

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

**MEDI-CAL
ASSUMPTIONS**

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MEDI-CAL ASSUMPTIONS
May 2013
FISCAL YEARS 2012-13 & 2013-14

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INTRODUCTION

The Medi-Cal Estimate, which is based upon the Assumptions outlined below, can be segregated into three main components: (1) the Fee-for-Service (FFS) base expenditures, (2) the base policy changes, and (3) regular policy changes. The FFS base estimate is the anticipated level of FFS program expenditures assuming that there will be no changes in program direction, and is derived from a 36-month historical trend analysis of actual expenditure patterns. The base policy changes anticipate the Managed Care, Medicare Payments, and non-FFS Medi-Cal program base expenditures. The regular policy changes are the estimated fiscal impacts of any program changes which are either anticipated to occur at some point in the future, or have occurred so recently that they are not yet fully reflected in the base expenditures. The combination of these three estimate components produces the final Medi-Cal Estimate.

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

FEE-FOR-SERVICE BASE ESTIMATES

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

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

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

ELIGIBILITY: NEW ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
E 0.1 (PC-222)	X	X	<u>Incarceration Verification Program</u> The Department is improving the process to identify individuals ineligible for Medi-Cal full and limited scope 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.
E 0.2 (OA-76)		X	<u>Vital Records Data</u> The Department previously received vital records data from California Department of Public Health (CDPH) in a case-by-case basis. To improve efficiency, the Department decided to establish automated and timely processes to receive data from CDPH on a regular basis.
E 0.3 (PC-240)		X	<u>AIM Linked Infants 250-300% FPL</u> Effective October 1, 2013, Access for Infants and Mothers (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.

“PC” refers to “Policy Change”.

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

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

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

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

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

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
E 1	(OA-13) (OA-63) (OA-73)	X	X	<p><u>Single Point of Entry</u></p> <p>The Department and the Managed Risk Medical Insurance Board (MRMIB) developed an application form for the Healthy Families Program (HFP), which is also used as a screening tool for the Medi-Cal children's percent programs. Applicants send this form is sent to a the Single Point of Entry (SPE), where it is screened to determine whether it should be forwarded to a county welfare department (CWD) for a Medi-Cal determination for the children's percent programs or to MRMIB for a Healthy Families determination.</p> <p>The Department pays the federal Title XIX and the federal Title XXI share for the Medi-Cal applications through an interagency agreement with MRMIB. The Department will continue to pay the federal share for the Medi-Cal applications; however, the interagency agreement with MRMIB will be eliminated in early 2013 upon final execution of a DHCS contract with MAXIMUS. No sooner than Effective January 1, 2013, when MRMIB ceases to enroll new applicants, all new applications submitted to SPE, whether paper or electronic, will be screened and forwarded to counties for a Medi-Cal determination. <u>Effective January 1, 2014, the contract with vendor for the HFP transition includes Single Point of Entry activities.</u></p>
E 2	(PC-2) (PC-6)	X	X	<p><u>Bridge to HFP</u></p> <p>The one-month Bridge from Medi-Cal to Healthy Families is currently for children who become ineligible for full-scope, zero share-of-cost (SOC) Medi Cal or are eligible for Medi-Cal with a SOC. To be eligible for this Bridge, a child must have income at or below the Healthy Families income standard of 200% of poverty (although the use of an income disregard effectively raises the upper limit to 250% of poverty). Title XXI federal funding is used for this additional coverage. Medi-Cal managed care plan members remain enrolled in the managed care plan during the one month of additional eligibility. Plans receive an additional capitation payment for each of these member months.</p> <p>No sooner than Effective January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition <u>began transitioning</u> into Medi-Cal through a phase-in methodology, which will eliminate <u>reduces</u> the need for the bridge from Medi-Cal to the HFP.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 3	(PC-15)	X	X	<p><u>Resource Disregard – % Program Children</u></p> <p>Based on the provisions of SB 903 (Chapter 624, Statutes of 1997), resources will not be counted in determining the Medi-Cal eligibility of children with income within the various Percentage Program limits. Enhanced federal funding is available through State Children’s Health Insurance Program (SCHIP).</p>
E 4	(PC-14)	X	X	<p><u>New Qualified Aliens</u></p> <p>The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), as amended, specifies that federal funding is not available for full-scope Medi-Cal services for most Qualified Nonexempt Aliens who enter the country on or after August 22, 1996, for the first five years they are in the country. Most New Qualified Aliens are only eligible for FFP for emergency services and pregnancy-related services. California is continuing to provide full-scope Medi-Cal services to aliens who have satisfactory immigration status under the pre-Welfare Reform laws. The cost of nonemergency services provided to the New Qualified Aliens is identified through a retroactive tracking system and the federal government is reimbursed on a retroactive basis for the FFP paid that is not available for these services.</p> <p>PRWORA requires deeming an alien’s sponsor’s income and resources for Medicaid. The Department is awaiting guidance from CMS to determine if FFP is available for services provided to Newly Qualified Aliens who have been in the country for five years and after the federal sponsored alien rules are applied. The Department will continue to claim FFP for nonemergency services for sponsored persons who have been here for more than five years until those instructions are issued.</p>
E 5	(PC-7)	X	X	<p><u>Refugees</u></p> <p>The federal Refugee Act of 1980 provides states with 100% of a State's Medicaid cost of services to Refugee Cash Assistance and Refugee Medical Assistance programs for up to eight months from the date of arrival in the United States, date of final grant of asylum, and date of certification for trafficking victims.</p> <p>The California Department of Public Health (CDPH) administers California’s Refugee Resettlement Program federal grant and the</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				Department invoices CDPH for the reimbursement of the Medical Assistance Program expenditures.
E 6	(OA-24)	X	X	<u>SSA Costs for Health Coverage Information</u>
				The Social Security Administration (SSA) obtains information about health coverage and assignment of rights to medical coverage for SSI/SSP recipients. The Department uses this information to defer medical costs to other payers. SSA bills the Department quarterly for these activities.
E 7	(OA-8)	X	X	<u>Postage & Printing</u>
				Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party resources are budgeted in the local assistance item as these costs are caseload driven. Postage and printing costs may be charged to local assistance if the postage and printing is for items that will be sent to or used by Medi-Cal beneficiaries. Beginning in October 2008, the design, translation, focus testing and printing of certain informing and application forms and the mailing to beneficiaries or distribution to community based organizations and counties are performed by the Health Care Options vendor. Under the federal Health Insurance Portability and Accountability Act (HIPAA), it is a legal obligation of the Medi-Cal program to send out a Notice of Privacy Practices (NPP) to each beneficiary household explaining the rights of beneficiaries regarding the protected health information created and maintained by the Medi-Cal program. The notice must be sent to all new Medi-Cal and Breast and Cervical Cancer Treatment Program (BCCTP) enrollees, and at least every 3 years to existing beneficiaries <u>and within 60 days of a material revision to the notice to current enrollees. Additionally, every 3 years, current enrollees must be notified of the availability of the notice and how to obtain the notice.</u> Postage and printing costs for the HIPAA NPP are included in this item.
				Costs for the printing and postage of notices and letters for the State-funded component of the BCCTP are included as a 100% General Fund cost.
E 8	(CA-10)	X	X	<u>Systematic Alien Verification Entitlement System</u>
				The federally mandated Systematic Alien Verification Entitlement (SAVE) system was implemented in California on October 1,

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

1988. This system allows State and local agencies to make inquiries from a federal database to obtain information on the immigration status of aliens applying for entitlement benefits. The Department conducted an evaluation of the various modes available to access SAVE, and chose the existing Income and Eligibility Verification System to provide that access. County administrative costs for using the SAVE system for Medi-Cal eligibility purposes are reimbursed 100% by the federal government.

