the base estimate.

	<u>TF</u>	<u>GF</u>	<u>FFP</u>
FY 2012-13	\$89,761,000	\$44,880,500	\$44,880,500
FY 2013-14	\$174,700,000	\$87,350,000	\$87,350,000

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	\$11,476,000	\$5,512,000
- STATE FUNDS	\$5,076,000	\$2,711,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$11,476,000	\$5,512,000
STATE FUNDS	\$5,076,000	\$2,711,000
FEDERAL FUNDS	\$6,400,000	\$2,801,000

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 expenditures. The GPT dollars come from the FY 2010-11 and FY 2011-12 Intergovernmental Transfers (IGTs) paid in FY 2012-13, the Ventura IGT paid in FY 2011-12, and the FY 2011-12 Two-Plan IGT paid in 2013-14. Changes are due to the increases in rates due to the implementation of SB 335 (Chapter 286, Statutes of 2011) and SB 208 (Chapter 714, Statutes of 2010) IGTs. Capitation rates starting July 1, 2011, and forward are affected by these mandates.

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)	\$5,076,000	\$2,711,000
FF (Title XIX) (Item 4260-101-0890)	\$5,479,000	\$2,605,000
FF (Title XXI) (Item 4260-113-0890)	\$370,000	\$196,000
ARRA (Item 4260-101-0890)	\$551,000	\$0
Total	\$11,476,000	\$5,512,000

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.

In February 2013, the Office of Legal Services delivered Molina a \$1.1 million check as settlement for *Molina Healthcare of California v. Toby Douglas*.

Reason for Change from Prior Estimate:

There is no change.

Funding:

100% General Fund (4260-101-0001)

MANAGED CARE IGT ADMIN. & PROCESSING FEE

REGULAR POLICY CHANGE NUMBER: 125
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1601

	<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 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:

The policy change was revised to incorporate updated IGT amounts.

Methodology:

1. The fee will be 20% of each IGT.
2. The state support costs are budgeted under state support. This policy change only budgets for the Local Assistance Reimbursement to GF amount.
3. Total IGT for FY 2012-13 is \$263,083,000. The FY 2010-11 San Mateo IGT, which will be paid out in FY 2012-13, is \$5,019,000. The 2012-13 IGT amount subject to the fee is \$231,065,000.

(In Thousands)	IGT amount subject to the fee	20% Admin. & Processing Fee	-	Support Cost Reimbursement to GF	=	Local Assistance Reimbursement to GF
FY 2012-13	\$ 231,065	\$ 46,213	-	\$ 251	=	\$ 45,962
FY 2013-14	\$ 245,938	\$ 49,188	-	\$ 251	=	\$ 48,937

Funding:

Reimbursement (4260-610-0995)

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 126
 IMPLEMENTATION DATE: 5/2013
 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 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

Previous estimates were based on various assumptions on high level data. They have been refined with an approved methodology and more detailed data.

Methodology:

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

GENERAL FUND REIMBURSEMENTS FROM DPHS

REGULAR POLICY CHANGE NUMBER: 126

2. Assume the initial General Fund repayment for the period July 1, 2011, through June 30, 2012, will be \$66,404,000 and will be made in FY 2012-13.
3. Assume the General Fund repayment for the period July 1, 2012, through December 31, 2012, will be \$20,508,000 and will be made in FY 2012-13.
4. Assume the General Fund repayments for the remaining FY 2012-13 period for January 1, 2013, through June 30, 2013, will be \$78,941,000. The period July 1, 2013, through June 30, 2014, will be \$54,574,000. The total repayment of \$133,514,000 will be made in FY 2013-14.

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
July 2011-June 2012 Reimbursement from DPHs	\$ 66,404,000	\$ 0
July 2012-December 2012 Reimbursement from DPHs	\$ 20,508,000	\$ 0
January 2013-June 2013 Reimbursement from DPHs	\$ 0	\$ 78,940,000
July 2013-June 2014 Reimbursement from DPHs	\$ 0	\$ 54,574,000
Total Reimbursement	\$ 86,912,000	\$ 133,514,000
GF	-\$ 86,912,000	-\$ 133,514,000
Net Impact	\$ 0	\$ 0

Funding:

Reimbursement (4260-610-0995)

100% State GF (4260-101-1001)

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)
 SB 853 (Chapter 717, Statutes of 2010)
 ABX1 21 (Chapter 11, Statutes of 2011)

Interdependent Policy Changes:

PC 120 Increase in Capitation Rates for Gross Premium Tax
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

FUNDING ADJUSTMENT OF GROSS PREMIUM TAX TO GF

REGULAR POLICY CHANGE NUMBER: 127

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.

Reason for Change from Prior Estimate:

Updated to reflect the FY 2010-11 and FY 2011-12 expenditures. The GPT dollars come from the FY 2010-11 and FY 2011-12 Intergovernmental Transfers (IGTs) paid in FY 2012-13, the Ventura IGT paid in FY 2011-12, and the FY 2011-12 Two-Plan IGT paid in 2013-14. Changes are due to the increases in rates due to the implementation of SB 335 (Chapter 286, Statutes of 2011) and SB 208 (Chapter 714, Statutes of 2010) IGTs. Capitation rates starting July 1, 2011, and forward are affected by these mandates.

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	\$5,076,000
GF	-\$5,076,000
Total	\$0
	FY 2013-14
Total Gross Premium Tax	\$2,711,000
GF	-\$2,711,000
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:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

FFS COSTS FOR MANAGED CARE ENROLLEES

REGULAR POLICY CHANGE NUMBER: 128

	Expenditures by Aid Category		
	Other	CCS/GHPP	Total
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

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: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1749

	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 capitated payments associated with the transition of Medi-Cal beneficiaries out of Senior Care Action Network (SCAN) and into Coordinate Care Initiative (CCI) managed care plans.

Authority:

Welfare & Institutions Code 14204

Interdependent Policy Changes:

PC 118 Senior Care Action Network (Other M/C)
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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 Department executed a one-year contract extension for January 1, 2013 through December 31, 2013. The contract extension facilitates transition of the SCAN Medi-Cal population into CCI managed care plans.

Reason for Change from Prior Estimate:

New eligible data from July to December 2012 resulted in new projections of plan enrollment.

Methodology:

1. Assume the transition of total SCAN membership will occur on January 1, 2014.

SCAN TRANSITION TO MANAGED CARE

REGULAR POLICY CHANGE NUMBER: 129

2. Assume the transition of total SCAN membership into the CCI managed care plan of the beneficiary's choice.
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	30,360	(\$11,800,000)	(\$11,800,000)	\$0
Riverside	9,976	(\$3,740,000)	(\$3,740,000)	\$0
San Bernardino	6,271	(\$2,166,000)	(\$2,166,000)	\$0
Total (Rounded)	46,607	(\$17,706,000)	(\$17,706,000)	\$0

Funding:

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

DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM PHC

REGULAR POLICY CHANGE NUMBER: 130
 IMPLEMENTATION DATE: 10/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1482

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$535,000
- STATE FUNDS	\$0	-\$267,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$535,000
STATE FUNDS	\$0	-\$267,500
FEDERAL FUNDS	\$0	-\$267,500

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 is expected to occur on October 1, 2013.

Reason for Change from Prior Estimate:

The implementation date has been changed from January 1, 2013, to October 1, 2013.

Methodology:

1. It is assumed the annual member months for undocumented beneficiaries in FY 2013-14 will be 3,430 for Solano County, 1,718 for Napa County, and 1,880 for Yolo County.
2. 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.

**DISCONTINUE UNDOCUMENTED BENEFICIARIES FROM
PHC
REGULAR POLICY CHANGE NUMBER: 130**

3. The FY 2013-14 cost, for period October 1, 2013 through June 30, 2014, for undocumented beneficiaries by county is expected to be:

Solano County:	$3,430 \times \$361.62 \times .75 = \$930,000$
Napa County:	$1,718 \times \$545.40 \times .75 = \$703,000$
Yolo County:	$1,880 \times \$567.19 \times .75 = \$800,000$

$$\$930,000 + \$703,000 + \$800,000 = \$2,433,000$$

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

FY 2013-14	\$2,433,000	FFS cost
	<u>-\$2,433,000</u>	Managed Care savings
	\$0	FY 2013-14 impact of shift to FFS

5. There will be a net savings in FY 2013-14 due to the capitation payments ending on September 30, 2013. There will be a lag in FFS payments due to the time it take for providers to bill and be paid for services.

	FY 2013-14
Managed Care Savings	<u>-\$2,433,000</u>
FFS Cost	\$2,433,000
FFS Payment Lag	0.7802
Lagged FFS Costs	<u>\$1,898,000</u>
Net costs (Rounded)	-\$535,000

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	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 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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

AB 1467 requires beneficiaries in the Family, Seniors, and Persons with Disabilities (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 default ratios prior to AB 1467.

Reason for Change from Prior Estimate:

No change

Methodology:

1. Implementation began July 1, 2012.
2. All Two-Plan and GMC counties will participate.

MANAGED CARE DEFAULT ASSIGNMENT**REGULAR POLICY CHANGE NUMBER: 131**

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 changes 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: 9/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1651

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$161,079,000
- STATE FUNDS	\$0	\$80,539,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$161,079,000
STATE FUNDS	\$0	\$80,539,500
FEDERAL FUNDS	\$0	\$80,539,500

DESCRIPTION

Purpose:

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

The implementation date changed from June to September 2013. Fee-for-service and managed care costs were updated.

Methodology:

1. The expansion will occur on September 1, 2013.
2. Assume that costs for the expansion will be 96% of current FFS costs.

MANAGED CARE EXPANSION TO RURAL COUNTIES

REGULAR POLICY CHANGE NUMBER: 132

3. The expansion of managed care will result in a cost in FY 2013-14 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:

	FY 2013-14
Managed Care Capitation Payments	\$963,921,000
FFS Savings	-\$1,004,084,000
FFS Payment Lag	.7996
FFS Lagged Savings	-\$802,842,000
FY Cost (Rounded)	\$161,079,000

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:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

There is no change.

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	<u>\$3,302,000</u>	<u>\$1,651,000</u>
Total for FY 2012-13	(\$36,332,000)	(\$18,166,000)
 FY 2013-14		
Potentially Preventable Admissions	<u>(\$39,634,000)</u>	<u>(\$19,817,000)</u>
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	\$25,550,000	\$106,752,000
- STATE FUNDS	\$12,775,000	\$53,376,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$25,550,000	\$106,752,000
STATE FUNDS	\$12,775,000	\$53,376,000
FEDERAL FUNDS	\$12,775,000	\$53,376,000

DESCRIPTION

Purpose:

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

Authority:

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:

Because this policy was implemented in September 2012, both managed care savings and FFS costs are partially reflected in the base.

Methodology:

1. Assume an average of 53,467 eligibles is affected each month.
2. A per-member-per-month (PMPM) of \$450 was assumed to cover the costs of the retroactive services.

ALIGN MANAGED CARE BENEFIT POLICIES**REGULAR POLICY CHANGE NUMBER: 134**

3. Assume a three-month delay in FFS due to the time required to enroll potential beneficiaries into Medi-Cal.
4. The FFS payment pattern was used to calculate the potential savings.
5. Because this change took place July 1, 2012, the COHS eligible projections and FFS costs are already affected by the change. Therefore, this policy change only reflects those portions of costs and savings that are not already in the base estimate.

The impact of the change in Total Funds is:

	Total	Applied to Base
FY 2012-13		
Align Managed Care Benefit Policies	(\$117,595,000)	\$1,490,000
Defer Managed Care Payment	\$24,060,000	\$24,060,000
Total	(\$93,535,000)	\$25,550,000
FY 2013-14		
Align Managed Care Benefit Policies	-\$2,815,000	\$106,752,000

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	-\$1,150,471,000	-\$1,152,958,000
- STATE FUNDS	-\$575,235,500	-\$576,479,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,150,471,000	-\$1,152,958,000
STATE FUNDS	-\$575,235,500	-\$576,479,000
FEDERAL FUNDS	-\$575,235,500	-\$576,479,000

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 214 Transition of Dual Eligibles-Managed Care Payments
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 135

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 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.

Reason for Change from Prior Estimate:

The implementation changed from September 2013 to January 2014.

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 January 1, 2014. Medicare FFS beneficiaries from San Mateo County will enroll over 3 months in even increments. Medicare FFS beneficiaries from the other seven 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 January 2013 who will start to receive the enhanced LTSS services from a managed care plan in the eight pilot counties.
4. Assume for participating dual eligibles, there will be an overall average 1.15% savings in FY 2013-14.
5. For non-dual eligibles, savings were calculated as follows:
 - Assume Inpatient Care will be reduced by 8.9% in FY 2013-14 and thereafter.
 - Assume LTC institutional services will be reduced by 4.2% in FY 2013-14. Assume it will be reduced by 10.9% annually thereafter.
 - 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.
 - Assume MSSP services will remain the same.
 - Savings were calculated based on actual expenditures during calendar year 2010, trended forward, for Medi-Cal beneficiaries utilizing nursing home, HCBS, and dual eligible without LTC institutional services.
6. FY 2012-13 dollars are due to the savings from deferring one managed care payment.
7. The delay in checkwrite is shown here for display purposes. The Fee For Service savings due to the CCI will result in a loss of savings in the delay of the checkwrite. The delay in checkwrite amounts for both FYs 2012-13 and 2013-14 are included in the base trend data. The delay in checkwrite for FY 2012-13 is \$320 million.

TRANSITION OF DUAL ELIGIBLES-LONG TERM CARE

REGULAR POLICY CHANGE NUMBER: 135

The chart 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	\$0	\$0	\$0	\$0
Managed Care Payments:				
Non HCBS	\$1,110,274	\$555,137	\$555,137	\$0
HCBS	\$556,006	\$262,900	\$293,106	\$0
Existing Managed Care duals	<u>-\$1,142</u>	<u>-\$571</u>	<u>-\$571</u>	<u>\$0</u>
Total	\$1,665,138	\$817,466	\$847,672	\$0
FFS Savings:				
Non HCBS	-\$712,506	-\$356,253	-\$356,253	\$0
HCBS	-\$2,624	-\$1,312	-\$1,312	\$0
Defer Mgd. Care Payment	<u>-\$437,828</u>	<u>-\$218,914</u>	<u>-\$218,914</u>	<u>\$0</u>
Total	-\$1,152,958	-\$576,479	-\$576,479	\$0
IHSS FFS Savings (In the Base)	-\$243,099	\$0	-\$243,099	\$0
Delay 1 Checkwrite (In the Base)	\$39,641	\$19,820	\$19,820	\$0
Transfer of IHSS Costs to DHCS	\$0	-\$242,189	\$0	\$242,189
Transfer of IHSS Costs to CDSS	\$503,439	\$0	\$0	\$503,439
Other Administration Costs	\$5,172	\$2,543	\$2,629	\$0
Total of CCI PCs including pass through	\$817,332	\$21,161	\$50,543	\$745,628

Funding:

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

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 136
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1659

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,426,051,000
- STATE FUNDS	\$0	\$129,448,500
PAYMENT LAG	1.0000	0.9516
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,357,030,100
STATE FUNDS	\$0	\$123,183,190
FEDERAL FUNDS	\$0	\$1,233,846,940

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 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

Section 1202 of the ACA requires Medi-Cal to increase primary care physician 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, American Board of Physician Specialties, and American Osteopathic Association. In addition, the rate

PAYMENTS TO PRIMARY CARE PHYSICIANS

REGULAR POLICY CHANGE NUMBER: 136

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, 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 March 1, 2013 to July 1, 2013 because the federal proposal has not been finalized, and payment system components need changes to implement the rate increase.
- The current estimate utilizes the 2013 Medicare Physician Fee Schedule to project the expenditures.

Methodology:

1. Implementation is expected to begin July 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 year 2014 are not available. As a result, for FY 2013-14, the 2013 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 45% of Medicare. The incremental increase needed to reach Medicare levels totaled \$389,698,000 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. ACA payments for primary care services are exempt from AB 97 (Chapter 3, Statutes of 2011) payment reductions.

The Department projects costs of \$258,897,000 TF (\$129,448,500 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	\$389,698
Managed care	\$390,093
	<u>\$779,791</u>

(Dollars In Thousands)

FY 2013-14	TF	FFP	GF
FFS	\$389,698	\$389,698	\$0
FFS Retro	\$192,316	\$192,316	\$0
Managed Care	\$390,093	\$390,093	\$0
Managed Care Retro	\$195,047	\$195,047	\$0
Total Increase Payment	<u>\$1,167,154</u>	<u>\$1,167,154</u>	<u>\$0</u>
FFS (AB97 Savings Lost)	\$109,248	\$54,624	\$54,624
Managed Care (AB97 Savings Lost)	\$149,649	\$74,825	\$74,824
Total AB 97 Savings Lost	<u>\$258,897</u>	<u>\$129,449</u>	<u>\$129,448</u>
Grant Total	\$1,426,051	\$1,296,603	\$129,448

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	3.46 %	3.72 %
APPLIED TO BASE		
TOTAL FUNDS	\$181,155,500	\$190,060,300
STATE FUNDS	\$90,577,740	\$95,030,140
FEDERAL FUNDS	\$90,577,740	\$95,030,140

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 & Institutions Code, section 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:

There is no material change.