E 9 (OA-55) X X

Maternal and Child Health-CDPH

Federal matching funds are available for county administrative costs relating to the following services for Medi-Cal eligible women, infants, children, and adolescents: (1) reduction of high death rate for African-American infants; (2) case management and follow-up services for improving access to early obstetrical care for pregnant women; (3) recruitment and technical assistance for providers under the Comprehensive Perinatal Services Program; (4) general maternal and child health scope of work local program activities, including perinatal education, services and referral; and (5) case management for pregnant teens, education and prevention of subsequent pregnancies. Effective July 1, 2009, all GF was eliminated from the Maternal and Child Health programs. Local agencies continue to match Title XIX funds with Certified Public Expenditures.

E 10 (OA-62) X X

Outreach – Children

The Budget Act of 1997 and AB 1572 (Chapter 625, Statutes of 1997) established funding for children's outreach. Activities included media, public relations, collateral, certified application assistance, and a toll-free line.

In the Budget Act of 2003, outreach was limited to funding of a toll-free line. An interagency agreement with MRMIB was executed to fund the toll-free line with MAXIMUS starting January 1, 2004.

~~No sooner than~~ **Effective** January 1, 2013, ~~the HFP will cease to enroll new subscribers and HFP subscribers will transition~~ **began transitioning** into Medi-Cal through a phase-in methodology. The Department will continue to fund the toll-free line, but the interagency agreement with MRMIB will be terminated ~~upon~~

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				execution of a new contract for those services between the Department and Maximus in FY 2012-13.
E 11	(CA-2)	X	X	<p><u>Statewide Automated Welfare Systems</u></p> <p>The Statewide Automated Welfare Systems (SAWS) consist of three county consortium systems: the Los Angeles Eligibility Automated Determination Evaluation and Reporting (LEADER), the Consortium-IV (C-IV) and the CalWORKs Information Network (CalWIN).</p> <p>The SAWS project management is now the responsibility of the Office of Systems Integration (OSI) within the Health and Human Services Agency. The Department provides expertise to OSI on program and technical system requirements for the Medi-Cal program and the Medi-Cal Eligibility Data System (MEDS) interfaces.</p> <p>The LEADER is the automated system for Los Angeles County and it is currently in the maintenance and operation phase. The County began the process to replace the LEADER system and has completed contract negotiations with the successful bidder (Accenture). Federal oversight agencies, <u>OSI, and the County board of supervisors</u> have reviewed and approved the LEADER Replacement System (LRS) development contract. <u>Development began in</u> currently scheduled for initiation in September <u>November</u> 2012. While the replacement system is being developed, the County received state and federal approval to extend the existing LEADER maintenance and operations contract, through April 2015.</p> <p>The CalWIN consortium and C-IV system are in the maintenance and operation phase.</p> <p>The State and the counties in the current LEADER and C-IV consortia are working together to develop a new consortium.</p>
E 12	(CA-3)	X	X	<p><u>CalWORKs Applications</u></p> <p>Beginning in 1998 a portion of the costs for CalWORKs applications can be charged to Medi-Cal. CDSS has amended the claim forms and time study documents completed by the counties to allow CalWORKs application costs that are also necessary for Medi-Cal eligibility to be shared between the two programs.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 13	(PC-4) (PC-FI)	X	X	<p><u>CHDP Gateway</u></p> <p>In order to help ensure that all children have access to medical care, the CHDP Gateway program was implemented July 1, 2003. Through this program, children receiving a CHDP screen are pre-enrolled in Medi Cal/Healthy Families for up to two months of full-scope benefits, during which time the family can choose to apply for continuing Medi-Cal/Healthy Families coverage. To facilitate this application, each child for whom the family indicates a desire for continuing Medi-Cal/Healthy Families coverage is sent a CHDP cover letter and a Medi-Cal/Healthy Families application form that is also used to screen for the Medi-Cal children's percent programs. The application contains a toll-free telephone number available to families who have questions about the program, and is printed in Medi-Cal threshold languages. The Healthy Families application is returned to the Single Point of Entry (SPE) and is screened for the Medi-Cal children's percent programs and forwarded to the county for a Medi-Cal determination or to Healthy Families.</p> <p>The state-funded CHDP Program continues to provide screens to children eligible for limited-scope Medi-Cal. Effective October 1, 2003, the federal share of funding for the pre-enrollment costs is Title XXI funds, as required by federal statute. Funding ratios are 65% FFP/35% GF for children with income between Medi-Cal limits and 250% of poverty. For children with income below Medi-Cal limits, the sharing ratio is 50% FFP/50% GF.</p> <p>Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment, so claims are no longer Title XXI funded. Children screened to HFP continue to be claimed under Title XXI.</p> <p>Medi-Cal receives funding from the Childhood Lead Poisoning Prevention (CLPP) Fund to cover blood lead testing as part of the CHDP Health Assessment for young children with risk factors for lead poisoning.</p> <p>No sooner than Effective January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition began transitioning into Medi-Cal through a phase-in methodology. Children subscribed in the HFP will be transitioned to the Medi-Cal Program, and All children receiving a screen through the CHDP</p>

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Gateway program will be pre-enrolled into Medi-Cal. DHCS will continue to receive enhanced Title XXI funding for these children.

Effective January 1, 2013, funding for aid code 8X shifted from SCHIP to Medicaid Children's Health Insurance Program (MCHIP).

E 14	(OA-72)	X	X	<p><u>Merit System Services for Counties</u></p> <p>Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. As many counties do not have a civil service system, the Department contracts with the State Personnel Board for Merit System Services to perform as a personnel board for those counties. Merit System Services administers a civil service system for employment and retention of Medi Cal staff in 30 County Welfare Departments (CWD) and oversight in the other 28 counties.</p>
E 15	(CA-6) (CA-9)	X	X	<p><u>County Cost of Doing Business</u></p> <p>Based on the Medi-Cal County Administration Cost Control Plan, county welfare department administrative cost increases for Medi-Cal eligibility determinations are limited to a maximum increase of the California Necessities Index (CNI) as calculated by the Department of Finance, or state employee salary increases, whichever is greater.</p>
E 16	(CA-5)	X	X	<p><u>Los Angeles County Hospital Intakes</u></p> <p>Los Angeles County uses Patient Financial Services Workers (PFSWs) to provide intake services for Medi-Cal applications taken in Los Angeles County hospitals. Welfare & Institutions (W&I) Code Section 14154 limits the reimbursement amount for PFSW intakes to the rate that is applied to Medi-Cal applications processed by the Los Angeles County Department of Social Services (DPSS) eligibility workers. The federal share for any costs not covered by the DPSS rate is passed through to the county.</p>
E 17	(CA-4)	X	X	<p><u>Eligible Growth</u></p> <p>The county administrative cost base estimate does not include costs anticipated due to the growth in the number of Medi-Cal only eligibles. Funds are added through a policy change item based on</p>

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

the cost impact of the expected growth in the average monthly number of Medi-Cal only eligibles. The number is adjusted with each Estimate with updates of the latest base eligible count. The policy change presumes that counties will hire staff to process the new applications and maintain the new cases. **Eligible growth will not be funded in FY 2013-14.**

E 18	(OA-58)	X	X	<u>Department of Social Services Administrative Costs</u>
<p>The Department provides Title XIX federal financial participation (FFP) to the California Department of Social Services (CDSS), via interagency agreements (IAs), for the administrative costs related to services provided to Medi-Cal beneficiaries under the In-Home Supportive Services (IHSS) Personal Care Services Program (IHSS PCSP), the Child Welfare Services/Case Management System (CWS/CMS), the Statewide Automated Welfare System (SAWS), and the Independence Plus Option Section 1915 (j) <u>IHSS Plus Option</u> (IPO) waiver <u>program</u>.</p>				
E 19	(PC-18) <u>(PC-16)</u> <u>(PC-17)</u>	X	X	<p><u>Public Assistance Reporting Information System (PARIS)</u> Interstate <u>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.</u> The Public Assistance Reporting Information System (PARIS) <u>PARIS-</u> Interstate match allows states to compare beneficiary information with other states to identify changes in residence and public assistance benefits in other states.</p>
E 20	(PC-16)	X	X	<p><u>PARIS-Federal</u></p> <p>This assumption has been merged with "E 20 Public Assistance Reporting Information System (PARIS)."</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 21	(CA-13)	X		<p><u>County Administration Reconciliation</u></p> <p>Within two years following the end of a fiscal year, county administrative expenditures are reconciled to the county administration allocation for the applicable fiscal year. In FY 2012-13, the Department will complete completed the final reconciliation for FY 2010-11 and the interim reconciliation for FY 2011-12. <u>In FY 2013-14, the Department plans to complete an interim reconciliation for FY 2012-13.</u></p>
E 22	(OA-47)	X	X	<p><u>Q5i Automated Data System Acquisition</u></p> <p>The Department acquired the Q5i automated quality control data system on June 10, 2011. There will be ongoing costs for associated software, maintenance and support. The Q5i system is used to support quality control efforts for the following state and federally mandated programs: Medi-Cal Eligibility Quality Control, County Performance Standards, Payment Error Rate Measurement, and Anti-Fraud/Program Integrity.</p>
E 23	(OA-16)	X	X	<p><u>Medi-Cal Eligibility Data System (MEDS)</u></p> <p>MEDS is currently the only statewide database containing eligibility information for public assistance programs administered by the Department and other departments. MEDS provides users with the ability to perform multi-program application searches, verify program eligibility status, enroll beneficiaries in multiple programs, and validate information on application status.</p> <p>Funding is required for MEDS master Client Index maintenance, data matches from various federal and state agencies, SSI termination process support, Medi-Cal application alerts, MMA Part D buy-in process improvements, eligibility renewal process, and reconciling county eligibility data used to support the counties in Medi-Cal eligibility determination responsibilities. Costs currently are offset by reimbursements made from other state departments using MEDS.</p> <p>In addition, maintenance funding is required for the Business Objects (BO) software application tool that enables the counties to perform On-Line Statistics and MEDS-alert reporting. The On-Line Statistics reporting system tracks and reports all county worker transactions for MEDS.</p>

ELIGIBILITY: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
E 24 (OA-60)	X	X	<p><u>Veterans Benefits</u></p> <p>AB 1807 (Chapter 1424, Statutes of 1987) permits the Department to make available federal Medicaid funds in order to obtain additional veterans benefits for Medi-Cal beneficiaries, thereby reducing costs to Medi-Cal. An interagency agreement exists with the Department of Veterans Affairs.</p>
E 25 (PC-13)	X	X	<p><u>CHIPRA – Elimination of 5-Year Bar on Full-Scope Medi-Cal for New Qualified and lawfully present Immigrant</u> Children and Pregnant Women</p> <p>The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) provides that immigrants who are designated as “Qualified Aliens” are eligible for full-scope Medi-Cal with federal financial participation (FFP) if they have been in the United States for at least five years. California currently provides full-scope Medi-Cal to otherwise eligible Qualified Aliens who have been in the U.S. for less than five years (<u>referred to as New Qualified Immigrants</u>) and pays for nonemergency services with 100% State funds if FFP is not available. (FFP is available regardless of immigration status for emergency and pregnancy-related services.) CHIPRA includes a provision which gives states the option to provide full-scope Medi-Cal with FFP to eligible Qualified Aliens who are children under the age of 21 or pregnant women even if they have been in the U.S. for less than five years. <u>CHIPRA also gives states the option to provide full-scope Medi-Cal with FFP to eligible immigrants who are lawfully residing children under the age of 21 or pregnant women (including some lawfully present immigrants who are not Qualified Aliens).</u> The Department received federal approval and implemented this option to implement these options on April 1, 2009 <u>of State Plan Amendment (SPA) 09-14 on April 1, 2009 which authorizes the state to implement both of these options.</u></p>
E 26			<p><u>Lanterman Developmental Center Closure</u></p> <p>This assumption has been moved to “Information Only” section.</p>
E 27 (PC-11)	X	X	<p><u>250% Working Disabled Program (WDP) Changes</u></p> <p>The assumption has been moved to the “Fully Incorporated into Base Data/Ongoing” section.</p>