Methodology:

(In Thousands)

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FQHCs Reconciliation	\$95,798	\$81,390
RHCs Reconciliation	\$3,661	\$4,883
LA CBRCs Reconciliation	\$80,569	\$80,954
July 2012 LA CBRC Rate Increase	\$9,000	\$9,000
July 2013 LA CBRC Rate Increase		\$25,000
Total	\$189,028	\$201,227

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	\$72,772,000	\$171,079,000
- STATE FUNDS	\$36,386,000	\$85,539,500
PAYMENT LAG	0.9155	0.9421
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$66,622,800	\$161,173,500
STATE FUNDS	\$33,311,380	\$80,586,760
FEDERAL FUNDS	\$33,311,380	\$80,586,760

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

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates

PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment

PC 228 MCO Tax Managed Care Plans

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.

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA) Fund. Effective August 1, 2013, the revenue generated by the collected LTC QA fee will be deposited into that fund, rather than the state General Fund (GF), which will be used for LTC provider reimbursement rate expenditures. The cost of the NF-B rate adjustment funded by LTC QA fee will

NF-B RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 138

continue to be budgeted in the GF. The Long Term Care Quality Assurance Fund Expenditure policy change budgeted the funding adjustment.

Reason for Change from Prior Estimate:

The changes are due to updated add-on rates and QA fee revenues in FY 2012-13 and FY 2013-14.

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 1.26% rate increase in the 2012-13 rate year. This policy change budgets the cost of the 1.26% rate increase. The savings 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.

NF-B RATE CHANGES**REGULAR POLICY CHANGE NUMBER: 138**

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.

(Dollars in Thousands)		
FFS	FY 2012-13	FY 2013-14
Rate Adjustment	\$32,140	\$111,124
MDS Add-On	\$7,227	\$657
Immunization Add-On	\$3,542	\$322
5010 Transaction Add-On	\$2,551	\$232
Informed Consent Add-On	\$1,842	\$2,010
Std Admin Add-On	\$284	\$309
CMS Revalidation Add-on	\$284	\$26
FUTA Add-on	\$1,559	\$1,700
Elder Justice Act Add-on	\$142	\$155
FFS Total	\$49,571	\$116,535
Managed Care	\$23,201	\$54,544
Total	\$72,772	\$171,079

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: 11/2012
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1617

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$78,878,000	\$0
- STATE FUNDS	\$39,439,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	100.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$0

DESCRIPTION

Purpose:

This policy change estimates the 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.

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:

The supplemental payment amount was updated based on the actual data.

Methodology:

1. Implementation of the 10% reduction began May 1, 2012 and ended July 31, 2012 for FFS. The reduction was not applied retroactively.
2. The cost of the one-time payment is \$78,878,000 TF (\$39,439,000 GF).
3. The amount of the reduction for AB 1629 facilities in FY 2011-12 was \$59,159,000 TF and \$19,719,000 TF in FY2012-13.

10% PYMT REDUCTION RESTORATION FOR AB 1629 FAC.**REGULAR POLICY CHANGE NUMBER: 139**

4. The Department completed reduction restoration payments in December 2012.
5. The increase in revenues due to the one-time payment will increase the amount of Quality Assurance (QA) fee collected.

\$78,878,000 (increased payments) - \$4,733,000 (more QA fee collection) = \$74,145,000 (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	\$21,986,000	\$98,636,000
- STATE FUNDS	\$10,993,000	\$49,318,000
PAYMENT LAG	0.9154	0.9291
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$20,126,000	\$91,642,700
STATE FUNDS	\$10,062,990	\$45,821,350
FEDERAL FUNDS	\$10,062,990	\$45,821,350

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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 24, 2010, in the case of *CHA v. David Maxwell-Jolly*, the court enjoined the Department from continuing to implement the freeze in reimbursement at the 2008-09 rate levels for DP/NF-Bs, Rural Swing Beds, DP Adult Subacute, and DP Pediatric Subacute facilities.

LTC RATE ADJUSTMENT

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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, 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 has obtained 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, Rural Swing Beds, FS Pediatric Subacute, ICF/DD, ICF/DD-H and ICF/DD-N facilities during rate year (RY) 2012-13 and 2013-14.
2. **DP Adult Subacute and DP Pediatric Subacute facilities:** These two 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 these two 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.
3. **DP/NF-Bs:** DP/NF-Bs are the enjoined providers. Rates are currently paid at the 2011-12 level. The impact of court actions as to the implementation of AB 97 rate freeze is budgeted in the Non-AB 1629 LTC Rate Freeze policy change.
4. The estimated rate increases are:

	RY 2012-13	RY 2013-14
DP Adult Subacute	0.00%	6.07%
DP Pediatric Subacute	3.78%	3.19%
DP/NF-Bs	0.00%	5.13%

5. 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.

LTC RATE ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 140

6. 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.
7. 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 above-mentioned providers will be \$0.25 excluding ICF/DD-H and ICF/DD-N facilities, who will receive \$0.48.
8. 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. The ICF/DD-N facilities will receive \$0.22.
9. AB 1835 (Chapter 230, Statutes of 2006) required an increase in the minimum wage in California. The add-on was applied to the rate, effective August 1, 2008. An add-on from \$0.18 through \$0.64 to the rates to reimburse the facilities for the additional costs will be effective for 2012-13 and 2013-14 rate year.
10. 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.
11. 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.
12. 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.
13. 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.
14. 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

LTC RATE ADJUSTMENT

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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.

15. 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.
16. 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 2012-13 add-on from \$0.02 through \$0.05 is only applicable to ICF/DD-Hs and ICF/DD-Ns.
17. The estimated 11-month impact of the August 1, 2012 rate increase in FY 2012-13 for managed care plans is \$5,971,000 and these costs are included in this policy change.

LTC RATE ADJUSTMENT

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(In Thousands)

Fee-for-Service	FY 2012-13	FY 2013-14
DP Adult Subacute Rate Increase 2012-13	\$0	\$0
DP Pediatric Subacute Rate Increase 2012-13	\$793	\$865
FS Pediatric Subacute QAF Impact 2012-13	\$8,670	\$9,458
Retro Rate Increase	\$1,007	\$24,923
MDS 3.0 2012-13	\$1,022	\$93
Vaccine 2012-13	\$1,514	\$138
Adult Day Holiday 2012-13	\$422	\$38
Minimum Wage	\$889	\$81
New - 5010 Transaction Standards 2012-13	\$629	\$57
New - Informed Consent 2012-13	\$200	\$18
New- FUTA 2012-13	\$579	\$53
New- CMS Revalidation 2012-13	\$43	\$4
New - Std Adm Agreement 2012-13	\$39	\$3
New- Elder Justice Act 2012-13	\$106	\$10
New- Carbon Monoxide 2012-13	\$102	\$9
DP Adult Subacute Rate Increase 2013-14		\$18,116
DP Pediatric Subacute Rate Increase 2013-14		\$695
FS Pediatric Subacute QAF Impact 2013-14		\$8,948
DP/NF-Bs Rate Increase 2013-14		\$24,699
MDS 3.0 2013-14		\$692
Vaccine 2013-14		\$1,419
Adult Day Holiday 2013-14		\$422
Minimum Wage		\$458
New - 5010 Transaction Standards 2013-14		\$0
New - Informed Consent 2013-14		\$200
New- FUTA 2013-14		\$579
New- CMS Revalidation 2013-14		\$0
New - Std Adm Agreement 2013-14		\$39
New- Elder Justice Act 2013-14		\$106
New- Carbon Monoxide 2013-14		\$0
Total FFS	\$16,015	\$92,123
Managed care	\$5,971	\$6,513
Total Cost	\$21,986	\$98,636

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	\$25,378,000	\$27,686,000
- STATE FUNDS	\$12,689,000	\$13,843,000
PAYMENT LAG	0.9455	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$23,994,900	\$27,686,000
STATE FUNDS	\$11,997,450	\$13,843,000
FEDERAL FUNDS	\$11,997,450	\$13,843,000

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans
 PC 229 Long Term Care Quality Assurance Fund

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.

AB 1629 RATE ADJUSTMENTS DUE TO QA FEE INCREASE

REGULAR POLICY CHANGE NUMBER: 141

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

Health (CDPH), affect the amount of QAF that can be collected and remain within the federal safe harbor limit.

A rate increase of 1.27% was to be provided for the 2012-13 rate year. However that increase was eliminated upon the passage of AB 1489 which implemented a rate freeze in the 2012-13 rate year, and a 3% increase in the 2013-14 rate year. The savings from the elimination of the 1.973% rate increase is budgeted for in the Eliminate 2012-13 Rate Increase & Supplemental Payment policy change.

AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance (LTCQA) Fund. Effective August 1, 2013, the revenue generated by the collected LTC QA fee will be deposited into that fund, rather than the state General Fund (GF), which will be used for LTC provider reimbursement rate expenditures. The cost of the rate adjustment funded by LTC QA fee increase will continue to be budgeted in the GF. The Long Term Care Quality Assurance Fund Expenditure policy change budgeted the funding adjustment.

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.

(Dollars in Thousands)	FY 2012-13	
	TF	GF
FFS	\$11,158	\$5,579
Managed care	\$14,220	\$7,110
Total:	\$25,378	\$12,689
	FY 2013-14	
	TF	GF
FFS	\$12,173	\$6,086
Managed care	\$15,513	\$7,757
Total:	\$27,686	\$13,843

Funding:

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

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 142
 IMPLEMENTATION DATE: 11/2012
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1612

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$22,598,000	\$18,219,000
- STATE FUNDS	\$11,299,000	\$9,110,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$22,598,000	\$18,219,000
STATE FUNDS	\$11,299,000	\$9,110,000
FEDERAL FUNDS	\$11,299,000	\$9,109,000

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), Government Code 76000.10
 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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 142

Federal approval to distribute EMATA funds to emergency air medical transportation providers was obtained on November 12, 2012. In the initial phase, the Department provided supplemental payments for Medi-Cal air medical transportation services provided to Medi-Cal beneficiaries from January 7, 2012 to June 30, 2012 (Phase I). Upon federal approval 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:

- The Phase II implementation date changed from December 2012 to June 2013 because of delay in expected federal approval and implementing necessary system changes, and
- Revised penalty collections.

Methodology:

1. Implementation date began November 2012.
2. For the Phase I, \$7,641,000 EMATA funds were used to calculate supplemental payments per transport. 20% of this amount was used to offset the FY 2011-12 GF costs of fee-for-service (FFS) emergency air medical transportation services. The remaining 80% was 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:

(Dollars in Thousands)	EMATA Fund	GF Offset (20%)	25% Reserve	Available for Rate Augmentation
FY 2012-13				
Jul. 2012-Dec. 2012	\$12,228	\$2,446	\$2,446	\$7,336
Total	\$12,228	\$2,446	\$2,446	\$7,336
FY 2013-14				
Jan. 2013-Jun. 2013	\$5,798	\$1,159	\$1,160	\$3,479
Jul. 2013-Dec. 2013	\$5,799	\$1,160	\$1,160	\$3,479
Total	\$11,597	\$2,319	\$2,320	\$6,958

AIR AMBULANCE MEDICAL TRANSPORTATION

REGULAR POLICY CHANGE NUMBER: 142

5. The estimated payments on a cash basis are:

	(In Thousands)			
FY 2012-13	TF	GF	FFP	EMATA
GF Offset	\$0	(\$3,973)		\$3,973
FFS	\$18,930		\$9,465	\$9,465
Managed Care	\$3,668		\$1,834	\$1,834
Total	\$22,598	(\$3,973)	\$11,299	\$15,272
FY 2013-14				
GF Offset	\$0	(\$2,319)		\$2,319
FFS	\$14,740		\$7,370	\$7,370
Managed Care	\$3,479		\$1,739	\$1,740
Total	\$18,219	(\$2,319)	\$9,109	\$11,429

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	\$13,415,000	\$19,992,000
- STATE FUNDS	\$6,707,500	\$9,996,000
PAYMENT LAG	0.8902	0.8959
% REFLECTED IN BASE	81.46 %	23.74 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,214,100	\$13,658,800
STATE FUNDS	\$1,107,030	\$6,829,400
FEDERAL FUNDS	\$1,107,030	\$6,829,400

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:

The assumed utilization rate for 2013 increased to 5.06% instead of 2.83% and the 2013 MEI increased to 0.8% instead of 0.73%.

Methodology:

1. Assume utilization will increase 5.35% in year 2012 and 5.06% 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
9,918,061	5.35%	10,448,972
2012 Visits		2013 Visits
10,448,972	5.06%	10,977,828

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 MEI increase percent for year 2013 is 0.8%. Therefore, the rates are:

	Rate without MEI	Rate with MEI
2011	\$154.41	$\$154.41 \times (1+0.4\%) = \155.03
2012	\$155.03	$\$155.03 \times (1+0.6\%) = \155.96
2013	\$155.96	$\$155.96 \times (1+0.8\%) = \157.21

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	\$1,531,457	\$1,537,583	\$6,126
2012	\$1,619,889	\$1,629,608	\$9,719
2013	\$1,712,088	\$1,725,785	\$13,697

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	\$6,126	\$3,063
2012 MEI Increase	\$7,289	\$3,645
Total	\$13,415	\$6,708
FY 2013-14		
2012 MEI Increase	\$9,719	\$4,860
2013 MEI Increase	\$10,273	\$5,136
Total	\$19,992	\$9,996

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	\$4,910,000	\$11,465,000
- STATE FUNDS	\$2,455,000	\$5,732,500
PAYMENT LAG	0.8295	0.9104
% REFLECTED IN BASE	76.38 %	34.27 %
APPLIED TO BASE		
TOTAL FUNDS	\$962,000	\$6,860,700
STATE FUNDS	\$481,000	\$3,430,360
FEDERAL FUNDS	\$481,000	\$3,430,360

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:

- Updated Hospice National Rates for hospice services
- 100% FY 2011-12 expenditure in Base

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 1.60% 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 and 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%.

(Dollars in Thousands)	FY 2012-13	FY 2013-14
FY 2012-13 Hospice Services	\$905	\$1,207
FY 2012-13 Room & Board	\$4,005	\$4,369
FY 2013-14 Hospice Services		\$1,721
FY 2013-14 Room & Board		\$4,168
TOTAL	\$4,910	\$11,465

Funding:

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

QUALITY AND ACCOUNTABILITY PAYMENTS PROGRAM

REGULAR POLICY CHANGE NUMBER: 145
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1563

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$37,578,000
- STATE FUNDS	\$0	\$16,877,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$37,578,000
STATE FUNDS	\$0	\$16,877,000
FEDERAL FUNDS	\$0	\$20,701,000

DESCRIPTION

Purpose:

This policy change estimates:

- Transfer from the General Fund (GF) to a Skilled Nursing Facility Quality and Accountability Special Fund (Special Fund), and
- Supplemental payments to freestanding nursing facilities (NF-Bs) through the Special Fund.

Authority:

SB 853 (Chapter 717, Statutes of 2010), Welfare & 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 April 2014 and will be paid through the Special Fund. The Special Fund will be comprised of penalties collected from 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 Department reimburses the California Department of Public Health (CDPH) administrative costs from the Special Fund. See the FFP for Department of Public Health Support Cost other administration policy change.

Reason for Change from Prior Estimate:

There is no material change.

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 2012-13, total amount of \$4,250,000, PLI savings for 2012-13 rate year, will be transferred from the GF to the Special Fund. AB 1489 eliminates the FY 2012-13 transfer. See the Eliminate 2012-13 Rate Increase & Supp. Payment policy change.
3. In FY 2012-13 and FY 2013-14, \$200,000 in 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, \$26,756,000 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.
5. In FY 2013-14, supplemental payments are estimated to be \$41,402,000 TF (\$20,701,000 Special Fund).

(Dollars In Thousands)

FY 2012-13	<u>TF</u>	<u>SF</u>	<u>GF</u>	<u>FFP</u>
Transfer from GF* to Special Fund**	\$0	(\$4,250)	\$4,250	\$0
FY 2013-14				
Supplemental Payments***	\$41,402	\$20,701	\$0	\$20,701
Transfer from GF* to Special Fund**	(\$3,824)	(\$26,756)	\$22,932	\$0
Total	\$37,578	(\$6,055)	\$22,932	\$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)***

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 147
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1185

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$2,224,000	-\$2,000,000
- STATE FUNDS	-\$1,112,000	-\$1,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$2,224,000	-\$2,000,000
STATE FUNDS	-\$1,112,000	-\$1,000,000
FEDERAL FUNDS	-\$1,112,000	-\$1,000,000

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:

PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 147

Reason for Change from Prior Estimate:

The changes are due to:

- The Department terminated contracts with two dental plans and is in the process of collecting the outstanding amounts owed. The Department plans to collect the amount in FY 2013-14.
- Updated monthly eligibles

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 2013-14.
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)	825,616	(\$305,000)
21+	\$2.91	\$1.45	(\$1.46)	467,696	(\$683,000)
PHP Jan-June 2012					
<21	\$11.83	\$11.46	(\$0.37)	1,254,116	(\$464,000)
21+	\$2.91	\$1.45	(\$1.46)	528,328	(\$772,000)
Total FY 2012-13 Dental Retroactive Adjustments					(\$2,224,000)
Total FY 2013-14 Outstanding invoices					(\$2,000,000)

DENTAL RETROACTIVE RATE CHANGES

REGULAR POLICY CHANGE NUMBER: 147

Funding:

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

LABORATORY RATE METHDOLOGY CHANGE

REGULAR POLICY CHANGE NUMBER: 148
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1703

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$14,775,000
- STATE FUNDS	\$0	-\$7,387,500
PAYMENT LAG	1.0000	0.8950
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$13,223,600
STATE FUNDS	\$0	-\$6,611,810
FEDERAL FUNDS	\$0	-\$6,611,810

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 March 2013 to July 2013 because of delay in expected federal approval.
- The current estimate utilizes the updated expenditure data to project the savings.