ELIGIBILITY: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
E 28	(CA-12)	X		<p><u>Reduction of CNI-Based COLA to Counties</u></p> <p>The Cost of Living Adjustment (COLA) for county staff who perform tasks as part of the Medi-Cal eligibility process will be eliminated for FY 2012-13.</p>
E 29	(PC-5) (PC-8) (OA-32)	X	X	<p><u>Medi-Cal Inpatient Services for Inmates</u></p> <p>AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department, counties, and the California Department of Corrections and Rehabilitation (CDCR) to claim federal reimbursement for inpatient hospital services for Medi-Cal eligible adult inmates in State and county correctional facilities when these services are provided off the grounds of the facility. Effective April 1, 2011, the Department began accepting Medi-Cal applications from the California Correctional Health Care Services (CCHCS) for eligibility determinations for State inmates. Claims will be processed retroactive to November 1, 2010. The Department will budget the FFP for services and CDCR administrative costs and CDCR will continue to budget the GF. Previously these services were paid by CDCR with 100% GF. Additionally, the Department is taking steps to implement Medi-Cal coverage of inpatient hospital services provided off the grounds of the correctional facility for eligible county inmates.</p> <p>AB 396 (Chapter 394, Statutes of 2011) authorized the Department and counties to claim federal reimbursement for inpatient hospital services and inpatient psychiatric services for 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.</p> <p>SB 1399 (Chapter 405, Statutes of 2010) authorizes the Board of Parole Hearings to grant medical parole to permanently medically incapacitated state inmates. A State inmate granted medical parole is potentially eligible for Medi-Cal. When an inmate is granted medical parole, CDCR submits a Medi-Cal application to the Department to determine eligibility. Previously these services were funded through CDCR with 100% GF.</p> <p><u>SB 1462 (Chapter 837, Statutes of 2012) authorizes a county sheriff, or designee, to request the resentencing of certain prisoners from a county correctional facility to medical probation or compassionate release. Resentencing is</u></p>

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

available as long as the prisoner does not pose a threat to public safety, has a life expectancy of six months or less, is physically incapacitated, or needs long term care. Prior to compassionate release or medical probation, a placement option must be secured. Also, the county must examine the prisoner's eligibility for Medi-Cal or other medical coverage to assist in funding the prisoner's medical treatment while on medical probation or compassionate release. Counties are required to pay the non-federal share of Medi-Cal expenditures associated with the bill's implementation for the period of time the offender would have otherwise been incarcerated.

E 30 (PC-12) X X

Lomeli, et al., v. Shewry

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

E 31

PARIS-Veterans Match

This assumption has been merged with "E 20 Public Assistance Reporting Information System (PARIS)."

E 32 (PC-2) X X
 (PC-62)
 (PC-FI)
 (OA-13)
 (CA-7)
 (PC-64)

Transition of Healthy Families Children to Medi-Cal

AB 1494 (Chapter 28, Statutes of 2012) requires, effective January 1, 2013, that children subscribed in the HFP will be transitioned into Medi-Cal through a phase-in methodology. Coverage of this population under Medicaid programs is permissible pursuant to the federal Social Security Act to provide full scope Medi-Cal benefits to such eligible children who are optional targeted low-income children with family incomes up to and including 200% of the federal poverty level (FPL).

Assets will be exempt for these children and an income disregard will be available creating an effective income level not to exceed 250% of the FPL. Individuals with incomes above 150% and up to 250% of the FPL will be subject to premiums at the same level of the Community Provider Plan (CPP) option as used under the

ELIGIBILITY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

~~current~~ HFP. Children with incomes at and below 150% of the FPL will not pay premiums.

In pursuing this option to cover these targeted low income children, the benefits and administrative costs provided to these children are eligible for enhanced federal funding of 65% **FFP / 35% GF** under Title XXI. To the extent possible, the children will be mandatorily enrolled into Medi-Cal managed care delivery systems; and to the extent such delivery models are not available, benefits will be provided under Medi-Cal fee-for-service arrangements. Implementation is contingent upon receiving necessary federal approvals.

~~The MRMIB, in consultation with the~~ **The** Department, ~~will provide~~ **has provided** written notice **notices** to beneficiaries enrolled in Healthy Families of **describing** their transition to the Medi-Cal program and changes ~~they should~~ **to** anticipate prior to their movement into Medi-Cal.

Under the HFP, the mental health services provided to the Seriously Emotionally Disturbed (SED) beneficiaries are carved out and provided by county mental health departments. Specialty mental health services for HFP SED beneficiaries transferred into the Medi-Cal program **who meet medical necessity criteria for Medi-Cal specialty mental health services** will continue to ~~receive these services~~ **be provided** through county mental health departments. County mental health departments are eligible to claim FFP through the CPE process.

E 33 (PC-9) X X
 (CA-8)

Maternal and Child Health Access (MCHA) vs. DHCS and MRMIB

The Department uses the Single Point of Entry (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. MCHA contends that the Department and Managed Risk Medical Insurance Board (MRMIB) are required to use the joint application as an application for all Medi-Cal programs, not just the FPL program, as is the current practice. In addition, MCHA raised several other issues relating to the administration of SPE, including notice requirements and infant eligibility.

On December 6, 2010, the court issued its decision ruling in favor of the Department on all issues except that for children ages 6-18 the State must screen for section 1931(b) Medi-Cal before

ELIGIBILITY: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

enrolling the child in HFP. Most significantly, the court upheld the Department's current practice of using the joint application as a screen for only one Medi-Cal program and the ruling did not change the current screening for the FPL Medi-Cal program.

On July 10, 2012, San Francisco Superior Court issued an order enforcing writ requiring that, by August 31, 2012, the SPE conduct the 1931(b) Medi-Cal program screen using the current application for children age 6 up to age 19 before enrolling a child in the HFP. The Department previously had agreed to implement a screen at SPE to identify "deemed eligible" infants. ~~The court ordered that Department and MRMIB file a status report by September 4, 2012.~~ These requirements will result in an increase in caseload duties for county eligibility workers and additional benefit costs. ~~No sooner than~~ **Effective** January 1, 2013, the HFP ~~will cease to enroll new subscribers~~ **began transitioning into Medi-Cal through a phase-in methodology. Additionally, the new screening process was implemented,** and all applications submitted to SPE ~~will be~~ **are** sent to county eligibility workers for a Medi-Cal determination.

Petitioners have applied for an award of attorneys fees.

AFFORDABLE CARE ACT

Effective January 1, 2014, the ACA will establish a new income eligibility standard for Medi-Cal based upon a Modified Adjusted Gross Income (MAGI) of 133% of the federal poverty level (FPL) for pregnant women, children up to age 19, and parent/caretaker relatives. In addition, the current practice of using various income disregards to adjust family income will be replaced with a single 5% income disregard. The ACA will also simplify the enrollment process and eliminates the asset test for MAGI eligible. Existing income eligibility rules for aged, blind, and disabled persons will not change.

The new standard will allow current recipients of Medi-Cal to continue to enroll in the program and grants the option for states to expand eligibility to a new group of individuals: primarily adults, age 19-64, without a disability and who do not have minor children.

In addition, the ACA will impose a tax upon those without health coverage, which will likely encourage many individuals who are currently eligible, but not enrolled, in Medi-Cal to enroll in the program. The Department expects this expansion group, to the extent the State chooses to exercise this option, and the currently eligible but not enrolled population to result in a significant number of new Medi-Cal beneficiaries.

For those newly eligible adults in the expansion group, the ACA will provide California with enhanced FFP at the following rates:

- 100% FFP from calendar years 2014 to 2016,
- 95% FFP in 2017,
- 94% FFP in 2018,
- 93% FFP in 2019,
- 90% FFP in 2020 and beyond.

For those who are currently eligible, but not enrolled, in Medi-Cal, enhanced FFP will not be available. Beginning in October 2015, the ACA will increase the CHIP FMAP provided to California by 23 percent, to 88 percent FFP, up from 65 percent.

The ACA requires the Department to establish a benefit package, called a benchmark plan, for the expansion population. CMS has not released the final rules that will govern the benchmark plan and, consequently, it is unknown what type of benchmark plan California will choose to offer.

~~The Department is currently assessing all required administrative changes that will be required to implement various other ACA rules as well as several provisions offered as options for states. Because various aspects of how the ACA will be implemented are still unknown, the Estimate only contains policy changes to estimate the following costs:~~

- ~~• Drug Medi-Cal;~~
- ~~• Medicaid Emergency Psychiatric Demonstration;~~
- ~~• Add on for LTC (Non-AB 1629 & AB 1629) Facilities;~~
- ~~• Recovery Audit Contract;~~
- ~~• HIPPA Operating Rules.~~

~~Other impacts to Medi-Cal will be determined in future Estimates.~~

AFFORDABLE CARE ACT: NEW ASSUMPTIONS

	Applicable F/Y <u>C/Y</u> <u>B/Y</u>	
ACA 0.1 (OA-75)	X	<p><u>ETL Data Solution</u></p> <p>The Centers for Medicare and Medicaid Services (CMS) is requesting data in a standardized format from the states, which allows streamlining the review of system projects related to the Affordable Care Act (ACA). The Department plans to implement an enterprise-wide Extract, Transform, and Load (ETL) data solution to modernize and streamline the data transmission processes from the Department to the CMS' Transformed Statistical Information System (T-MSIS). The project provides modern capabilities to improve business processes; and the ability to collect comprehensive data regarding cost, quantity and quality of health care provided for Medi-Cal beneficiaries. The Department intends to procure a contractor to provide technical support for the design, development and implementation, and ongoing operation and maintenance of the ETL data solution.</p>
ACA 0.2 (PC-230) (PC-234) (PC-238) (PC-239) (OA-78) (CA-14)	X	<p><u>ACA Mandatory and Optional Expansions</u></p> <p>Effective January 1, 2014, the ACA provides states with 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 new Medi-Cal beneficiaries. In addition, the ACA requires enrollment simplification for several current coverage groups and imposes a tax 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. The expansion population will be eligible for full-scope Medi-Cal and a percentage will need substance use disorder treatment services and/or mental health services.</p> <p>The ACA provides California with enhanced FFP for the newly eligible adults at the following rates:</p> <p style="padding-left: 40px;">100% FFP from 2014 to 2016, 95% FFP in 2017, 94% FFP in 2018, 93% FFP in 2019, 90% FFP in 2020 and beyond.</p> <p>The enhanced FFP is not available for individuals who are currently eligible for Medi-Cal, but not enrolled. Additionally,</p>

AFFORDABLE CARE ACT: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

enhanced FFP is not available for county administrative costs related to the implementation of ACA.

Effective January 1, 2014, a percentage of the newly eligible NQA and existing pregnancy only populations are estimated to shift into Covered California. The Department will cover all out-of-pocket expenditures and any benefit gaps that may occur from shifting into Covered California.

ACA 0.3 (PC-236) X

1% FMAP Increase for Preventive Services

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 does not impose cost sharing on these services.

ACA 0.4 (PC-237) X

ACA Expansion-CDCR Inmates Inpatient Hospital Costs

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.

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
ACA 1 (PC-136)	X	X	<p><u>Payments to Primary Care Physicians</u></p> <p>The ACA requires Medi-Cal to increase primary care service rates to 100% of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The Department will receive 100% FFP for the additional incremental increase in Medi-Cal rates that were in effect as of July 1, 2009 to the Medicare level for primary care services.</p>
ACA 2 (PC-51)	X	X	<p><u>Managed Care Drug Rebates</u></p> <p>The ACA extended the federal drug rebate requirement to Medicaid managed care outpatient covered drugs. In addition to County Organized Health Systems, Medi-Cal drug rebates are now also provided by:</p> <ul style="list-style-type: none"> • Geographic Managed Care (GMC) health plans • Two-Plan model health plans, and the • Health Plan of San Mateo (HPSM), a County Organized Health System (COHS). <p>Previously, only COHS health plans except for HPSM were subject to the rebate requirement.</p> <p>The Department will invoice for these rebates, retroactive to March 23, 2010, beginning in March 2013.</p>
ACA 3 (PC-41)	X		<p><u>Federal Drug Rebate Change</u></p> <p>The ACA increases the mandated federal rebate to 23.1% of the Average Manufacturer's Price (AMP) from the previous 15.1% for single source drugs and increases 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 GF share at the current FMAP rate, for all rebates collected.</p>
ACA 4 (OA-7)	X	X	<p><u>CalHEERS Development</u></p> <p>The ACA mandates the establishment of health insurance exchanges, in California, known as the Health Benefit Exchange (HBEX) to provide competitive health care coverage for individuals and small employers. As required by ACA, States must establish</p>

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

the ability to accept online application and to determine an applicant’s eligibility for subsidized coverage. States are also required to use a single, streamlined application to apply for all applicable health subsidy programs. The application may be filed online, in person, by mail, by telephone, or with the Medicaid and Children’s Health Insurance Program (CHIP) agency. To meet this requirement, the Department-and the Exchange have formed a partnership to acquire a Systems Integrator to design and implement the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) as the business solution.

ACA also offers new enhanced federal funding for developing/upgrading Medicaid eligibility systems and for interactions of such systems with the ACA-required Exchanges.

ACA 5 (OA-26) X X
 (OA-39)

MEDS Integration into **Interface with CalHEERS**

CalHEERS will be programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through ~~the HBEX~~ **Covered California**, Medi-Cal and the Healthy Families program. In order to provide seamless integration with the new CalHEERS system, the Department will establish and design the implementation of technology solutions for ongoing maintenance of Medi-Cal Eligibility Data System (MEDS) changes and integration with CalHEERS.

The Department will receive the enhanced federal funding for the requirements validation, design, development, testing, and implementation of MEDS related systems changes needed to interface with the CalHEERS.

The Department ~~will hire~~ **hired** a contractor **contractors** to conduct a feasibility study and develop a federal Advanced Planning Document (APD) **to modernize MEDS. The Department plans to finalize and send CMS the APD to obtain approval for the MEDS modernization procurement by the end of FY 2012-13. The Department anticipates hiring contractors to assist with:**

- **The writing of the Request for Proposal (RFP),**
- **Procurement,**
- **Design,**

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- **Development, and**
- **Implementation.**

for transitioning **The MEDS modernization will transition** MEDS from a stand-alone legacy system to a modernized, integrated solution that addresses the requirements of the ACA, and increases the Department's alignment with the federal Medicaid Information Technology Architecture (MITA).