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 July of 2013. The retroactive date for the 10% payment reduction is July 1, 2012.
2. The new laboratory rate methodology will be implemented on October 1, 2013.

LABORATORY RATE METHDOLOGY CHANGE**REGULAR POLICY CHANGE NUMBER: 148**

3. The projected weighted average savings for new reimbursement methodology is 10% for 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 \$9,850,000 TF.
6. Savings in FY 2013-14 will consist of nine months of the new methodology, three months of the 10% payment reduction savings, and 12 months of retroactive savings.
7. The total recoupment of the retroactive savings from July 1, 2012 to June 30, 2013, is estimated to be \$9,850,000 TF and is expected to recover over 24 months beginning July 2013.

Monthly Recoupment:

\$9,850,000 Total Recoupment / 24 Months = \$410,416

FY 2013-14 Recoupment:

\$410,416 Monthly Recoupment * 12 Months = \$4,925,000

(Dollars In
Thousands)**FY 2013-14**

	TF	GF
Savings	(\$9,850)	(\$4,925)
Recoupment	(\$4,925)	(\$2,462)
Total Savings:	(\$14,775)	(\$7,387)

Funding:

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

REDUCTION TO RADIOLOGY RATES

REGULAR POLICY CHANGE NUMBER: 149
 IMPLEMENTATION DATE: 5/2013
 ANALYST: Yao-Hui Yu
 FISCAL REFERENCE NUMBER: 1505

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$10,136,000	-\$60,813,000
- STATE FUNDS	-\$5,068,000	-\$30,406,500
PAYMENT LAG	0.5505	0.9581
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$5,579,900	-\$58,264,900
STATE FUNDS	-\$2,789,930	-\$29,132,470
FEDERAL FUNDS	-\$2,789,930	-\$29,132,470

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 & 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. Due to delay in expected federal approval, 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.

Reason for Change from Prior Estimate:

- The Department changed the implementation date from January 2013 to May 2013 because of delay in expected federal approval.
- Based on the discussion with Center for Medicare and Medicaid Services (CMS), the Department will not reduce 24 previously identified codes.

Methodology:

1. Implementation will begin in May 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%.

REDUCTION TO RADIOLOGY RATES**REGULAR POLICY CHANGE NUMBER: 149**

4. Based on 2010 Medi-Cal payment rate data, the rate reductions will result in an annual fee-for-service (FFS) savings of \$39,633,000. The 2010 Medi-Cal payment rate includes a 1% reduction to radiology services as required by AB 1183 (Chapter 758, Statutes of 2008).

FFS Monthly Savings:

\$39,633,000/12 months = \$3,303,000

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 April 30, 2013, is estimated to be \$33,028,000 and is expected to occur over 18.71 months beginning May 2013.

Total recoupment of retroactive savings:

\$39,633,000/12 months *10 months = \$33,028,000

Monthly recoupment amount is \$1,765,000

(Dollars In Thousands)

FY 2012-13

	TF	GF
2012-13 Savings	(\$6,606)	(\$3,303)
Recoupment of Retro Savings	(\$3,530)	(\$1,765)
Total	(\$10,136)	(\$5,068)

FY 2013-14

	TF	GF
2013-14 Savings	(\$39,633)	(\$19,817)
Recoupment of Retro Savings	(\$21,180)	(\$10,590)
Total	(\$60,813)	(\$30,407)

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	-\$1,354,000	-\$81,517,000
- STATE FUNDS	-\$677,000	-\$40,758,500
PAYMENT LAG	1.0000	0.8890
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,354,000	-\$72,468,600
STATE FUNDS	-\$677,000	-\$36,234,310
FEDERAL FUNDS	-\$677,000	-\$36,234,310

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.

NON-AB 1629 LTC RATE FREEZE

REGULAR POLICY CHANGE NUMBER: 150

Effective June 1, 2011, AB 97 requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5. The Department received approval from the Centers 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.

On December 13, 2012, the United States Court of Appeal for the Ninth Circuit issued a decision in which it reversed the previous issued injunctions against AB 97 payment reductions and rate freeze. The plaintiffs had requested a rehearing.

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 has obtained the 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. The effective date of AB 97 rate freeze is June 1, 2011.
2. Rates are currently being paid at the 2010-11 level for Rural Swings Beds and at the 2011-12 level for DP/NF-B.
3. It will take the Department at least three months to implement the rate freeze if the injunctions were lifted. Assume the Department receives favorable rulings by August 2013, implementation of the AB 97 rate freeze will resume beginning November 2013.
4. Assume the Department will recover rate freeze retroactive savings beginning February 1, 2014.

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	-\$43,198,000	-\$51,473,000
- STATE FUNDS	-\$21,599,000	-\$25,736,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$43,198,000	-\$51,473,000
STATE FUNDS	-\$21,599,000	-\$25,736,500
FEDERAL FUNDS	-\$21,599,000	-\$25,736,500

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
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

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 April 2014. The supplemental payments are budgeted in the Quality and Accountability Payments Program policy change.

ABX1 19 (Chapter 4, Statutes of 2011) provides AB 1629 facilities an overall rate increase of 1.26% for the 2012-13 rate year. The NF-B Rate Changes policy change budgets the rate increase.

ELIMINATE 2012-13 RATE INCREASE & SUPP. PAYMENT

REGULAR POLICY CHANGE NUMBER: 151

AB 1489:

- Freezes the AB 1629 facility rates for the 2012-13 rate year at the rate on file as of August 1, 2011,
- Provides a 3% rate increase for the 2013-14 rate year, and
- Retains 2012-13 savings from capping the PLI cost category at the 75th percentile in the GF.

The Centers for Medicare & Medicaid Services (CMS) approved the AB 1489 rate freeze State Plan Amendment (SPA) on December 19, 2012.

Reason for Change from Prior Estimate:

The changes are due to updated PLI data and long-term care quality assurance revenues in 2012-13 rate year.

Methodology:

1. The estimated savings from redirecting funding for 12-13 rate increases are \$47,184,000 TF (\$23,592,000 GF) in FY 2012-13 and \$51,473,000 TF (\$25,736,500 GF) in FY 2013-14.
2. The estimated 2012-13 PLI savings are \$4,250,000 GF in FY 2012-13.
3. The estimated savings from 3rd checkwrite payment deferral are \$74,800,000 TF (\$37,400,000 GF) and 100% incorporated in the Base Estimate.

(Dollars in Thousands)	<u>TF</u>	<u>GF</u>	<u>SF</u>
FY 2012-13			
Eliminate 12-13 Rate Increase (lagged)*	(\$43,198)	(\$21,599)	
Retain 12-13 PLI Savings**	\$0	(\$4,250)	\$4,250
Subtotal	(\$43,198)	(\$25,849)	\$4,250
Delay 3rd Checkwrite (In Base)	(\$74,800)	(\$37,400)	\$0
Total	(\$117,998)	(\$63,249)	\$4,250
FY 2013-14			
Eliminate 12-13 Rate Increase*	(\$51,473)	(\$25,736)	\$0

Funding:

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

SNF Quality & Accountability (4260-698-3167)**

100% General Fund (4260-605-0001)**

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	-\$77,669,000	-\$71,347,000
- STATE FUNDS	-\$38,834,500	-\$35,673,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	25.92 %	0.60 %
APPLIED TO BASE		
TOTAL FUNDS	-\$57,537,200	-\$70,918,900
STATE FUNDS	-\$28,768,600	-\$35,459,460
FEDERAL FUNDS	-\$28,768,600	-\$35,459,460

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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

10% PAYMENT REDUCTION FOR LTC FACILITIES

REGULAR POLICY CHANGE NUMBER: 152

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 ended on July 31, 2012.

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. The Department paid back the 10% payment reduction to this facility type in December 2012. See the 10% Pymt Reduction Restoration for AB 1629 Fac. policy change for more information.
4. **ICF/DDs:** This phase includes ICF/DD, ICF/DD-N, and ICF/DD-H. Assume implementation of payment reductions will begin October 1, 2013. The recoupment effective date is August 1, 2012. Therefore, there are 14 months of FFS retroactive savings (August 1, 2012 to September 30, 2013). Erroneous Payment Corrections (EPCs) will begin in November 1, 2013 to recoup FFS retroactive savings over 30 months.
5. **FS Pediatric Subacute:** The Department decided to exempt FS Pediatric Subacute from the application of the payment reduction due to an access study.
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 \$18,680,000 in FY 2012-13 and \$22,623,000 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	(\$19,719)	\$0
ICF/DDs	FFS	\$0	(\$9,441)
	FFS Retro	\$0	(\$3,916)
	Subtotal	\$0	(\$13,357)
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	(\$58,318)	(\$48,040)
	Total FFS Retro	(\$18,680)	(\$22,623)
	Total Managed Care	(\$671)	(\$684)
Grand Total		(\$77,669)	(\$71,347)

Funding:

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

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1580

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$1,031,248,000	-\$1,041,964,000
- STATE FUNDS	-\$515,624,000	-\$520,982,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	8.07 %	7.70 %
APPLIED TO BASE		
TOTAL FUNDS	-\$948,026,300	-\$961,732,800
STATE FUNDS	-\$474,013,140	-\$480,866,390
FEDERAL FUNDS	-\$474,013,140	-\$480,866,390

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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

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 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.

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.
- Additional providers and services are exempt from the reduction.

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 Pediatric Day Health Care (PDHC) and Audiology Program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program. Implementation of the payment reductions began December 20, 2011. There are seven months of FFS retroactive savings (June 1, 2011 to December 20, 2011). Erroneous Payment Corrections (EPCs) to recoup FFS retroactive savings began July 1, 2012 for payment reductions that are not enjoined.
 - The PDHC providers are exempt from the 10% payment reduction effective April 1, 2012. The Department stopped the 10% payment reduction on October 25, 2012. The refund for reduced payment for services on or after April 1, 2012 will be issued in FY 2013-14.
 - The Department proposes to exempt audiology services provided by Type C Communication Disorder Center that are located in the California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco, and Sonoma from the 10% payment reduction, effective October 19, 2012.
 - Residential Care Facilities for the Elderly and Care Coordinator Agencies are not subject to the 10% payment reduction. The Department stopped the 10% payment reduction in February 2013 and anticipates refunding the payment reduction for the period June 1, 2011 through January 31, 2013 in FY 2012-13.
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 will begin November 1, 2013. There are 29 months of FFS retroactive savings (June 1, 2011 to

10% PROVIDER PAYMENT REDUCTION

REGULAR POLICY CHANGE NUMBER: 153

October 31, 2013). EPCs to recoup FFS retroactive savings will begin February 1, 2014.

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 \$245,023,000 in FY 2012-13 and \$246,122,000 in FY 2013-14.

	(In Thousands)	FY 2012-13	FY 2013-14
Phase I	FFS	(\$64,542)	(\$67,418)
	FFS Retro	(\$15,453)	(\$15,053)
	Phase I Total	(\$79,995)	(\$82,471)
Phase II	FFS	(\$459,559)	(\$459,559)
	FFS Retro	(\$229,570)	(\$229,570)
	Phase II Total	(\$689,129)	(\$689,129)
Phase III	FFS		(\$2,058)
	FFS Retro		(\$1,499)
	Phase III Total		(\$3,557)
	FFS	(\$524,101)	(\$529,035)
	FFS Retro	(\$245,023)	(\$246,122)
	Managed Care	(\$262,124)	(\$266,807)
	Grand Total	(\$1,031,248)	(\$1,041,964)

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	\$7,195,802,000	\$4,212,457,000
- STATE FUNDS	\$3,646,726,000	\$2,127,154,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$7,195,802,000	\$4,212,457,000
STATE FUNDS	\$3,646,726,000	\$2,127,154,000
FEDERAL FUNDS	\$3,549,076,000	\$2,085,303,000

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
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

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
- 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:

The changes are due to QAF II and QAF III fee collection amounts received were less than previously scheduled.

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. On a cash basis, payments to the hospitals are estimated to be:

HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 154

(In Thousands)	<u>TF</u>	<u>SF(HQARF)</u>	<u>FF</u>
FY 2012-13			
AB 1383*	\$22,000	\$11,000	\$11,000
SB 335***	\$7,173,802	\$3,635,726	\$3,538,076
Total	\$7,195,802	\$3,646,726	\$3,549,076
FY 2013-14			
SB 90**	\$2,000	\$1,000	\$1,000
SB 335***	\$4,210,457	\$2,126,153	\$2,084,304
Total	\$4,212,457	\$2,127,153	\$2,085,304

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	\$220,284,000	\$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	\$220,284,000	\$205,995,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$220,284,000	\$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 received FY 2010-11 revised claims from counties which resulted in additional payments of \$1.87 million.

Methodology:

- Under the American Recovery and Reinvestment Act of 2009 (ARRA), 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. The Department will apply the appropriate FMAP to the reconciliation.

HOSPITAL OUTPATIENT SUPPLEMENTAL PAYMENT**REGULAR POLICY CHANGE NUMBER: 155**

2. The reconciliation mandated by AB 915 against audited cost reports began in FY 2012-13. 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 \$210,899,000 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 completed 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:

(In Thousands)	<u>Regular FFP</u>	<u>FY 2012-13 ARRA</u>	<u>Total FFP</u>
FY 2002-03 (Reconciliation)	\$9,385		\$9,385
FY 2005-06	\$531		\$531
FY 2007-08	\$947		\$947
FY 2008-09	\$71	\$29	\$100
FY 2010-11	\$17,966	\$3,406	\$21,372
FY 2011-12	<u>\$187,949</u>		<u>\$187,949</u>
	\$216,849	\$3,435	\$220,284
		<u>FY 2013-14 ARRA</u>	<u>Total FFP</u>
FY 2003-04 (Reconciliation)	\$9,400		\$9,400
FY 2012-13	<u>\$196,595</u>		<u>\$196,595</u>
	\$205,995	\$0	\$205,995

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	\$136,622,000	\$82,000,000
- STATE FUNDS	\$68,311,000	\$41,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$136,622,000	\$82,000,000
STATE FUNDS	\$68,311,000	\$41,000,000
FEDERAL FUNDS	\$68,311,000	\$41,000,000

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, sections 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 and FY 2013-14 payments were adjusted to incorporate updated payment figures.

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	\$12,330	\$12,330	\$24,660
FY 2011-12	\$35,481	\$35,481	\$70,962
FY 2012-13	\$20,500	\$20,500	\$41,000
Total Payments for FY 2012-13	\$68,311	\$68,311	\$136,622

FFP FOR LOCAL TRAUMA CENTERS

REGULAR POLICY CHANGE NUMBER: 156

(In Thousands)	<u>Special Deposit Fund</u>	<u>FFP</u>	<u>TF</u>
FY 2012-13	\$20,500	\$20,500	\$41,000
FY 2013-14	\$20,500	\$20,500	\$41,000
Total Payments for FY 2013-14	\$41,000	\$41,000	\$82,000

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: 7/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1140

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$455,989,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$455,989,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$455,989,000

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.

The State Plan Amendment (SPA) for this program was approved on August 8, 2012. Supplemental payments to freestanding, non-hospital based clinics will be retroactive to October 14, 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:

Payments are postponed to FY 2013-14 due to administrative processing delays.

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

FREESTANDING CLINICS SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 157

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. Supplemental payments for freestanding, non-hospital based clinics are expected to begin July 2013.
3. Annual supplemental payments to freestanding, non-hospital based clinics are expected to total between \$60,000,000 and \$75,000,000.
4. Supplemental payments are paid after the completion of cost report audits.

Program payment amounts are estimated to be:

(In Thousands)

FY 2013-14	TF	ARRA	FFP
FY 2006-07	\$60,000		\$60,000
FY 2007-08	\$60,000		\$60,000
FY 2008-09	\$63,000	\$5,928	\$57,072
FY 2009-10	\$66,000	\$12,420	\$53,580
FY 2010-11	\$74,989	\$12,094	\$62,895
FY 2011-12	\$66,000		\$66,000
FY 2012-13	\$66,000		\$66,000
Total	\$455,989	\$30,442	\$425,547

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. The Selective Provider Contracting Program (SPCP) ends June 30, 2013 due to the implementation of the Diagnosis Related Group payment methodology. A State Plan Amendment (SPA) will be required to maintain the Federal authority for SB 1732. The Department expects the Center for Medicare and Medicaid Services will approve the SPA by December 2013.

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 change.