ACA 6 (OA-21) X X

Prevention of Chronic Disease Grant Project

Section 4108 of the ACA authorizes the five-year Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) grant project. The Department was awarded 100% federal funds to implement the Medi-Cal Incentives to Quit Smoking Project. This project will use outreach and incentives to encourage access to smoking cessation services for Medi-Cal beneficiaries. The Department has established an Interagency Agreement with UCSF for the administration, implementation, and evaluation of the MIPCD project.

ACA 7 (PC-173) X X

Community First Choice Option

Section 2401 of the ACA establishes a new State Plan option to provide home and community-based attendant services and supports. These services and supports may be offered through the federal Community First Choice Option (CFCO). The CFCO, which was available commencing October 1, 2010, allows States to receive a 6% increase in federal match for expenditures related to this option ~~retroactively to December 1, 2011.~~

On December 1, 2011, the Department and CDSS, submitted a SPA proposing to transition eligible participants in the Personal Care Services and In-Home Supportive Services Plus Option programs into CFCO. The SPA, approved on September 4, 2012, allows additional Title XIX funds to be available under CFCO **retroactively to December 1, 2011.**

On May 7, 2012, CMS released the final regulation requiring that to be eligible to receive CFC services; individuals must meet the following requirements:

- An institutional level of care furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded,

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- An institution providing psychiatric services for individuals under 21, or
- An institution for mental diseases for individuals age 65 or over.

Since California submitted its SPA prior to the publication of the final regulation, CMS will provide the State with a transitional period of one year from the effective date of the CFC final regulation to comply with the eligibility criteria in the final regulation. This level of care criteria will sunset July 6, 2013. Thus, the Department must amend the SPA effective July 6, 2013, to reflect updates to the State Plan that are in compliance with the final regulation.

ACA 8 (PC-FI)X

X

Implementation of ACA Rules

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

To stay in compliance, the Dental FI will needs to hire additional staff. ~~Costs will be incurred once all control agencies approve a change order in October 2012.~~ **Additional costs are expected to be incurred beginning in March 2013.**

ACA 9 (PC-138)
(PC-140)

X

Add-on for LTC (Non-AB 1629 & AB 1629) Facilities

Effective 2014, under the Affordable Care Act, long-term care facilities which elect to provide health insurance for employees, and are not currently doing so, will experience additional costs to provide health coverage. An add-on to the rates to reimburse the facilities for the additional costs will be effective 2014.

ACA 10 (PC-21)
(OA-51)

X

Recovery Audit Contractor

~~The Department has proposed legislation~~ **SB 1529 (Chapter 797, Statutes of 2012) authorizes the Department** to enter into contracts with one or more eligible Medicaid Recovery Audit Contractors (RACs) pursuant to section 6411(a) of the ACA. RACs' duties include reviewing post payment fee-for-service Medi-Cal claims, identifying improper payments, and educating

AFFORDABLE CARE ACT: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

providers. RACs are paid on a contingency basis based on the following terms:

- 12.5% of amounts recovered after an identified overpayment, and
- 10% of amounts refunded after an identified underpayment.

The Department does not assume any cost for the contract.

The Department awarded Health Management Systems, Inc. (HMS) the contract in April 2012 and expects to approve the final contract in FY 2012-13.

ACA 11(PC-FI) X
(Reworded)

X

HIPAA Operating Rules

The ACA includes provisions for Administrative Simplification, which builds on HIPAA with several new, expanded, or revised provisions. ACA requires the adoption of new HIPAA operating rules for eligibility and claim status transactions, effective January 1, 2013, along with Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) transactions, effective January 1, 2014, as well as new standards for EFT and ERA. The Dental FI intends to make modifications to California Dental Medicaid Management Information System (CD-MMIS). The CA-MMIS FI intends to make modifications to California Medicaid Management Information System (CA-MMIS). Each FI plans to submit change orders, if necessary, to meet the new requirements. The Department is still working on the implementation of the operating rules for eligibility and claim status transactions. ACA requires the Department to adopt additional operating rules for the following by January 1, 2014:

- EFT transactions
- ERA transactions

The Department plans to submit APDs for each requirement, if necessary.

ACA 12 (PC-19)
(PC-20)

X

Disproportionate Share Hospital Reduction

The ACA requires the aggregate, nationwide reduction of State Disproportionate Share Hospital (DSH) allotments of \$500 million for FY 2013-14. Reductions will increase for each fiscal year

AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

through FY 2019-20. The reduction for each state will be determined by CMS.

BENEFITS: NEW ASSUMPTIONS

	Applicable <u>C/Y</u>	F/Y <u>B/Y</u>	
B 0.1 (PC-217)	X		<p><u>Change Family PACT Program Benefits</u></p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
B 0.2 (PC-221)	X	X	<p><u>California Children's Services Program Pilots</u></p> <p>The Bridge to Reform (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) eligible population in at least four geographical locations within the State. The four organized health care delivery systems can use up to four models listed below for care delivery:</p> <ul style="list-style-type: none"> • Enhanced primary care case management model, • Provider-based accountable care organization model, • Existing Medi-Cal managed care plans, and • Specialty health care plan. <p>The Health Plan of San Mateo expects to begin operation in April 2013 and receive payments beginning in May 2013. The Department anticipates other geographical location plans to be implemented in FY 2013-14.</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable		
		C/Y	B/Y	
B 1	(OA-56)	X	X	<p><u>Public Health Nurses for Foster Care Health Care Program for Children in Foster Care</u></p> <p>The Budget Act of 1999 included funds for the CDSS to establish a program utilizing foster care public health nurses in the child welfare program to help foster care children gain access to health-related services. The public health nurses are employed by the counties and funded through CDSS General Funds and Title XIX matching funds. The Department has an interagency agreement with CDSS.</p> <p>On October 7, 2008, P.L. 110-352, the Fostering Connections to Success and Increasing Adoptions Act of 2008, was signed into law. P.L. 110-351 is an amendment to the Social Security Act to connect and support relative caregivers, improve outcomes for children in foster care, provide for tribal foster care and adoption access, and improve incentives for adoption. On January 1, 2010, the Department, through CDSS, implemented the new requirements to provide Health Oversight and Coordination.</p> <p><u>The 2011 State/Local Program Realignment Initiative (Realignment) shifted the responsibilities for California child welfare system to the counties. Vehicle License Fund and Sales Tax revenues supplant the GF as the non-federal share. Due to concerns from state, federal, and local stakeholders that Realignment would effectively eliminate this program as a cohesive and effective statewide system, SB 1013 (Chapter 35, Statutes of 2012) provides continuing funding under the existing model to local Child Health and Disability Prevention programs. CDSS will redirect funds for this purpose from the newly established Local Revenue Fund of 2011. SB 1013 also requires this program to be realigned to local control once the Department obtains the federal approval for child welfare agencies to claim FFP. CDSS anticipates that the transfer of the program to local control will occur by FY 2013-14.</u></p>
B 2	(PC-23)	X	X	<p><u>Local Education Agency (LEA) Providers</u></p> <p>Through the LEA Billing Option, LEAs can become Medi-Cal providers and submit claims for services to Medi-Cal beneficiaries within their jurisdiction. LEA providers may bill retroactively for services rendered up to one year prior to their date of enrollment as long as claims are billed within the statutory billing limit. LEAs claim FFP for specific services as authorized in W&I Code Section 14132.06. LEA providers are paid an interim rate based on pre-</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
				established billing allowances and audits are performed to reconcile actual costs with interim payments.
B 3	(PC-178)	X	X	<u>Medi-Cal TCM Program</u> The Targeted Case Management (TCM) program provides funding to counties and chartered cities/local government agencies (LGAs) for assisting Medi-Cal beneficiaries in accessing needed medical, social, educational, and other services. Through rates established in the annual cost reports, local governments claim FFP for these case management services. TCM providers are paid an interim rate based on pre-established billing allowances and audits are performed to reconcile actual costs with interim payments.
B 4	(PC-176)	X	X	<u>Targeted Case Management Services – CDDS</u> The Department provides Title XIX FFP for regional center case management services, as provided to eligible developmentally disabled clients via contract with the California Department of Developmental Services (CDDS) and authorized by the Lanterman Act. CDDS conducts a time study every three years and an annual administrative cost survey to determine each regional center's actual cost to provide Targeted Case Management (TCM). A unit of service reimbursement rate for each regional center is established annually. To obtain FFP, the federal government requires that the TCM rate be based on the regional center's cost of providing case management services to all of its consumers with developmental disabilities, regardless of whether the consumer is TCM eligible. FFP for Medi-Cal eligibles is authorized by a SPA.
B 5	(OA-1) (OA-9)	X	X	<u>Medi-Cal Administrative Activities</u> AB 2377 (Chapter 147, Statutes of 1994) authorized the State to implement the Medi-Cal Administrative Claiming process. The Medi Cal program submits claims on behalf of local governmental agencies (LGAs) to obtain FFP for Medicaid administrative activities necessary for the proper and efficient administration of the Medi-Cal program. These activities ensure that assistance is provided to Medi-Cal eligible individuals and their families for the receipt of Medi-Cal services.