CAPITAL PROJECT DEBT REIMBURSEMENT

REGULAR POLICY CHANGE NUMBER: 158

Methodology:

(In Thousands)

FY 2012-13

	TF	GF	FFP
Hospitals	\$91,708	\$45,854	\$45,854
DP-NFs	\$20,268	\$0	\$20,268
Total	\$111,976	\$44,854	\$66,122

FY 2013-14

	TF	GF	FFP
Hospitals	\$92,086	\$46,043	\$46,043
DP-NFs	\$20,471	\$0	\$20,471
Total	\$112,557	\$46,043	\$66,514

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: 7/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1600

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$140,000,000
- STATE FUNDS	\$0	\$70,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$140,000,000
STATE FUNDS	\$0	\$70,000,000
FEDERAL FUNDS	\$0	\$70,000,000

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:

Not Applicable

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.

AB 1467 (Chapter 23, Statutes of 2012) changed the NDPH reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. The Department submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS), but because CMS approval has not been received timely, the Department is no longer pursuing this reimbursement methodology change. NDPHs will continue to receive supplemental payments.

Reason for Change from Prior Estimate:

FY 2012-13 NDPH IGT supplemental payments are delayed to FY 2013-14.

NDPH IGT SUPPLEMENTAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 159

Methodology:

1. The estimated NDPH IGT supplemental payments are:

(In Thousands)

FY 2013-14	TF	GF**	IGT*	FF
FY 2012-13 Payments to NDPHs	\$70,000	\$0	\$35,000	\$35,000
FY 2012-13 Children's Services	\$0	(\$3,322)	\$3,322	\$0
FY 2013-14 Payments to NDPHs	\$70,000	\$0	\$35,000	\$35,000
FY 2013-14 Children's Services	\$0	(\$3,322)	\$3,322	\$0
Total	\$140,000	(\$6,644)	\$76,644	\$70,000

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	\$49,808,000	\$44,145,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$49,808,000	\$44,145,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$49,808,000	\$44,145,000

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 actual 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, city and county, or health care district. In addition, the acute care hospital must meet specified requirements and provide skilled nursing services to Medi-Cal Beneficiaries.

Reason for Change from Prior Estimate:

- Updated actual costs became available.
- FY 2008-09 reconciliation payment will be paid in FY 2013-14.

Methodology:

1. Under the American Recovery and Reinvestment Act of 2009 (ARRA), California's Federal Medical Assistance Percentage (FMAP) increased from 50% to 61.59% for October 1, 2008 through December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 added six additional months of increased FMAP. California's FMAP will be 58.77% for January 1, 2011 through March 31, 2011, and 56.88% for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level.
2. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date that payment occurs, there will be some expenditures made in FY 2012-13 that will receive the

CERTIFICATION PAYMENTS FOR DP-NFS**REGULAR POLICY CHANGE NUMBER: 160**

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.

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 \$49,808,000 FFP and \$44,145,000 FFP will be available in FY 2012-13 and FY 2013-14, respectively.

(In Thousands)

	FFP	FY 2012-13 ARRA	Total FFP
FY 2012-13	\$46,852	\$2,956	\$49,808
Total	\$46,852	\$2,956	\$49,808

	FFP	FY 2013-14 ARRA	Total FFP
FY 2008-09 Reconciliation	\$1,800	\$313	\$2,113
FY 2009-10 Reconciliation	\$1,883	\$437	\$2,320
FY 2013-14	\$39,712	\$0	\$39,712
Total	\$43,395	\$750	\$44,145

Funding:

Title XIX FFP (4260-101-0890)

IGT PAYMENTS FOR HOSPITAL SERVICES

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	\$25,000,000	\$15,000,000
- STATE FUNDS	\$12,500,000	\$7,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$25,000,000	\$15,000,000
STATE FUNDS	\$12,500,000	\$7,500,000
FEDERAL FUNDS	\$12,500,000	\$7,500,000

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:

The Welfare & Institutions Code 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.

This policy change provides authority to accept the IGTs from counties or health care districts, match them with federal funds, and distribute the funds to hospitals designated by the counties or health care districts for the purpose of supporting hospitals serving Medi-Cal beneficiaries.

This policy change is a placeholder for possible IGT requests. The IGTs are not subject to the conditions stated under the Welfare & Institutions Code, section 14166.12.

Reason for Change from Prior Estimate:

Estimates were revised based on a decreased IGT demand.

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:

SB 2563 established a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department reimburses eligible providers 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:

1. Assume annual reimbursements for disproportionate share of outpatient services are \$10,000,000 TF (\$5,000,000 GF).
- 2.

(Dollars in Thousands)

	<u>TF</u>	<u>FF</u>	<u>GF</u>
FY 2012-13	\$10,000	\$5,000	\$5,000
FY 2013-14	\$10,000	\$5,000	\$5,000

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT DSH

REGULAR POLICY CHANGE NUMBER: 162

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. The Department reimburses eligible providers 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:

1. Assume annual reimbursements to SRHs providing outpatient services are \$8,000,000 TF (\$4,000,000 GF).
- 2.

(Dollars in Thousands)

	<u>TF</u>	<u>FF</u>	<u>GF</u>
FY 2012-13	\$8,000	\$4,000	\$4,000
FY 2013-14	\$8,000	\$4,000	\$4,000

MEDI-CAL REIMBURSEMENTS FOR OUTPATIENT SRH

REGULAR POLICY CHANGE NUMBER: 163

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	\$3,800,000	\$3,600,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,800,000	\$3,600,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$3,800,000	\$3,600,000

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:

A portion of supplemental payments previously scheduled to be made in FY 2013-14 will be made in FY 2012-13. Additionally, supplemental payments relating to FY 2013-14 will be made in FY 2013-14.

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:

(In Thousands)

FY 2012-13

	FFP	Total FFP
State Veterans' Homes for FY 2011-12	\$2,000	\$2,000
State Veterans' Homes for FY 2012-13	\$1,800	\$1,800
Total	\$3,800	\$3,800

FY 2013-14

State Veterans' Homes for FY 2012-13	\$1,800	\$1,800
State Veterans' Homes for FY 2013-14	\$1,800	\$1,800
Total	\$3,600	\$3,600

Funding:

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

GEMT SUPPLEMENTAL PAYMENT PROGRAM

REGULAR POLICY CHANGE NUMBER: 165
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1661

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$138,645,000	\$160,000,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$138,645,000	\$160,000,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$138,645,000	\$160,000,000

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 Department anticipates GEMT payments for FY 2012-13 to be made in June 2013 instead of August 2013.

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 FMAP rate.
3. A payment of \$138,645,000 is expected to be made in June 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 2012-13	CPE	Regular FFP	ARRA	Total FFP
FY 2009-10	\$70,000	\$35,000	\$8,113	\$43,113
FY 2010-11	\$160,000	\$80,000	\$15,532	\$95,532
Total	\$230,000	\$115,000	\$23,645	\$138,645
FY 2013-14	CPE	Regular FFP	ARRA	Total FFP
FY 2011-12	\$160,000	\$80,000	\$0	\$80,000
FY 2012-13	\$160,000	\$80,000	\$0	\$80,000
Total	\$320,000	\$160,000	\$0	\$160,000

Funding:

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

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170
 IMPLEMENTATION DATE: 12/2011
 ANALYST: Taryn Gerald
 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, implement, or upgrade (AIU) and meaningfully use (MU) 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:

ARRA of 2009
 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 federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. To qualify, health care providers must AIU and MU certified EHR technology in accordance with the HITECH Act. The Centers for Medicare and Medicaid Services (CMS) approved the implementation of the provider incentive program which began October 3, 2011.

The Department plans to expand the current Medicaid Management Information Systems (MMIS) to integrate a State Level Registry (SLR) payment functionality, allowing for more seamless and efficient participation and payment for eligible providers. The payments are intended to accelerate AIU and encourage MU of the EHR technology by providers serving the Medi-Cal population. 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 financial participation (FFP).

The Medi-Cal Fiscal Intermediary (FI) began implementing a system necessary for the Department to enroll, pay and audit providers who participate in the Medi-Cal EHR Incentive Program. System costs

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170

are budgeted in the FI Estimate.

Administrative costs for the State's Health Information Technology (HIT) program are budgeted separately in the ARRA HITECH Incentive Program policy change.

Reason for Change from Prior Estimate:

There is no change.

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 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.

ARRA HITECH - PROVIDER PAYMENTS

REGULAR POLICY CHANGE NUMBER: 170

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: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1656

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$1,008,729,000	\$195,701,000
- STATE FUNDS	\$504,364,500	\$97,850,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$1,008,729,000	\$195,701,000
STATE FUNDS	\$504,364,500	\$97,850,500
FEDERAL FUNDS	\$504,364,500	\$97,850,500

DESCRIPTION

Purpose:

This policy change estimates the erosion of savings related to 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
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

AB 97 requires the Department to implement a payment reduction of up to 10% to specified providers in fee-for services (FFS), effective June 1, 2011. The actuarial equivalent of that amount to specified managed care providers was scheduled to be implemented July 1, 2011; however, because of the delay in implementation, the rates for retroactive periods cannot be certified as actuarially sound. The

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 171

impact of AB 97 for managed care will be determined on a prospective basis.

On October 27, 2011, the Department received federal approval to reduce provider payments up to 10%.

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 enjoined from implementing the rate freeze and 10% reductions. On March 8, 2012, the district court issued an order modifying the injunction to allow the Department to apply the rate freeze and 10% reduction to services rendered June 1, 2011 through December 27, 2011, that were not reimbursed prior to December 28, 2011 at the unreduced level.

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 enjoined from implementing the 10% payment reduction for prescription drugs. On March 12, 2012, the district court issued an order modifying the injunction to allow DHCS to apply the 10% payment reduction to prescription drugs provided from June 1, 2011 through December 27, 2011 that were not reimbursed prior to December 28, 2012 at the unreduced level.

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 10% 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 June 1, 2011 through January 9, 2012 that had not been reimbursed prior to January 10, 2012 at the unreduced payment level.

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 except for services rendered June 1, 2011 through January 30, 2012 that had not been reimbursed prior to January 31, 2012 at the unreduced payment level. In compliance with this injunction, the Department is enjoined from implementing a 10% payment reduction.

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".

On December 13, 2012, the United States Court of Appeals for the Ninth Circuit issued a decision in which it reversed the injunctions against AB 97 payment reductions issued in all four of the above cases. The plaintiff has requested a rehearing.

AB 97 INJUNCTIONS

REGULAR POLICY CHANGE NUMBER: 171

Reason for Change from Prior Estimate:

The estimate assumes positive resolution of the court injunctions in August 2013 instead of March 2013.

Methodology:

1. It will take the Department at least three months to implement FFS reductions if the injunctions were lifted. Assuming the Department receives favorable rulings on the appeals by August 2013, implementation of the AB 97 reductions to the enjoined providers will resume beginning November 2013. As a result, it is estimated that 12 months of FFS savings from the enjoined providers will be lost in FY 2012-13 and four months in FY 2013-14.
2. Assume the Department will implement managed care reductions in September 2013. Consequently, 12 months of managed care savings will be lost in FY 2012-13 and two months in FY 2013-14.
3. Assume the Department will recover FFS retroactive savings for the enjoined providers beginning February 2014.

(In Thousands)

Lawsuits

	FY 2012-13	FY2013-14
<i>California Hospital Association, et al. v. Douglas et al.</i>	\$56,804	\$12,480
<i>Managed Pharmacy Care, et al. v. Sebelius, et al.*</i>	\$411,570	\$94,935
<i>California Medical Transportation Association v. Douglas, et al.</i>	\$15,747	\$3,359
<i>California Medical Association, et al. v. Douglas, et al.*</i>	\$673,382	\$135,281
Managed Care Savings Loss due to Delayed Implementation	\$262,796	\$44,582

*Loss of savings from pharmacy is included in both lawsuits.

Funding:

Title XIX (4260-101-0001/0890)

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 173
 IMPLEMENTATION DATE: 12/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1595

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$391,096,000	\$322,584,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$391,096,000	\$322,584,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$391,096,000	\$322,584,000

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 Plan option, which became available to states on October 1, 2010, to provide home and community-based attendant services and supports through CFCO. CFCO allows States to receive a 6% increase in federal match for expenditures related to this option. The state submitted a State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) which proposed moving federally eligible Personal Care Services Program (PCSP) and In-Home Supportive Services (IHSS) Plus Option (IPO) program participants into CFCO. The Department budgets Title XIX FFP for the provision of IHSS Plus Option 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 generates new federal funds and creates 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, amending eligibility criteria for CFCO.

Reason for Change from Prior Estimate:

This FY 2013-14 estimate was revised based on additional county match fund savings that was not previously budgeted.

COMMUNITY FIRST CHOICE OPTION

REGULAR POLICY CHANGE NUMBER: 173

Methodology:

1. It is assumed all eligible participants will enroll retroactively to December 1, 2011.
2. Assume billing for additional FFP will be retroactive to December 2011.
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: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1232

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$146,199,000	\$198,021,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$146,199,000	\$198,021,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$146,199,000	\$198,021,000

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:

- 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	\$274,082	\$127,883	\$137,041	\$9,158	\$146,199	07-65896
FY 2013-14	\$373,099	\$175,078	\$186,549	\$11,472	\$198,021	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

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$15,502,000	\$6,298,000
- STATE FUNDS	\$15,502,000	\$6,298,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$15,502,000	\$6,298,000
STATE FUNDS	\$15,502,000	\$6,298,000
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:

The Department reached audit settlements with the Office of Inspector General (OIG):

- 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 the denied claims were traced to beneficiaries with aid codes that do not qualify for FFP. The Department returned the federal portion of the improperly claimed payments for services to CMS.
- Federal audit A-09-11-02040 regarding family planning services provided by the Family Planning Access, Care and Treatment (FPACT) program. The OIG found several claims that were not eligible for the claimed 90% federal Medicaid reimbursement for family planning services. The majority of claims were ineligible for reimbursement since the primary purpose of the beneficiary’s visit was not family planning.
- Federal audit A-09-12-02077 regarding drug and supplies provided by the FPACT program. The OIG found several claims were not eligible for the claimed 90% federal Medicaid reimbursement for family planning services. The majority of the claims were ineligible for reimbursement due to the primary purpose of the visit was not family planning.
- Federal audit A-09-11-02016 regarding unallowable Medi-Cal payments for items and services furnished, ordered, or prescribed by excluded providers. The OIG found Medi-Cal payments made to excluded providers that were not eligible for FFP.

AUDIT SETTLEMENTS

REGULAR POLICY CHANGE NUMBER: 180

Reason for Change from Prior Estimate:

Payment for FY 2013-14 is a new audit settlement.

Methodology:

1. The Federal audit A-09-07-00039 identified California Medicaid beneficiaries with aid codes that do not qualify for FFP. The Department returned \$14,471,000 FFP to CMS in FY 2012-13.
2. The Federal audit A-09-07-02040 identified claims where the beneficiary's primary purpose was not family planning. The Department will return \$5,671,000 FFP to CMS in FY 2013-14.
3. The Federal audit A-09-12-02077 identified drug and supplies where the beneficiary's primary purpose was not family planning. The Department will return \$627,000 FFP to CMS in FY 2013-14.
4. The Federal audit A-09-11-02016 identified unallowable payments made for items and services furnished, ordered, or prescribed by excluded providers. The Department will return \$1,030,720 to CMS in FY 2012-13. Of this total amount, \$1,009,300 is a reimbursement from the Department of Social Services.

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 (IA) 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 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 is budgeted in the Other Administration CDDS Dental Services policy change.

Reason for Change from Prior Estimate:

There is no 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: Jennifer Hsu
 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 costs 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) and the costs of the increased rates due to the Quality Assurance Fee.

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.

ICF-DD ADMIN. AND QA FEE REIMBURSEMENT - CDDS

REGULAR POLICY CHANGE NUMBER: 182

Methodology:

1. The following estimates have been provided by CDDS.

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	\$3,225,000	\$2,177,000
- STATE FUNDS	\$1,612,500	\$1,088,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$3,225,000	\$2,177,000
STATE FUNDS	\$1,612,500	\$1,088,500
FEDERAL FUNDS	\$1,612,500	\$1,088,500

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 February 2013, non-contract hospital inpatient cost settlements are estimated to total **\$3,225,000** for FY 2012-13 and **\$2,177,000** 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	\$2,524,000
- STATE FUNDS	-\$9,273,500	-\$9,273,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,082,000	\$2,524,000
STATE FUNDS	-\$9,273,500	-\$9,273,500
FEDERAL FUNDS	\$11,355,500	\$11,797,500

DESCRIPTION

Purpose:

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

Authority:

Public Law 93-638

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 2013-14 estimate was changed to incorporate the anticipated rate adjustment.

Methodology:

1. Currently, there are 50 Indian health clinics participating in Medi-Cal.
2. In fiscal year (FY) 2011-12, the Department spent \$18,547,000.

INDIAN HEALTH SERVICES

REGULAR POLICY CHANGE NUMBER: 186

3. 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.
4. 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.
5. The FY 2013-14 budget includes an additional \$379,000 due to the anticipated rate increase to \$328 from \$316 for the period of January 2013 through June 2013. The annual rate increase for the additional \$12 is \$757,000.