Both LGAs and local educational "consortiums" (LECs) contract with the Department for reimbursement and may amend prior year

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

contracts up to the two-year retrospective federal claiming limitation. Prior year contract amendments are generated when additional funds, such as special local initiatives and Proposition 10 fund spending determination of LGA status, are made available as the certified public expenditure.

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

The Department is currently working with CMS on an implementation plan for mental health plans to claim FFP for MAA.

B 6 (PC-33) X X

SCHIP Funding for Prenatal Care

In order to maximize federal funding, SB 77 (Chapter 38, Statutes of 2005), requires MRMIB to file a SPA in the CHIP to claim Title XXI 65% federal funding for prenatal care provided to women currently ineligible for federal funding for this care. The cost for this care is currently 100% General Fund. Funding is being claimed for undocumented women, and for legal immigrants who have been in the country for less than five years. CMS approved the SPA in March 2006.

B 7 (OA-12) X X

Coordinated Care Management Pilot

The Budget Act of 2006 includes approval to establish and implement a Coordinated Care Management (CCM) Demonstration Project. The key elements of the CCM Project include maintaining access to medically necessary and appropriate services, improving health outcomes, and providing care in a more cost-effective manner for two populations enrolled in the fee-for-service Medi-Cal Program who are not on Medicare:

- CCMP-SPD (CCM-1): Seniors and persons with disabilities (SPDs) who have chronic conditions, or who may be seriously ill and near the end of life; ~~and~~, CCM-1 was

BENEFITS: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y**completed with the mandatory enrollment of the SPD population into Medi-Cal managed care health plans;**

- **CCMP-SMI (CCM-2):** Persons with chronic health condition(s) and serious mental illnesses. **The SMI portion will expire on July 31, 2013; and**
- **CBAS (CCM-2):** This contract has been amended to include Adult Day Health Care (ADHC) services as the Department transitions eligible ADHC beneficiaries into the new Community Based Adult Services (CBAS) Medi-Cal benefit. **The CBAS portion will expire on August 31, 2014.**

~~APS Healthcare Inc. has been awarded both CCM-1 and CCM-2 contracts, which began in January 2010 and April 2010 respectively.~~

B 8	(PC-189)	X	X	<p><u>CLPP Funding for EPSDT Lead Screens</u></p> <p>Medi-Cal receives funding from the CLPP Fund to cover Early Periodic Screening, Diagnosis and Treatment (EPSDT) blood lead testing for beneficiaries with risk factors for lead poisoning. CLPP funding will be used for the non-federal share of the cost.</p>
B 9	(PC-37)	X	X	<p><u>Physician and Clinic Seven Visits Soft Cap</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) caps the number of physician visits and clinic visits (including visits at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)) at seven per fiscal year per Medi-Cal beneficiary. Visits that meet one of the five exception circumstances are not counted in the seven-visit cap. This cap applies to adults 21 years of age or older, except those in nursing facilities, pregnant women, presumptive eligibility and FPACT beneficiaries. The cap applies only to Medi-Cal fee-for-service (FFS); managed care plans already control utilization more tightly than the cap process.</p>
B 10	(PC-34)	X	X	<p><u>Hearing Aid Cap</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements a \$1,510 cap per beneficiary for hearing aid expenditures. Hearing aid reimbursements are composed of three primary categories: 1) repairs, 2) ear molds, and 3) hearing aids. The majority of the reimbursements are for the actual costs of hearing aids. Hearing aids may be dispensed individually (monaural) or as a pair</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable		
		C/Y	B/Y	F/Y
				(binaural). The hearing aid cap is for adults 21 years of age or older who are not in nursing facilities or pregnant women.
B 11	(PC-39)	X	X	<p><u>Copayment for Non-Emergency ER Visits</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of \$50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented without exemptions in the managed care setting. The hospital will collect the copayment from the beneficiaries at the time of service, and the hospital will be reimbursed the appropriate Medi-Cal reimbursement rate minus the copayment. AB 1467 (Chapter 23, Statutes of 2012) stipulates that for the purposes of Medi-Cal copayments, an emergency service is defined as the treatment of an emergency medical condition or services that result in an inpatient admission.</p>
B 12	(PC-35)	X	X	<p><u>Elimination of OTC Cough and Cold Products</u></p> <p>This assumption has been moved to “Fully Incorporated Into Base Data/Ongoing” section.</p>
B 13	(PC-177)	X	X	<p><u>EPSDT Screens</u></p> <p>The Child Health and Disability Prevention (CHDP) program is responsible for the screening component of the EPSDT benefit of the Medi-Cal program, including the health assessments, immunizations, and laboratory screening procedures for Medi-Cal children.</p>
B 14	(PC-181) (OA-65)	X	X	<p><u>CDDS Dental Services</u></p> <p>The Lanterman Act requires the California Department of Development Services (CDDS) to provide dental services to its clients. Because Medi-Cal no longer covers most dental services for adults 21 years of age and older, CDDS has entered into an interagency agreement with the Department to have the Medi-Cal dental fiscal intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of processing claims and benefits will be reimbursed by CDDS. Processing of CDDS claims started on January 12, 2012.</p>