(In Thousands)	FY 2012-13	FY 2013-14
CY 2012 rate increase	\$1,388	\$1,388
CY 2013 rate increase	\$0	\$757
Retro Jan –June 2012 rate increase	\$694	\$0
Retro Jan –June 2013 rate increase	\$0	\$379
Total rate increase	\$2,082	\$2,524
FY 2010-11 Base expenditures	\$18,547	\$18,547
Total expenditures	\$20,629	\$21,071*

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	\$21,071		\$21,071
Net Impact		\$2,524	(\$9,274)	\$11,797

*Totals may differ due to rounding.

CIGARETTE AND TOBACCO SURTAX FUNDS

REGULAR POLICY CHANGE NUMBER: 188
 IMPLEMENTATION DATE: 1/2006
 ANALYST: Erickson Chow
 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 a decrease in FY 2013-14 due to a decrease in the Unallocated Account.

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	\$24,589,000
Total CTPS/Prop. 99	\$83,640,000
GF	-\$83,640,000
Net Impact	\$0

FY 2013-14

Hospital Services Account	\$58,946,000
Physicians' Services Account	\$105,000
Unallocated Account	\$23,540,000
Total CTPS/Prop. 99	\$82,591,000
GF	-\$82,591,000
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 FUND

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 the funding for blood lead tests performed by the Medi-Cal program. It estimates the technical adjustment in funding from 100% State General Fund (GF) to Childhood Lead Poisoning Prevention (CLPP) Fund.

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 who 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:

There is no change.

Methodology:

1. Funding for Medi-Cal and CHDP Gateway is at 50% State Funds.

CLPP FUND**REGULAR POLICY CHANGE NUMBER: 189**

2. In FY 2011-12, \$1,142,000 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 2011-12.
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.

	CLPP Fund
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
 PC 209 Extend Gross Premium Tax
 PC 207 Extend Gross Premium Tax – Incr. Capitation Rates
 PC 208 Extend Gross Premium Tax – Funding Adjustment
 PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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.

HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 190

The grant 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.

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	<u>\$310,000</u>
Total	\$1,187,000

2. On a cash basis, the estimated receipts of funds for children's health care coverage are:

(In Thousands)	<u>TF</u>	<u>GF</u>	<u>Hosp. QA Rev Fund</u>
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)

TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 192
 IMPLEMENTATION DATE: 1/2014
 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 managed care health plans beginning January 1, 2014.

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.

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.

TRANSFER OF IHSS COSTS TO DHCS

REGULAR POLICY CHANGE NUMBER: 192

Reason for Change from Prior Estimate:

The implementation date changed from September 2013 to January 2014.

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	\$0	\$0	\$0	\$0
Managed Care Payments:				
Non HCBS	\$1,110,274	\$555,137	\$555,137	\$0
HCBS	\$556,006	\$262,900	\$293,106	\$0
Existing Managed Care duals	-\$1,142	-\$571	-\$571	\$0
Total	\$1,665,138	\$817,466	\$847,672	\$0
FFS Savings:				
Non HCBS	-\$712,506	-\$356,253	-\$356,253	\$0
HCBS	-\$2,624	-\$1,312	-\$1,312	\$0
Defer Mgd. Care Payment	-\$437,828	-\$218,914	-\$218,914	\$0
Total	-\$1,152,958	-\$576,479	-\$576,479	\$0
IHSS FFS Savings (In the Base)	-\$243,099	\$0	-\$243,099	\$0
Delay 1 Checkwrite (In the Base)	\$39,641	\$19,820	\$19,820	\$0
Transfer of IHSS Costs to DHCS	\$0	-\$242,189	\$0	\$242,189
Transfer of IHSS Costs to CDSS	\$503,439	\$0	\$0	\$503,439
Other Administration Costs	\$5,172	\$2,543	\$2,629	\$0
Total of CCI PCs including pass through	\$817,332	\$21,161	\$50,543	\$745,628

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	\$0	\$0
- STATE FUNDS	\$0	\$0
PAYMENT LAG	0.0000	0.0000
% 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 achieved through the operational flexibilities.

Authority:

State Plan

Interdependent Policy Changes:

Not Applicable

Background:

The Department will develop and implement cost-effective policies for the target services to optimize health outcome, enhance quality, and produce efficiency. The prospective process will:

- Identify covered medical, dental, and behavior health intervention services.
- Analyze the feasibility of implementing the proposed changed to the target services.
- Establish a post-implementation assessment to ensure that changes achieve the intended results.

Reason for Change from Prior Estimate:

Related trailer bill language was not approved.

Methodology:

Currently, there is no initiative in connection with this policy change.

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	-\$1,810,000	\$0
- STATE FUNDS	-\$905,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,810,000	\$0
STATE FUNDS	-\$905,000	\$0
FEDERAL FUNDS	-\$905,000	\$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 Pharmacy Duplicates project to review claims sent from providers to ensure claims are not duplicated. The FI is working closely with Audits and Investigations (A&I) to determine final recovery amounts.

Reason for Change from Prior Estimate:

The new estimate represents the total recoverable amount.

Methodology:

1. The Department identified \$2,012,000 in duplicate claims.
2. Assume all duplicates costs will be collected in FY 2012-13.
3. 10% of collections are paid to HP.

Total Cost to HP for FY 2012-13: \$2,012,000 x 10% = \$201,200

FI COST CONTAINMENT PROJECTS

REGULAR POLICY CHANGE NUMBER: 194

4. Net recoveries (savings) for FY 2012-13: \$2,012,000 - \$201,200 = \$1,810,800

<u>Project Number</u>	<u>Savings Begin</u>	<u>Title</u>	<u>FY 2012-13 Savings</u>
07-17	Dec 12	Pharmacy Duplicates	\$1,810,800

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	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 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 0.316%. A low SMIF rate affords providers little to no incentive to repay Medi-Cal overpayments promptly. Federal law requires the Department to return the federal portion of an overpayment to Centers for Medicare and Medicaid Services (CMS) within 60 days. A higher SMIF rate encourages and expedites repayment of Medi-Cal overpayments.

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:

There is no change.

Methodology:

1. The current California Constitution 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%

OVERPAYMENTS - INTEREST RATE CHANGE

REGULAR POLICY CHANGE NUMBER: 195

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.

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: 10/2012
 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	70.00 %	57.24 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,200,000	-\$1,710,400
STATE FUNDS	-\$1,140,000	-\$1,624,880
FEDERAL FUNDS	-\$60,000	-\$85,520

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:

There is no change.

Methodology:

1. The contractor began auditing invoices in July 2012.
2. Recovery of overpayments began 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 upon current fiscal year recoveries through January 2013 of \$2,728,000, it is assumed that annual recoveries will be \$4,000,000.

(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	0.8894	1.0000
% REFLECTED IN BASE	85.20 %	82.80 %
APPLIED TO BASE		
TOTAL FUNDS	-\$1,627,400	-\$2,373,600
STATE FUNDS	-\$813,680	-\$1,186,800
FEDERAL FUNDS	-\$813,680	-\$1,186,800

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; provides statewide group training classes for providers; and provides training to providers identified with billing irregularities 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 material 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: 1/2014
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1640

	<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 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 (duals 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.

TRANSITION OF DUAL ELIGIBLES - MEDICARE SAVINGS

REGULAR POLICY CHANGE NUMBER: 198

Reason for Change from Prior Estimate:

Based upon the agreement with the federal government, the state will not receive Medicare savings attributed to this proposal.

Methodology:

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	\$0	\$0	\$0	\$0
Managed Care Payments:				
Non HCBS	\$1,110,274	\$555,137	\$555,137	\$0
HCBS	\$556,006	\$262,900	\$293,106	\$0
Existing Managed Care duals	-\$1,142	-\$571	-\$571	\$0
Total	\$1,665,138	\$817,466	\$847,672	\$0
FFS Savings:				
Non HCBS	-\$712,506	-\$356,253	-\$356,253	\$0
HCBS	-\$2,624	-\$1,312	-\$1,312	\$0
Defer Mgd. Care Payment	-\$437,828	-\$218,914	-\$218,914	\$0
Total	-\$1,152,958	-\$576,479	-\$576,479	\$0
IHSS FFS Savings (In the Base)	-\$243,099	\$0	-\$243,099	\$0
Delay 1 Checkwrite (In the Base)	\$39,641	\$19,820	\$19,820	\$0
Transfer of IHSS Costs to DHCS	\$0	-\$242,189	\$0	\$242,189
Transfer of IHSS Costs to CDSS	\$503,439	\$0	\$0	\$503,439
Other Administration Costs	\$5,172	\$2,543	\$2,629	\$0
Total of CCI PCs including pass through	\$817,332	\$21,161	\$50,543	\$745,628

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	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 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:

There is no material change.

Methodology:

1. Assume three trained staff members will be ready to complete 12 reconciliation audits each month beginning July 1, 2012.

FQHC/RHC AUDIT STAFFING**REGULAR POLICY CHANGE NUMBER: 199**

2. Based on 2009 reconciliation audit data, each reconciliation audit saves \$29,452. Therefore each redirected staff position saves:

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

(In Thousands)	<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)

IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER: 201
 IMPLEMENTATION DATE: 8/2012
 ANALYST: Davonna McClendon
 FISCAL REFERENCE NUMBER: 1746

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$65,494,000	-\$154,157,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	-\$65,494,000	-\$154,157,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	-\$65,494,000	-\$154,157,000

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% in FY 2012-13 and 8% in FY 2013-14.

Authority:

Welfare & Institutions Code 12301.06
 AB 1612 (Chapter 725, Statutes of 2010)
 SB 1041 (Chapter 47, Statutes of 2012)
Oster v. Lightbourne and *Dominguez v. Schwarzenegger* Settlements

Interdependent Policy Changes:

Not Applicable

Background:

Personal care services are rendered under the administrative direction of the California Department of Social Services (CDSS) for the IHSS program.

AB 1612 implemented a 3.6% across-the-board reduction in services hours for IHSS effective February 1, 2011 with a sunset date of June 30, 2012. Subsequently, through SB 1041, the 3.6% across-the-board 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.

In accordance with the IHSS Settlement Agreement, filed March 28, 2013, IHSS service hours will be reduced by 8% effective July 1, 2013. This reduction will be lowered to 7% effective July 1, 2014. The IHSS settlement resolves two class-action lawsuits: *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*.

Reason for Change from Prior Estimate:

In FY 2012-13, the savings amounts were updated by CDSS, while the FY 2013-14 savings were increased to reflect an 8% across-the-board reduction based on the settlements reached in the *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger* lawsuits.

IHSS REDUCTION IN SERVICE HOURS

REGULAR POLICY CHANGE NUMBER: 201

Methodology:

The estimated savings are provided by CDSS.

Funding:

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

ELIMINATION OF STATE MAXIMUM RATES

REGULAR POLICY CHANGE NUMBER: 204
 IMPLEMENTATION DATE: 7/2012
 ANALYST: Raman Pabla
 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, sections 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, sections 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:

There is no 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 not 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. In 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: Andrew Yoo
 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:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

There is no 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.

EXTEND HOSPITAL QAF - CHILDREN'S HEALTH CARE

REGULAR POLICY CHANGE NUMBER: 205

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).

(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: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1761

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$2,438,060,000
- STATE FUNDS	\$0	\$1,223,680,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$2,438,060,000
STATE FUNDS	\$0	\$1,223,680,000
FEDERAL FUNDS	\$0	\$1,214,380,000

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:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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:

The changes are due to updated proposed fee model.

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.

EXTEND HOSPITAL QAF - HOSPITAL PAYMENTS

REGULAR POLICY CHANGE NUMBER: 206

2. In FY 2013-14, the estimated six-month payments (January 1, 2014 through June 30, 2014) to the hospitals are:

(In Thousands)	<u>TF</u>	<u>SF(HQARF)</u>	<u>FF</u>
FY 2013-14	\$2,438,060	\$1,223,680	\$1,214,380

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: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1652

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$332,796,000
- STATE FUNDS	\$0	\$166,398,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$332,796,000
STATE FUNDS	\$0	\$166,398,000
FEDERAL FUNDS	\$0	\$166,398,000

DESCRIPTION

Purpose:

This policy change estimates the cost of capitation rate increases that are offset by gross premium tax proceeds resulting from the extension of the gross premium tax. 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 extend the gross premium tax through June 30, 2013, 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. Due to a delay in approval, the FY 2012-13 payments are not expected to be paid until FY 2013-14.

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 increase the capitation rates due to the payments made to the State that result directly from the imposition of the gross premium tax.
2. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

EXTEND GROSS PREMIUM TAX - INCR. CAPITATION RATES

REGULAR POLICY CHANGE NUMBER: 207

3. 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 2013-14	\$166,398	\$166,398	\$332,796

Funding:

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

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 208
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1655

	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 transfer of funds from the Gross Premium Tax Fund to the General Fund as a result of a proposal to extend the Gross Premium Tax.

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 extend the collection of a gross premium tax on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2013. The proceeds from the tax are used to offset capitation rates. Due to a delay in approval, the FY 2012-13 transfer is not expected to occur until FY 2013-14.

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

Reason for Change from Prior Estimate:

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

Methodology:

1. The gross premium tax is estimated by using a 2.35% tax rate applied to projected managed care revenues.

EXTEND GROSS PREMIUM TAX-FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 208

2. Assume that transfers from the Department of Insurance take place three months after quarterly tax payments.

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	\$ (166,398,000)	\$ 166,398,000	\$ 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.

Authority:

Proposed Legislation

Background:

The Administration is proposing legislation to extend the gross premium tax sunset date that, under current law, ended 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 extension of the gross premium tax sunset date through June 30, 2013. Due to a delay in approval, the FY 2012-13 payments are not expected to be made until FY 2013-14.

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 is estimated by using a 2.35% tax rate applied to projected managed care revenues.
2. 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.
3. The total available Gross Premium Tax revenue in FY 2013-14 is estimated to be \$166,398,000. Of this amount MRMIB will receive \$128,102,000. The Department will receive \$38,296,000.

EXTEND GROSS PREMIUM TAX

REGULAR POLICY CHANGE NUMBER: 209

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	\$ (38,296,000)	\$ 38,296,000	\$ 0

Funding:

100% State GF (4260-101-0001)

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

ENROLLMENT STABILIZATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 212
 IMPLEMENTATION DATE: 10/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1606

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	-\$7,127,000
- STATE FUNDS	\$0	-\$3,563,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$7,127,000
STATE FUNDS	\$0	-\$3,563,500
FEDERAL FUNDS	\$0	-\$3,563,500

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

Interdependent Policy Changes:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

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 policy change no longer includes the mailing costs and systems cost.

ENROLLMENT STABILIZATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 212

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.
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)
Mailing & Related Costs*	\$2,993,000	\$1,496,500
Total	(\$4,134,000)	(\$2,067,000)

*Included in the HCO Estimate in the Fiscal Intermediary section.

Funding:

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

TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS

REGULAR POLICY CHANGE NUMBER: 214
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1766

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,665,138,000
- STATE FUNDS	\$0	\$817,466,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,665,138,000
STATE FUNDS	\$0	\$817,466,000
FEDERAL FUNDS	\$0	\$847,672,000

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

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates

PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment

PC 228 MCO Tax Managed Care Plans

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),

TRANSITION OF DUAL ELIGIBLES-MANAGED CARE PAYMENTS REGULAR POLICY CHANGE NUMBER: 214

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.

Initially, the CCI will be implemented in eight pilot counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Reason for Change from Prior Estimate:

The implementation date changed from September 2013 to January 2014.

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 January 1, 2014. Medicare FFS beneficiaries from San Mateo County will enroll over 3 months in even increments. Medicare FFS beneficiaries from the other seven 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 January 2014 who will be phased into a managed care plan in the eight pilot counties.
4. Assume for participating dual eligibles, there will an overall average 1.15% savings in FY 2013-14.
5. For non-dual eligibles, savings were calculated as follows:
 - Assume Inpatient Care will be reduced by 8.9% in FY 2013-14 and thereafter.
 - Assume LTC institutional services will be reduced by 4.2% in FY 2013-14. Assume it will be reduced by 10.9% annually thereafter.
 - 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.
 - 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	<u>TF</u>	<u>GF</u>	<u>FFP</u>	<u>Reim- bursement</u>
Medicare Shared Savings	\$0	\$0	\$0	\$0
Managed Care Payments:				
Non HCBS	\$1,110,274	\$555,137	\$555,137	\$0
HCBS	\$556,006	\$262,900	\$293,106	\$0
Existing Managed Care Duals	-\$1,142	-\$571	-\$571	\$0
Total	\$1,665,138	\$817,466	\$847,672	\$0
FFS Savings:				
Non HCBS	-\$712,506	-\$356,253	-\$356,253	\$0
HCBS	-\$2,624	-\$1,312	-\$1,312	\$0
Defer Mgd. Care Payment	-\$437,828	-\$218,914	-\$218,914	\$0
Total	-\$1,152,958	-\$576,479	-\$576,479	\$0
IHSS FFS Savings (In the Base)	-\$243,099	\$0	-\$243,099	\$0
Delay 1 Checkwrite (In the Base)	\$39,641	\$19,820	\$19,820	\$0
Transfer of IHSS Costs to DHCS	\$0	-\$242,189	\$0	\$242,189
Transfer of IHSS Costs to CDSS	\$503,439	\$0	\$0	\$503,439
Other Administration Costs	\$5,172	\$2,543	\$2,629	\$0
Total of CCI PCs including pass through	\$817,332	\$21,161	\$50,543	\$745,628

Funding:

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

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG

REGULAR POLICY CHANGE NUMBER: 216
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1769

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$23,142,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$23,142,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$23,142,000

DESCRIPTION

Purpose:

This policy change estimates the federal fund payments for uncompensated care services provided by Indian Health Service (IHS) tribal health facilities.

Authority:

California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

Not Applicable

Background:

The Centers for Medicare & Medicaid Services (CMS) approved a waiver amendment to make uncompensated care payments through the Safety Net Care Pool (SNCP) – Uncompensated Care to IHS facilities.

Covered Services for Uninsured Individuals

IHS facilities may receive uncompensated care payments for the provision of California Medicaid State Plan primary care services and optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5 (Chapter 20, Statutes of 2009) to individuals:

- with income up to 133% of the Federal Poverty Level (FPL),
- who are not eligible for a Low Income Health Program (LIHP) or Medi-Cal, and
- have no source of third party coverage for the services they receive under this demonstration.

Covered Services for Medi-Cal Enrollees

For Medi-Cal enrolled individuals, IHS facilities may receive uncompensated care payments for the provision of optional benefit services eliminated from the California Medicaid State Plan as required by ABX3 5.

FFP Claiming Methodology

Claims for allowable services will be paid at the IHS encounter rate. Claiming for Federal Financial Participation (FFP) will be based on certified public expenditures under this demonstration. For

UNCOMPENSATED CARE PAYMENTS FOR TRIBAL HEALTH PROG REGULAR POLICY CHANGE NUMBER: 216

services provided to IHS eligible individuals, claims will be reimbursed with 100% FFP. For services provided to non-IHS eligible individuals, claims will be reimbursed at California's Federal Medical Assistance Percentage (FMAP) rate.

Optional services eliminated from the State Plan include:

- Acupuncture
- Audiology
- Chiropractic
- Dental
- Incontinence creams and washes
- Optician/optical lab
- Podiatry
- Psychology
- Speech therapy

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume IHS facilities provide uncompensated care services to 22,000 IHS eligible uninsured individuals annually.
2. Assume the annual average number of encounters per individual is 3.
3. The IHS global encounter rate is \$316.
4. For uninsured individuals, the estimated total annual uncompensated care payment is \$20,856,000 FFP.

$$22,000 \text{ individuals} \times 3 \text{ encounters} \times \$316 = \$20,856,000 \text{ FFP}$$

5. Assume IHS facilities lost \$10,000,000 FFP annually from the requirement under ABX3 5 that excludes specified optional benefits from coverage under the Medi-Cal program. It is expected that IHS facilities will claim \$10,000,000 FFP annually for optional benefit services under this program.
6. To IHS facilities, the estimated total annual uncompensated care payment is \$30,856,000 FFP.

$$\$20,856,000 + \$10,000,000 = \$30,856,000 \text{ FFP Annually}$$

7. The program is effective from April 5, 2013 through December 31, 2013. All payments are expected to be made in FY 2013-14 and are estimated to be:

$$\$30,856,000 / 12 \text{ months} \times 9 \text{ months} = \mathbf{\$23,142,000 \text{ FFP in FY 2013-14}}$$

Funding:

Title XIX FFP (4260-101-0890)

CHANGE FAMILY PACT PROGRAM BENEFITS

REGULAR POLICY CHANGE NUMBER: 217
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1770

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$32,605,000
- STATE FUNDS	\$0	-\$11,653,600
PAYMENT LAG	1.0000	0.8380
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$27,323,000
STATE FUNDS	\$0	-\$9,765,720
FEDERAL FUNDS	\$0	-\$17,557,270

DESCRIPTION

Purpose:

This policy change estimates the savings from benefit changes to the Family Planning, Access, Care and Treatment (PACT) program.

Authority:

Affordable Care Act Section 2303(a)(3)

Interdependent Policy Changes:

Not Applicable

Background:

The Office of Family Planning conducts on-going monitoring and utilization management of the Family PACT program to evaluate the cost-effectiveness of services and identify opportunities to reduce program costs while maintaining the same quality of care. Effective July 1, 2013, the Department plans to:

- Reduce chlamydia screening of women over 25 years of age,
- Decrease over-utilization of emergency contraception,
- Adopt a Medi-Cal Preferred List for oral contraceptives,
- Eliminate urine culture, and
- Discontinue brand name anti-fungal drugs.

Under the Affordable Care Act, services for Family PACT are limited to medical diagnosis and treatment services provided pursuant to a family planning service in a family planning setting. Effective July 1, 2013, the Department plans to eliminate mammograms and pregnancy test only benefit to maintain compliance with Federal rules.

Reason for Change from Prior Estimate:

This is a new policy change.

CHANGE FAMILY PACT PROGRAM BENEFITS

REGULAR POLICY CHANGE NUMBER: 217

Methodology:

1. Assume the implementation date July 1, 2013.
2. Based on FY 2011-12 data, assume an annual savings of \$32,605,000 TF from following benefit changes:

Benefit	FMAP*	TF
Chlamydia Screening	90%	\$16,586,000
Emergency Contraception	90%	\$5,505,000
Medi-Cal List of Oral Contraceptives	90%	\$4,000,000
Urine Culture	50%	\$335,000
Brand Name Antifungal Drug	50%	\$812,000
Mammograms	0%	\$5,042,000
Pregnancy Test Only	90%	\$325,000
Total Savings		\$32,605,000

*FMAP: Federal Medical Assistance Percentage

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

Funding:

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

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

GF (4260-101-0001)

COST SHIFT OF CCS STATE-ONLY TO MEDI-CAL EPC

REGULAR POLICY CHANGE NUMBER: 218
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1771

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$32,114,000	\$0
- STATE FUNDS	\$16,057,000	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$32,114,000	\$0
STATE FUNDS	\$16,057,000	\$0
FEDERAL FUNDS	\$16,057,000	\$0

DESCRIPTION

Purpose:

This policy change estimates the cost shift correction of county California Children's Services (CCS) State-Only funds to Medi-Cal funds.

Authority:

Title XIX, Social Security Act

Interdependent Policy Changes:

Family Health Estimate CCS PC-15 Cost Shift of CCS State-Only to Medi-Cal EPC

Background:

In June 2012, the Department identified payment problems for CCS State-Only services:

- The system erroneously paid Medi-Cal claims with CCS State-Only General Fund (GF) and matching County funds instead of Medi-Cal funds.
- The system denied claims that should have been approved for payment.

The Department is currently completing the first stage of the Erroneous Payment Correction (EPC) to adjust the funding shift.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume the EPC will be completed in June 2013.
2. Assume the cost shift from CCS State-Only GF and matching County funds to Medi-Cal funds is \$32,114,000 TF.

COST SHIFT OF CCS STATE-ONLY TO MEDI-CAL EPC

REGULAR POLICY CHANGE NUMBER: 218

Funding:

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

YOUTH REGIONAL TREATMENT CENTERS

REGULAR POLICY CHANGE NUMBER: 219
 IMPLEMENTATION DATE: 6/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1772

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,844,000	\$5,688,000
- STATE FUNDS	\$1,422,000	-\$711,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,844,000	\$5,688,000
STATE FUNDS	\$1,422,000	-\$711,000
FEDERAL FUNDS	\$1,422,000	\$6,399,000

DESCRIPTION

Purpose:

This policy change budgets the federal financial participation (FFP) for Youth Regional Treatment Centers (YRTCs).

Authority:

Public Law 102-573 (Title 25, U.S.C. 1665c)

Interdependent Policy Changes:

Not Applicable

Background:

The Department will implement the enrollment and reimbursement of YRTCs for services rendered to American Indian youths. The Indian health clinics refer these youths to YRTCs for culturally appropriate in-patient substance abuse treatment. The Department will receive 100% Federal Medical Assistance Percentage (FMAP) under Title XIX for YRTC services provided to eligible American Indian Medi-Cal members under the age of 21.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Assume the program effective date is January 1, 2013. The Department expects to make payments beginning June 1, 2013.
2. Details of the estimated expenditures:
 - a. The estimated annual number of youths: 50
 - b. The average stay per youth: 120 days
 - c. The estimated daily rate per youth: \$948

YOUTH REGIONAL TREATMENT CENTERS**REGULAR POLICY CHANGE NUMBER: 219**

50 youths x 120 days per youth x \$948 per day = \$5,688,000 TF annually, or \$1,422,000 TF per quarter.

3. Assume the program will pay the quarterly expenditures upfront at 50% FMAP, and receive Federal Financial Participation (FFP) reimbursement in the following quarter.

(In Thousands)	TF	GF	FFP
FY 2012-13			
Jan. 2013-June 2013	\$2,844	\$1,422	\$1,422
Total	\$2,844	\$1,422	\$1,422
FY 2013-14			
Jan. 2013-June 2013*	\$0	(\$1,422)	\$1,422
July 2013-Sept. 2013	\$1,422		\$1,422
Oct. 2013-Dec. 2013	\$1,422		\$1,422
Jan. 2014-March 2014	\$1,422		\$1,422
April 2014-June 2014**	\$1,422	711	\$711
Total	\$5,688	(\$711)	\$6,399

* FFP reimbursement from FY 2012-13

** FFP to be reimbursed in FY 2014-15

Funding:

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

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

SUNSET OF SPECIALTY DRUG CONTRACTS

REGULAR POLICY CHANGE NUMBER: 220
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Erickson Chow
 FISCAL REFERENCE NUMBER: 1773

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$15,051,000
- STATE FUNDS	\$0	\$7,525,500
PAYMENT LAG	1.0000	0.9292
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$13,985,400
STATE FUNDS	\$0	\$6,992,690
FEDERAL FUNDS	\$0	\$6,992,700

DESCRIPTION

Purpose:

This policy change estimates added costs due to not being able to contract for specialty drug services.

Authority:

Welfare & Institutions Code, section 14105.3

Interdependent Policy Changes:

PC 223 Implementation of Specialty Drug Contracts

Background:

Medi-Cal beneficiaries use specialty drugs and services when they have conditions such as:

- Chronic Renal Failure-Dialysis;
- Organ Transplant;
- Pulmonary Hypertension;
- Diseases of errors of metabolism (including growth hormone problems, phenylketonuria, hemophilia, and cystic fibrosis);
- HIV/AIDs;
- Oncology; and
- Acute psychiatric disorders

Specialty drugs and services require special equipment and handling. Current law allows the Department to contract for these drugs and services rather than reimbursing them through the usual methodologies for pharmacy services. However, the contracting authority in the statute expires on June 30, 2013. The law anticipated that once there was a reduction in pharmacy reimbursement, access to these specialty drugs and services would not be available without additional payment. The Department hasn't negotiated contracts for specialty drug services because there have been no major reductions in reimbursement.

Beginning September 1, 2013, the Department will implement a reduction in reimbursement under AB 97 (Chapter 3, Statutes of 2011). Upon implementation of the reduction, most specialty drug providers

SUNSET OF SPECIALTY DRUG CONTRACTS

REGULAR POLICY CHANGE NUMBER: 220

will not provide these services. Because of the sunset in current law, the Department will not be able to contract for these services, forcing many Medi-Cal beneficiaries to seek these services in other settings at a higher cost.

This cost increase will occur through increased utilization of emergency department services, extended stays in acute and sub-acute care settings, and increased medical interventions resulting from decreased access to standard care for individuals with medical conditions requiring these specialty drugs and services.

Reason for Change from Prior Estimate:

New policy change

Methodology:

1. Medi-Cal reimbursement for specialty drugs in calendar year 2012 was just over \$1.4 billion with an estimated 256,000 Medi-Cal users.
2. Assume there will be a greater risk for beneficiaries receiving expensive treatment in more expensive venues (i.e., emergency rooms (ER), acute care, and/or Long Term Care Treatment).
3. Assume there are 117,000 beneficiaries who are high-risk. They have diseases with treatments that require close monitoring and drug compliance in order to avoid disease progression.
4. Assume there are 139,000 beneficiaries who are medium risk. They have diseases that, when not treated properly, can have deleterious effects to both the patient and the treatment costs.
5. The Medi-Cal average rate per E.R. visit is \$143.57 for all eligible. It is assumed that those that require special drugs would have a considerably higher cost compared to the average patient. The cost is assumed to be 4 times the average ($\$143.57 \times 4 = \574.28 ER cost)
6. Assume that 15 percent of high-risk patients will require added emergency room visits without access to pharmacies providing specialty drugs and services.

$$117,000 \text{ (high-risk)} \times 15\% \text{ (ER use)} \times \$574.28 \text{ (ER cost} \times 4) = \$10,079,000$$

7. Assume that 10 percent of medium-risk patients will require added emergency room visits without access to pharmacies providing specialty drugs and services

$$139,000 \text{ (med-risk)} \times 10\% \text{ (ER use)} \times \$574.28 \text{ (ER cost} \times 4) = \$7,982,000$$

8. Assume the AB 97 pharmacy reductions will be implemented on September 1, 2013.

9. Estimated cost:

$$\$10,079,000 + \$7,982,000 = \$18,061,000 \text{ Annual Cost}$$

$$\text{FY 2013-14 (10 months): } \$18,061,000 \times \frac{10}{12} = \mathbf{\$15,051,000 \text{ TF } (\$7,525,000 \text{ GF})}$$

Funding:

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

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 221
 IMPLEMENTATION DATE: 4/2013
 ANALYST: Randolph Alarcio
 FISCAL REFERENCE NUMBER: 1775

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$2,126,000	\$27,637,000
- STATE FUNDS	\$1,063,000	\$13,818,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$2,126,000	\$27,637,000
STATE FUNDS	\$1,063,000	\$13,818,500
FEDERAL FUNDS	\$1,063,000	\$13,818,500

DESCRIPTION

Purpose:

This policy change estimates the costs of implementing organized health care delivery systems for CCS Medi-Cal beneficiaries.

Authority:

ABX4 6 (Chapter 6, Statutes of 2009)
 SB 208 (Chapter 714, Statutes of 2010)
 California Bridge to Reform Section 1115(a) Medicaid Demonstration (BTR)

Interdependent Policy Changes:

OA 2 CCS Case Management
 PC 109 County Organized Health Systems (COHS)

Background:

The BTR, approved by CMS effective November 1, 2010, allows the Department to develop and implement four organized health care delivery systems to serve the California Children's Services (CCS) Medi-Cal eligible population in at least four geographical locations within the State (CCS Pilot). The four organized health care delivery systems can use up to four models listed below for care delivery:

- Enhanced primary care case management model,
- Provider-based accountable care organization model,
- Existing Medi-Cal managed care plans, and
- Specialty health care plan.

Currently, the County Organized Health Systems (COHS) provides health care services to CCS Medi-Cal beneficiaries residing in the San Mateo County. The County Organized Health Systems (COHS) policy change budgets the health care costs and the CCS Case Management policy change budgets the administrative costs for CCS Medi-Cal beneficiaries. The Health Plan of San Mateo (HPSM), a separate health care plan, expects to begin operation in April 2013 and receive the capitation rate

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 221

payment for providing health care and administrative services to the CCS Medi-Cal beneficiaries.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The CCS Pilot program only impacts CCS Medi-Cal beneficiaries and does not include CCS State-Only population.
2. The CCS Pilot program will transition CCS Medi-Cal beneficiaries residing in San Mateo County from the COHS to the HPSM.
3. The estimated capitation rate for HPSM is \$1,417.28, including health care and administrative costs.

Average Monthly Enrollment	Capitation Rate	Monthly Payment	Annual Payment
1,500	\$1,417	\$2,126,000	\$25,512,000

4. Assume the annual administrative cost \$3,522,000 and 70% of the CCS Medi-Cal administrative costs will be transferred to the HPSM.

Annual HPSM administrative costs:
\$3,522,000 x 70% = \$2,465,000 TF (monthly \$205,000 TF)

5. Assume the HPSM will receive the capitation payments beginning May 2013.
6. June capitation payment will be deferred to the following the fiscal year.
7. Assume the CCS Pilot program is budget neutral.

	TF	HPSM	COHS	CCS Case Management
FY 2012-13	\$0	\$2,126,000	(\$1,921,000)	(\$205,000)
FY 2013-14				
2012-13	\$0	\$4,252,000	(\$3,841,000)	(\$411,000)
2013-14	\$0	\$23,385,000	(\$21,125,000)	(\$2,260,000)
Total	\$0	\$27,637,000	(\$24,966,000)	(\$2,671,000)

CALIFORNIA CHILDREN'S SERVICES PROGRAM PILOTS

REGULAR POLICY CHANGE NUMBER: 221

The estimated capitation payments on a cash basis are:

(In Thousands)

	TF	FFP	GF
FY 2012-13	2,126	\$1,063	\$1,063
 FY 2013-14			
2012-13	\$4,252	\$2,126	\$2,126
2013-14	\$23,385	\$11,693	\$11,693
Total	\$27,637	\$13,819	\$13,819

Funding:

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

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 222
 IMPLEMENTATION DATE: 11/2012
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1776

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	-\$39,000	-\$168,000
- STATE FUNDS	-\$19,500	-\$84,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	20.71 %	4.55 %
APPLIED TO BASE		
TOTAL FUNDS	-\$30,900	-\$160,400
STATE FUNDS	-\$15,460	-\$80,180
FEDERAL FUNDS	-\$15,460	-\$80,180

DESCRIPTION

Purpose:

This policy change estimates the savings from discontinuing inmates who are ineligible for Medi-Cal due to their incarceration.

Authority:

Welfare & Institutions Code, section 14053

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 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

The Department established the Incarceration Verification Program (IVP) to improve the process of identifying individuals ineligible for Medi-Cal benefits due to incarceration. Improving verification and identification capabilities lowers program expenditures and yields cost savings through the discontinuance of ineligible beneficiaries. All identified inmates will lose eligibility for Medi-Cal; however, some will remain eligible in the Medi-Cal Inmate Eligibility program for inpatient care.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

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

INCARCERATION VERIFICATION PROGRAM

REGULAR POLICY CHANGE NUMBER: 222

2. Based on monthly reports of IVP and California Department of Corrections and Rehabilitation Division of Juvenile Justice (CDCR-DJJ) matches, it is estimated that 70 managed care beneficiaries will be discontinued from Medi-Cal in FY 2012-13, and 77 in FY 2013-14.
3. Total managed care savings is estimated to be \$39,000 TF in FY 2012-13, and \$168,000 TF in FY 2013-14.
4. In FY 2012-13, it is estimated that 20.71% of the managed care savings is captured in the base trends. In FY 2013-14, it is estimated that 4.55% of the managed care savings is captured in the base trends.

FY 2012-13	TF	% in Base	Savings in Base
Managed Care Savings	(\$39,000)	20.71%	(\$8,000)
FY 2013-14	TF	% in Base	Savings in Base
Managed Care Savings	(\$168,000)	4.55%	(\$8,000)

5. Total estimated savings not in the base trends:

FY 2012-13	TF	GF
Total Savings	(\$31,000)	(\$15,500)
FY 2013-14	TF	GF
Total Savings	(\$160,000)	(\$80,000)

Funding:

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

IMPLEMENTATION OF SPECIALTY DRUG CONTRACTS

REGULAR POLICY CHANGE NUMBER: 223
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Erickson Chow
 FISCAL REFERENCE NUMBER: 1778

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$15,051,000
- STATE FUNDS	\$0	-\$7,525,500
PAYMENT LAG	1.0000	0.9292
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$13,985,400
STATE FUNDS	\$0	-\$6,992,690
FEDERAL FUNDS	\$0	-\$6,992,700

DESCRIPTION

Purpose:

This policy change estimates savings due to contracting for specialty drug services.

Authority:

Proposed Trailer Bill Language

Interdependent Policy Changes:

PC 220 Sunset of Specialty Drug Contracts

Background:

Medi-Cal beneficiaries use specialty drugs and services when they have conditions such as:

- Chronic Renal Failure-Dialysis;
- Organ Transplant;
- Pulmonary Hypertension;
- Diseases of errors of metabolism (including growth hormone problems, phenylketonuria, hemophilia, and cystic fibrosis);
- HIV/AIDs;
- Oncology; and
- Acute psychiatric disorders

Specialty drugs and services require special equipment and handling. Current law allows the Department to contract for these drugs and services rather than reimbursing them through the usual methodologies for pharmacy services. However, the contracting authority in the statute expires on June 30, 2013. The law anticipated that once there was a reduction in pharmacy reimbursement, access to these specialty drugs and services would not be available without additional payment. The Department hasn't negotiated contracts for specialty drug services because there have been no major reductions in reimbursement.

Beginning September 1, 2013, the Department will implement a reduction in reimbursement under AB 97 (Chapter 3, Statutes of 2011). Upon implementation of the reduction, most specialty drug providers will not provide these services. Because of the sunset in current law, the Department would not be

IMPLEMENTATION OF SPECIALTY DRUG CONTRACTS

REGULAR POLICY CHANGE NUMBER: 223

able to contract for these services, forcing many Medi-Cal beneficiaries to seek these services in other settings at a higher cost.

This cost increase will occur through increased utilization of emergency department services, extended stays in acute and sub-acute care settings, and increased medical interventions resulting from decreased access to standard care for individuals with medical conditions requiring these specialty drugs and services.

The proposed Trailer Bill Language would eliminate the sunset date for special drug contracting allowing the Department to contract for these services.

Reason for Change from Prior Estimate:

New policy change

Methodology:

1. Medi-Cal reimbursement for specialty drugs in calendar year 2012 was just over \$1.4 billion with an estimated 256,000 Medi-Cal users.
2. Assume there will be a greater risk for beneficiaries receiving expensive treatment in more expensive venues (i.e., emergency rooms (ER), acute care, and/or Long Term Care Treatment).
3. Assume there are 117,000 beneficiaries who are high-risk. They have diseases with treatments that require close monitoring and drug compliance in order to avoid disease progression.
4. Assume there are 139,000 beneficiaries who are medium risk. They have diseases that, when not treated properly, can have deleterious effects to both the patient and the treatment costs.
5. The Medi-Cal average rate per E.R. visit is \$143.57 for all eligible. It is assumed that those that require special drugs would have a considerably higher cost compared to the average patient. The cost is assumed to be 4 times the average ($\$143.57 \times 4 = \574.28 ER cost)
6. Assume that 15 percent of high-risk patients will require added emergency room visits without access to pharmacies providing specialty drugs and services.

$$117,000 \text{ (high-risk)} \times 15\% \text{ (ER use)} \times \$574.28 \text{ (ER cost} \times 4) = \$10,079,000$$

7. Assume that 10 percent of medium-risk patients will require added emergency room visits without access to pharmacies providing specialty drugs and services

$$139,000 \text{ (med-risk)} \times 10\% \text{ (ER use)} \times \$574.28 \text{ (ER cost} \times 4) = \$7,982,000$$

8. Assume the AB 97 pharmacy reductions and the specialty drug contracts will be implemented on September 1, 2013.

9. Estimated cost that will be saved due to this policy change is:
 $\$10,079,000 + \$7,982,000 = \$18,061,000$ Annual Savings

$$\text{FY 2013-14 (10 months): } \$18,061,000 \times \frac{10}{12} = \mathbf{\$15,051,000 \text{ TF } (\$7,525,000 \text{ GF})}$$

Funding:

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

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 226
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1781

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$812,173,000
- STATE FUNDS	\$0	\$406,086,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$812,173,000
STATE FUNDS	\$0	\$406,086,500
FEDERAL FUNDS	\$0	\$406,086,500

DESCRIPTION

Purpose:

This policy change estimates the cost of capitation rate increases that are offset by sales tax proceeds. The tax proceeds will be used for the non-federal share of capitation rate increases.

Authority:

Proposed Legislation

Interdependent Policy Changes:

PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

The Administration is proposing legislation to apply the statewide sales 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. The tax would be effective July 1, 2013.

Reason for Change from Prior Estimate:

New policy change

Methodology:

1. The sales 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 sales tax.
2. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.
3. The premium revenue was multiplied by the statewide sales tax amount of 3.9375% to determine total tax revenue.

MCO TAX MGD. CARE PLANS - INCR. CAP. RATES

REGULAR POLICY CHANGE NUMBER: 226

4. Capitation rate increases due to the sales tax are initially paid from the General Fund (GF). The GF is then reimbursed in arrears through a funding adjustment from Fund 3156 on a quarterly basis. The reimbursement is budgeted in the MCO Tax Mgd Care Plans–Funding Adjustment policy change.

The costs of capitation rate increases related to the imposition of the sales tax are expected to be:

(In Thousands)	<u>Sales Tax</u>	<u>FFP</u>	<u>TF</u>
FY 2013-14	\$406,086	\$406,086	\$812,173

Funding:

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

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT

REGULAR POLICY CHANGE NUMBER: 227
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1782

	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 transfer of funds collected from the sales tax on managed care plans to the General Fund (GF) to be used by the Department to fund related managed care capitation rate increases.

Authority:

Proposed Legislation

Interdependent Policy Changes:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 228 MCO Tax Managed Care Plans

Background:

The Administration is proposing legislation to impose the statewide sales 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.

The tax would be effective July 1, 2013. One half of the tax revenue will be retained by the Department to offset GF cost for capitated rate increases as a result of the imposition of the tax. This policy change estimates the offset of GF costs for the capitated rate increases.

Reason for Change from Prior Estimate:

New policy change

Methodology:

1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.

MCO TAX MGD. CARE PLANS - FUNDING ADJUSTMENT**REGULAR POLICY CHANGE NUMBER: 227**

2. The premium revenue was multiplied by the statewide sales tax rate of 3.9375% to determine total tax revenue.
3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.
4. Assume a three-month lag between when tax payments are paid to the Department of Insurance and when they are transferred to the Department.
5. The FY 2013-14 impact of the increase in capitation payments related to the sales tax is included in the MCO Tax Mgd. Care Plans– Incr. Cap. Rates policy change.

The sales tax fund transfers to the GF are expected to be:

	<u>GF</u>	<u>Sales Tax</u>	<u>TF</u>
FY 2013-14	\$ (304,565,000)	\$ 304,565,000	\$ 0

Funding:

100% State GF (4260-101-0001)

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

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 228
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1783

	<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 sales tax on managed care organizations (MCOs) to the General Fund (GF) to be retained by the Department beginning July 1, 2013.

Authority:

Proposed Legislation

Interdependent Policy Changes:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment

Background:

The Administration is proposing legislation to impose the statewide sales 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.

The tax would be effective July 1, 2013. One half of the tax revenue will be retained by the Department to offset GF cost for the Medi-Cal program. This policy change estimates GF savings resulting from the imposition of the sales tax.

Reason for Change from Prior Estimate:

New policy change

Methodology:

1. Total premium revenue for Medi-Cal managed care plans is based upon the Medi-Cal Estimate.
2. The premium revenue was multiplied by the statewide sales tax rate of 3.9375% to determine total tax revenue.

MCO TAX MANAGED CARE PLANS

REGULAR POLICY CHANGE NUMBER: 228

3. Total tax revenue was multiplied by 50% to determine the share that offsets GF cost for the Medi-Cal program.
4. Assume a three-month lag between when tax payments are paid to the Department of Insurance and when they are transferred to the Department.
5. The FY 2013-14 impact of the increase in capitation payments related to the sales tax is included in the MCO Tax Mgd. Care Plans – Incr. Cap. Rates policy change.

The sales tax fund transfers to the GF are expected to be:

	<u>GF</u>	<u>Sales Tax</u>	<u>TF</u>
FY 2013-14	\$ (304,565,000)	\$ 304,565,000	\$ 0

Funding:

100% State GF (4260-101-0001)

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

LONG TERM CARE QUALITY ASSURANCE FUND EXPENDITURES

REGULAR POLICY CHANGE NUMBER: 229
 IMPLEMENTATION DATE: 8/2013
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1784

	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 budgets the funding adjustment from Long Term Care Quality Assurance Fund (LTCQAF) to 100% State General Fund (GF).

Authority:

AB 1467 (Chapter 23, Statutes of 2012)

Interdependent Policy Changes:

PC 226 MCO Tax Mgd. Care Plans - Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans - Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

AB 1762 (Chapter 230, Statutes of 2003) and ABX1 19 (Chapter 4, Statutes of 2011) imposed a Quality Assurance (QA) fee for certain Long Term Care (LTC) provider types. AB 1629 (Chapter 875, Statutes of 2004) imposed a QA fee, in conjunction with a facility specific reimbursement program, for additional LTC providers. The revenue generated from the fee is used to draw down federal match, offset LTC rate reimbursement payments and may also provide funding for LTC reimbursement rate increases. The following LTC providers are subject to a QA fee.

- Freestanding Nursing Facilities Level-B (FS/NF-Bs)
- Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)
- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

AB 1467 established the LTCQAF. Effective August 1, 2013, the revenue generated by the LTC QA fees collected will be deposited into the fund, rather than the state General Fund, which will be used for LTC provider reimbursement rate expenditures.

**LONG TERM CARE QUALITY ASSURANCE FUND
EXPENDITURES
REGULAR POLICY CHANGE NUMBER: 229**

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Based on three year of QA fee revenue collection data, the average annual QA fee revenue on a cash basis is \$413,217,000. Assume the growth rate is 5.67%.

Estimated QA fee revenue collected in FY 2013-14 is:

$\$413,217,000 \times (1+5.67\%) = \$436,646,000$

(In Thousands)

	TF	GF	LTCQAF
FY 2013-14	\$0	(\$436,646)	\$436,646

Funding:

Long Term Care Quality Assurance Fund (4260-101-3213)

100% General Fund (4260-101-0001)

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 230
 IMPLEMENTATION DATE: 10/2013
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1785

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$410,648,000
- STATE FUNDS	\$0	\$193,770,700
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$410,648,000
STATE FUNDS	\$0	\$193,770,700
FEDERAL FUNDS	\$0	\$216,877,300

DESCRIPTION

Purpose:

This policy change estimates the costs of the Affordable Care Act (ACA) mandatory expansion of coverage to currently eligible but not enrolled beneficiaries.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the ACA provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this optional expansion population to result in a significant number of new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon those without health coverage. These mandatory requirements will likely encourage many individuals who are currently eligible but not enrolled in Medi-Cal to enroll in the program.

A percentage of the Medi-Cal expansion population will need substance use disorder treatment services and/or mental health services. Expenditures for Drug Medi-Cal and county mental health services are not included in this policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

- 1) Effective January 1, 2014, the ACA will simplify eligibility for several coverage groups (Children, Pregnant Women, and 1931b).

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 230

- 2) The Department expects the eligibility simplification and ACA outreach efforts to result in a significant number of currently eligible but not enrolled Medi-Cal beneficiaries. In order to quantify the amount of individuals, the Department analyzed historical enrollment trends when simplification efforts were implemented, and referenced several published studies regarding churning impacts of Medicaid enrollment.
- 3) In FY 2013-14, it is estimated 606,000 eligibles will enroll in Medi-Cal. Of these, 350,000 are assumed to retain coverage through enrollment simplification efforts, 55,000 are Healthy Families Program (HFP) eligible but not enrolled children, and 201,000 are those currently eligible but never enrolled.
- 4) In FY 2013-14, it is estimated the weighted average per-member-per-month (PMPM) for those currently eligible but not enrolled is \$135.97 except for HFP eligibles. The estimated PMPM for HFP eligible but not enrolled children is \$93.04. Both PMPM costs include: managed care capitation rates, managed care carve-outs, and dental capitated rates.
- 5) It is assumed each of the eligible groups joining Medi-Cal due to ACA will phase-in over different periods of time. The currently eligible but never enrolled group will start enrolling in October 2013 and fully phase-in by March 2014. The HFP and eligibility simplification groups will phase-in over 9-months beginning January 1, 2014.
- 6) The ACA requires Medi-Cal to increase the 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.
- 7) The ACA requires the expansion of Foster Care Medicaid coverage to age 26. Currently, Medi-Cal provides coverage up to age 21. In FY 2013-14, it is estimated the costs from expanding coverage for the Foster Care beneficiaries is \$10,671,000 TF (\$5,336,000 GF).
- 8) Included in this policy change are adjustments made for managed care organization (MCO) taxes.

ACA MANDATORY EXPANSION

REGULAR POLICY CHANGE NUMBER: 230

9) In FY 2013-14, the total estimated costs for the ACA mandatory expansion are:

(Dollars in Thousands)	FY 2013-14		
	<u>TF</u>	<u>GF</u>	<u>FFP</u>
Currently Eligible but Uninsured (0-64)			
1931(b) and Percent of Poverty Capitation	\$139,856	\$69,928	\$69,928
Eligible but Never Enrolled Capitation	\$165,773	\$82,886	\$82,886
HFP <150% of FPL Capitation	<u>\$13,399</u>	<u>\$4,690</u>	<u>\$8,709</u>
Subtotal	\$319,028	\$157,504	\$161,524
Dental Capitation	\$6,079	\$2,710	\$3,368
Managed Care Carve-Outs	\$57,105	\$28,221	\$28,884
100% of Medicare Primary Care Rates	<u>\$17,766</u>	<u>\$0</u>	<u>\$17,766</u>
Total Currently Eligible but Uninsured Costs	\$399,977	\$188,436	\$211,541
Foster Care Expansion to 26 years old	\$10,671	\$5,336	\$5,336
MCO Tax - Benefit to GF	<u>\$0</u>	<u>-\$6,990</u>	<u>\$0</u>
Net Impact to State	\$410,648	\$186,782	\$216,877
Funding:			
(Dollars in thousands)	<u>TF</u>	<u>GF/SF</u>	<u>FFP</u>
Title XIX 50/50 FFP (4260-101-0001/0890)	\$375,080	\$187,540	\$187,540
Title XIX 65/35 FFP (4260-113-0001/0890)	\$17,802	\$6,231	\$11,571
Title XIX 100% FFP (4260-101-0890)	\$17,766	\$0	\$17,766
3156 MCO Tax (Non-GF) (4260-601-3156)	\$6,989	\$6,989	\$0
Title XIX 100% GF (4260-101-0001)	<u>(\$6,989)</u>	<u>(\$6,989)</u>	<u>\$0</u>
Totals	\$410,648	\$193,771	\$216,877

PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS

REGULAR POLICY CHANGE NUMBER: 231
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Cang Ly
 FISCAL REFERENCE NUMBER: 1786

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$46,000,000
- STATE FUNDS	\$0	-\$23,000,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$46,000,000
STATE FUNDS	\$0	-\$23,000,000
FEDERAL FUNDS	\$0	-\$23,000,000

DESCRIPTION

Purpose:

This policy change estimates the savings from redirecting American Recovery and Reinvestment Act of 2009 (ARRA) funds from the Private Hospital Supplemental Fund to the General 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)

Interdependent Policy Changes:

PC 79 MH/UCD & BTR — Private Hospital Supplemental Payment

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.

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 Selective Provider Contracting Program (OSPCP). See the MH/UCD & BTR—Private Hospital Supplemental Payment policy change for more information.

Under 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. The Private Hospital Supplemental Fund includes funds received due to increased ARRA FMAP.

PRIVATE HOSPITAL SUPPLEMENTAL FUND SAVINGS

REGULAR POLICY CHANGE NUMBER: 231

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

- In FY 2013-14, the Department will redirect \$23,000,000 ARRA funds from the Private Hospital Supplemental Fund to the General Fund.

(In Thousands)	TF	SF	FFP
FY 2013-14			
Redirected ARRA	(\$46,000)	(\$23,000)	(\$23,000)

Funding:

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

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 232
 IMPLEMENTATION DATE: 7/2013
 ANALYST: Andrew Yoo
 FISCAL REFERENCE NUMBER: 1787

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$540,000
- STATE FUNDS	\$0	\$270,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$540,000
STATE FUNDS	\$0	\$270,000
FEDERAL FUNDS	\$0	\$270,000

DESCRIPTION

Purpose:

This policy change estimates the payments to participating Pediatric Palliative Care Waiver (PPCW) agencies for administrative costs.

Authority:

AB 1745 (Chapter 340, Statutes of 2006)

Interdependent Policy Changes:

Not Applicable

Background:

AB 1745 required the Department to submit an application to the Centers for Medicare and Medicaid Services (CMS) for a federal waiver for a Pediatric Palliative Care Pilot Project. The waiver makes available services comparable to those available through hospice that can be provided at the same time the child would receive curative services. The waiver was approved beginning April 1, 2009 through March 31, 2012. A waiver renewal was approved by CMS through March 31, 2017.

Currently, the Department does not reimburse PPCW agencies for administrative costs. This policy change provides \$300 per member per month to reimburse the PPCW agencies for indirect services, such as administrative support, overhead, and program training.

Reason for Change:

This is a new policy change.

Methodology:

The following assumptions were used to estimate the program cost adjustment:

1. Assume a total of 150 members enroll in PPCW annually.
2. Assume a \$300 per member per month cost for administrative costs.

PEDIATRIC PALLIATIVE CARE WAIVER

REGULAR POLICY CHANGE NUMBER: 232

3. This program is effective July 1, 2013.

150 members x \$300 per member per month x 12 months = \$540,000

(In Thousands)	<u>GF</u>	<u>FF</u>	<u>TF</u>
FY 2012-13	\$ 0	\$ 0	\$ 0
FY 2013-14	\$ 270	\$ 270	\$ 540

Funding:

Title XIX FFP (4260-101-0890)

RETRO MC RATE ADJUSTMENTS FOR FY 2012-13

REGULAR POLICY CHANGE NUMBER: 233
 IMPLEMENTATION DATE: 9/2013
 ANALYST: Candace Epstein
 FISCAL REFERENCE NUMBER: 1788

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$105,531,000
- STATE FUNDS	\$0	\$52,765,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$105,531,000
STATE FUNDS	\$0	\$52,765,500
FEDERAL FUNDS	\$0	\$52,765,500

DESCRIPTION

Purpose:

This policy change estimates managed care capitation rate increases for FY 2012-13.

Authority:

Welfare & Institutions Code, section 14087.3

Interdependent Policy Changes:

PC 108 Two Plan Model
 PC 109 County Organized Health Systems
 PC 110 Geographic Managed Care
 PC 226 MCO Tax Mgd. Care Plans – Incr. Cap. Rates
 PC 227 MCO Tax Mgd. Care Plans – Funding Adjustment
 PC 228 MCO Tax Managed Care Plans

Background:

Retroactive rate adjustments are due to the rate redeterminations for the Rate Year 2012-13 for Two Plan, COHS, and GMC. Capitation rate increases for FY 2012-13 will be paid in FY 2013-14.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. The Department determined the difference between what was calculated to be paid for FY 2012-13 and what was actually paid for FY 2012-13. This difference will be paid in FY 2013-14.

RETRO MC RATE ADJUSTMENTS FOR FY 2012-13

REGULAR POLICY CHANGE NUMBER: 233

(In Thousands)

FY 2013-14	FF	GF	TF
Two Plan	\$52,455	\$52,456	\$104,911
COHS	-\$364	-\$364	-\$728
GMC	\$674	\$674	\$1,348
Total	\$52,765	\$52,766	\$105,531

Funding:

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

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 234
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1789

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$1,426,631,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$1,426,631,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$1,426,631,000

DESCRIPTION

Purpose:

This policy change estimates the costs of the Affordable Care Act (ACA) optional expansion of coverage to newly eligibles.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the ACA provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects the optional expansion population to result in a significant number of new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a penalty upon the uninsured. These new mandatory requirements will increase enrollment of the currently eligible but not enrolled population. Costs for the mandatory requirements are budgeted separately in the ACA Mandatory Expansion policy change.

A percentage of the Medi-Cal expansion population will need substance use disorder treatment services and/or mental health services. Expenditures for Drug Medi-Cal and county mental health services are not included in this policy change.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

- 1) Effective January 1, 2014, the ACA will expand eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the FPL. The Department expects the overall population to result in a significant number of newly eligible Medi-Cal beneficiaries.

ACA OPTIONAL EXPANSION

REGULAR POLICY CHANGE NUMBER: 234

- 2) The Department utilized enrollment projections from the California Simulation of Insurance Markets (CalSIM Version 1.8) model designed by the UCLA Center for Health Policy Research and the UC Berkeley Labor Center.
- 3) The Department estimates 635,000 newly eligible beneficiaries will enroll in Medi-Cal in FY 2013-14. Of the newly eligible beneficiaries, LIHP represent the majority (490,000).
- 4) The Department estimates the LIHP population to transition on January 1, 2014. In FY 2013-14, the remaining 145,000 newly eligibles will phase-in over 6-months beginning January 1, 2014.
- 5) In FY 2013-14, the estimated weighted average per-member-per-month (PMPM) for the newly eligible population is \$406.47. The PMPM includes managed care capitation rates, managed care carve-outs, mental health inpatient and pharmacy carve-outs, and dental capitated rates.
- 6) The ACA requires Medi-Cal to increase the primary care service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department receives 100% FFP for the additional incremental increase in Medi-Cal rates.
- 7) This policy change includes adjustments made for the Managed Care Organization (MCO) tax. The MCO tax fund (4260-601-3156) offsets the general fund (4260-101-0001).
- 8) In FY 2013-14, the total estimated total costs for the ACA optional expansion are:

FY 2013-14	TF	GF	FF
Newly Eligible Costs	\$1,426,631	\$0	\$1,426,631
MCO Tax ^{1,2}	\$0	-\$28,743	\$0
Total	\$1,426,631	-\$28,743	\$1,426,631

Funding:

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

¹100% State GF (4260-101-0001)²MCO Tax Fund (4260-601-3156)

1% FMAP INCREASE FOR PREVENTIVE SERVICES

REGULAR POLICY CHANGE NUMBER: 236
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Jennifer Hsu
 FISCAL REFERENCE NUMBER: 1791

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$0
- STATE FUNDS	\$0	-\$2,500,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$0
STATE FUNDS	\$0	-\$2,500,000
FEDERAL FUNDS	\$0	\$2,500,000

DESCRIPTION

Purpose:

This policy change estimates the savings from receiving an additional one percent in federal medical assistance percentage (FMAP) for specified preventive services effective January 1, 2014.

Authority:

Affordable Care Act Section 4106
 Proposed Trailer Bill Language

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the Affordable Care Act (ACA) provides states with the option to receive an additional one percent in FMAP for providing specified preventive services. Eligible preventive services are those assigned grade A or B by the United States Preventive Services Task Force (USPSTF), and approved vaccines and their administration, recommended by the Advisory Committee on Immunization Practices (ACIP). For states to be eligible in receiving the enhanced FMAP, they must cover the specified preventive services in their standard Medicaid benefit package and cannot impose copayments for these services. California currently provides these preventive services within the standard benefit package and has proposed legislation to prohibit copayments for preventive services.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

- 1) The Department estimates the one percent increase in FMAP will offset the general fund by \$2,500,000 in FY 2013-14.

Funding:

100% Title XIX FFP (4260-101-0890)
 100% Title XIX GF (4260-101-0001)

ACA EXPANSION-CDCR INMATES INPT. HOSP. COSTS

REGULAR POLICY CHANGE NUMBER: 237
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1792

	FY 2012-13	FY 2013-14
FULL YEAR COST - TOTAL FUNDS	\$0	\$24,631,000
- STATE FUNDS	\$0	\$0
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$24,631,000
STATE FUNDS	\$0	\$0
FEDERAL FUNDS	\$0	\$24,631,000

DESCRIPTION

Purpose:

This policy change estimates the Federal Financial Participation (FFP) provided to the California Department of Corrections and Rehabilitation (CDCR) for the cost of inpatient services for “newly eligible” inmates beginning January 1, 2014.

Authority:

AB 1628 (Chapter 729, Statutes of 2010)

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily single, childless adults, at or below 138 percent of the federal poverty level (FPL). The Department expects this optional expansion population to result in a significant number of “newly eligible” Medi-Cal beneficiaries.

AB 1628 authorizes the Department, counties, and the CDCR to claim FFP for inpatient hospital services to Medi-Cal 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.

This policy change estimates the FFP provided to CDCR for the cost of inpatient services specifically for “newly eligible” inmates beginning January 1, 2014. FFP provided to CDCR/California Correctional Health Care Services (CCHCS) for inpatient costs from July 1, 2013 through December 31, 2013 is budgeted in PC-86 BTR-LIHP Inpatient Hosp. Costs for CDCR Inmates.

Reason for Change from Prior Estimate:

This is a new policy change.

ACA EXPANSION-CDCR INMATES INPT. HOSP. COSTS

REGULAR POLICY CHANGE NUMBER: 237

Methodology:

1. CDCR provided the estimated FFP on a cash basis:

(In Thousands)	<u>TF</u>	<u>FF</u>
FY 2013-14	\$24,631	\$24,631

Funding:

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

ACA EXPANSION-NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 238
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1793

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$7,916,000
- STATE FUNDS	\$0	-\$5,416,000
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$7,916,000
STATE FUNDS	\$0	-\$5,416,000
FEDERAL FUNDS	\$0	-\$2,500,000

DESCRIPTION

Purpose:

This policy change estimates the savings from shifting all newly enrolled New Qualified Aliens (NQA) and the optional expansion NQA eligibles into the California Health Benefit Exchange beginning January 1, 2014.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

HR 3734 (1996), Personal Responsibility and Work Opportunity Act (PRWORA) specified that federal financial participation (FFP) is not available for full-scope Medi-Cal services for most qualified nonexempt aliens during the first 5 years they are in the country. Currently, FFP is only available for emergency services. California law requires that legal immigrants receive the same services as citizens and pays for nonemergency services with 100% State GF.

Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this optional expansion population to result in a significant number of new Medi-Cal beneficiaries. Additionally, the ACA requires states to participate in online health benefit exchanges, whether they establish their own, partner with other states in a multi-state exchange, or have a federal government administered exchange. The online health benefit exchange will provide the public with the ability to purchase competitive cost-efficient health coverage. Individuals with incomes below 400% FPL will be eligible for federal subsidies to help offset the monthly premium costs. California is developing a state-operated Health Benefit Exchange called Covered California, which will open for the public no later than January 1, 2014. Covered California will be available for citizens and legal residents to purchase health coverage.

ACA EXPANSION-NEW QUALIFIED ALIENS

REGULAR POLICY CHANGE NUMBER: 238

This policy change estimates the savings from shifting new NQA eligibles and the optional expansion NQA eligibles from Medi-Cal into Covered California. The Department will cover all out-of-pocket expenditures that may occur by shifting into Covered California.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

- 1) Effective January 1, 2014, the new NQA eligibles and the optional expansion NQA eligibles will begin shifting into Covered California through a phase-in methodology.
- 2) In FY 2013-14, it is estimated 13,471 NQAs will shift into Covered California.
- 3) In FY 2013-14, the total estimated savings are:

(in thousands)	<u>TF</u>	<u>GF</u>	<u>FF</u>
FY 2013-14 savings	-\$7,916	-\$5,416	-\$2,500

Funding:

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

ACA EXPANSION-PREGNANCY ONLY

REGULAR POLICY CHANGE NUMBER: 239
 IMPLEMENTATION DATE: 1/2014
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1794

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	-\$52,705,000
- STATE FUNDS	\$0	-\$26,352,500
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	-\$52,705,000
STATE FUNDS	\$0	-\$26,352,500
FEDERAL FUNDS	\$0	-\$26,352,500

DESCRIPTION

Purpose:

This policy change estimates the savings from shifting current pregnant women with incomes between 100-200% of the federal poverty level (FPL) receiving pregnancy only services into the California Health Benefit Exchange beginning January 1, 2014.

Authority:

Not Applicable

Interdependent Policy Changes:

Not Applicable

Background:

Effective January 1, 2014, the Affordable Care Act (ACA) provides states the option to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL). The Department expects this optional expansion population to result in a significant number of new Medi-Cal beneficiaries. Additionally, the ACA requires states to participate in online health benefit exchanges, whether they establish their own, partner with other states in a multi-state exchange, or have a federal government administered exchange. The online health benefit exchange will provide the public with the ability to purchase competitive cost-efficient health coverage. Individuals with incomes below 400% FPL will be eligible for federal subsidies to help offset the monthly premium costs. California is developing a state-operated Health Benefit Exchange called Covered California, which will open for the public no later than January 1, 2014. Covered California will only be available for citizens and legal immigrants to purchase health coverage.

Pregnant women with incomes between 100-200% of the FPL are eligible for Medi-Cal pregnancy only coverage. Pregnancy only coverage is limited to pregnancy related services throughout the entire pregnancy.

This policy change estimates the savings from shifting the current pregnant women receiving pregnancy only services through Medi-Cal into Covered California. The Department will cover all out-of-pocket expenditures that may occur from shifting into Covered California.

ACA EXPANSION-PREGNANCY ONLY

REGULAR POLICY CHANGE NUMBER: 239

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

- 1) Effective January 1, 2014, the beneficiaries currently receiving pregnancy only coverage will begin shifting into Covered California through a 12-month phase-in.
- 2) In FY 2013-14, it is estimated 13,363 eligibles will shift into Covered California.
- 3) In FY 2013-14, the total estimated total savings are:

(in thousands)	<u>TF</u>	<u>GF</u>	<u>FF</u>
FY 2013-14 savings	-\$52,705	-\$26,352	-\$26,352

Funding:

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

AIM LINKED INFANTS 250-300% FPL

REGULAR POLICY CHANGE NUMBER: 240
 IMPLEMENTATION DATE: 10/2013
 ANALYST: Ryan Witz
 FISCAL REFERENCE NUMBER: 1797

	<u>FY 2012-13</u>	<u>FY 2013-14</u>
FULL YEAR COST - TOTAL FUNDS	\$0	\$33,357,000
- STATE FUNDS	\$0	\$11,674,950
PAYMENT LAG	1.0000	1.0000
% REFLECTED IN BASE	0.00 %	0.00 %
APPLIED TO BASE		
TOTAL FUNDS	\$0	\$33,357,000
STATE FUNDS	\$0	\$11,674,950
FEDERAL FUNDS	\$0	\$21,682,050

DESCRIPTION

Purpose:

This policy change estimates the benefits cost to transition the AIM Linked Infants with incomes between 250-300% into the Medi-Cal delivery system.

Authority:

Proposed Trailer Bill Language

Interdependent Policy Changes:

Not Applicable

Background:

Effective October 1, 2013, AIM Linked Infants will begin transitioning into the Medi-Cal delivery system through a phase-in methodology. Children who previously paid premiums with Managed Risk Medical Insurance Board (MRMIB) will continue paying premiums for coverage following the transition into the Medi-Cal delivery system.

Reason for Change from Prior Estimate:

This is a new policy change.

Methodology:

1. Effective October 1, 2013, the Department estimates approximately 3,997 AIM Linked Infants with incomes between 250-300% FPL will transition into the Medi-Cal delivery system.
2. The Department assumes MRMIB will budget the costs for the AIM Linked Infants from July 1, 2013 through September 30, 2013.
3. MRMIB provided the estimated costs for FY 2013-14 on a cash basis.

AIM LINKED INFANTS 250-300% FPL

REGULAR POLICY CHANGE NUMBER: 240

(In Thousands)	<u>TF</u>	<u>GF</u>	<u>FF</u>
FY 2013-14	\$33,357	\$11,675	\$21,682

Funding:

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