BENEFITS: OLD ASSUMPTIONS

	Applicable		
	<u>C/Y</u>	<u>B/Y</u>	
B 15 (OA-67)		X	<p><u>Quitline Administrative Services</u></p> <p>Quitline provides a free telephone-based counseling program to help smokers quit. CMS is allowing the State to receive a 50% match of funds attributable to the administrative costs associated with Quitline providing services to Medicaid individuals. Since CDPH funds the helpline, the Department will claim the FFP and reimburse CDPH via an interagency agreement.</p>
B 16 (PC-1)	X	X	<p><u>Family PACT Program</u></p> <p>Originally implemented as a state-only program in 1997, Family PACT became a Section 1115 demonstration project effective December 1, 1999. It provides family planning services to eligible, uninsured Californians with income at or below 200% of poverty. FFP at 90% has been assumed for most family planning services, testing for sexually transmitted infections (STIs), and sterilizations. The Federal Medical Assistance Percentage (FMAP) has been assumed for treatment of STIs and other family planning companion services. No FFP has been assumed for the treatment of some family planning-related medical conditions, including inpatient care for complications from family planning services. Costs for undocumented persons are assumed to be 13.95% of the Family PACT costs, as agreed upon by CMS, and are budgeted at 100% GF. Family PACT drugs will be included in the Medicaid Drug Rebate Program.</p> <p>A State Plan Amendment (SPA), to replace the Family PACT waiver in accordance with the Federal Patient Protection and Affordable Care Act was approved on March 24, 2011. Under the SPA, effective retroactively to July 1, 2010, eligible family planning services and supplies formerly reimbursed with 100% General Funds will receive a 90% federal matching rate for certain eligible procedure codes, and family planning-related services will receive reimbursement at the State's regular FMAP rate.</p>
B 17 (OA-22) (OA-69)	X	X	<p><u>Family PACT Evaluation</u></p> <p>An important component of the Family PACT Program is evaluating the effectiveness of the program. The University of California, San Francisco conducts the program evaluation. The evaluation includes, but is not limited to, analyzing: the changes in birth rates; access by targeted populations; change in provider base for targeted geographical areas; provider compliance; claims analysis; and the cost effectiveness of the services.</p>

BENEFITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

A new contract to provide data, to monitor and evaluate the Family PACT program was negotiated for a five year term beginning July 1, 2010.

The Department budgets the Title XIX federal Medicaid funds for the contract. The matching GF is budgeted in the CDPH budget in the FY 2012-13 Family PACT Evaluation policy change.

AB 1464 (Chapter 21, Statutes of 2012) transferred the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13 in the FY 2012-13 Family PACT Evaluation policy change.

B 18 (OA-27) X X
(OA-70)

Family PACT Support, Provider Education and Client Outreach

The Family PACT Program has two main objectives. One is to increase access to services in targeted populations of adolescents, males, and medically underserved women. The other is to increase the number of providers who serve these clients. Education and various support services are provided to Family PACT providers and potential providers, as well as clients and potential clients. The Office of Family Planning contracts with a variety of entities to provide these services.

A contract to provide Family PACT support, provider education, and outreach was negotiated for a three-year term beginning April 1, 2009. The Department has initiated a new procurement for these services.

The Department budgets the Title XIX federal Medicaid funds for these activities. The matching GF is budgeted in the CDPH budget for the FPACT Support, Provider Education & Client Outreach policy change.

AB 1464 (Chapter 21, Statutes of 2012) transferred the Family PACT program to the Department effective July 1, 2012. This component of the Family PACT program will be budgeted by the Department beginning FY 2012-13 in the Family PACT Program Administration policy change.

BENEFITS: OLD ASSUMPTIONS

		Applicable C/Y	F/Y B/Y	
B 19	(PC-FI)	X	X	<p><u>Family PACT Materials Distribution</u></p> <p>An important component of the Family PACT Program is the distribution of client education materials to providers. The state, through the fiscal intermediary, has the responsibility to develop, print, purchase, and distribute over 125 different publications.</p>
B 20	(PC-FI)	X	X	<p><u>Family PACT Systems</u></p> <p>The establishment of the Family PACT Program required fiscal intermediary systems enhancements and modifications. The system changes have been made and are ongoing, as required for program maintenance.</p>
B 21	(OA-8)	X	X	<p><u>Family PACT HIPAA Privacy Practices Beneficiary Notification</u></p> <p>Under the federal HIPAA, it is a legal obligation of the Medi-Cal program to provide a Notice of Privacy Practices (NPP) to each Family PACT beneficiary explaining the rights of beneficiaries regarding the protected health information created and maintained by the program. Medi-Cal has an ongoing responsibility to provide this Notice to all new enrollees, <u>and to existing enrollees when a substantial change is made to the notice.</u> <u>Additionally, Medi-Cal must</u> inform all beneficiaries about how to get a copy of this Notice at least every 3 years, or whenever a substantial change is made to the Notice. Due to confidentiality concerns, distribution of the NPP to these beneficiaries is accomplished by distribution at the clinic. This assumption is to cover the cost of printing and mailing the NPPs to the clinics.</p>
B 22	(PC-31)	X	X	<p><u>Increased Federal Matching Funds for FPACT</u></p> <p>On March 24, 2011, CMS approved a State Plan Amendment (SPA) for the Family PACT Program, in accordance with the Federal Patient Protection and Affordable Care Act. Under the SPA, eligible family planning services and supplies formerly reimbursed exclusively with 100% State General Fund will receive a 90% federal matching rate, and family planning related services will receive reimbursement at the State's regular FMAP rate, effective retroactively to July 1, 2010.</p>

BENEFITS: OLD ASSUMPTIONS

		Applicable <u>C/Y</u>	F/Y <u>B/Y</u>	
B 23	(PC-30)	X	X	<p><u>Family PACT Retroactive Eligibility</u></p> <p>Effective April 1, 2011, Medi-Cal allows retroactive eligibility for Family PACT qualifying clients for up to three months prior to the first day of the month of application to the Family PACT program.</p> <p>The Department implemented the following:</p> <ul style="list-style-type: none"> • Retroactive eligibility certification procedure, • Claim process for newly-enrolled clients, and • Procedures to ensure reimbursement for retroactive period.
B 24				<p><u>Cervical Cancer Screening</u></p> <p>This assumption has been moved to the “Withdrawn” section.</p>
B 25	(PC-27)	X	X	<p><u>Dense Breast Notification Supplemental Screening</u></p> <p>SB 1538 (Chapter 458, Statutes of 2012) would require health facilities administering mammograms 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.</p>

HOME & COMMUNITY BASED SERVICES:

Long-Term Care Alternatives

Medi-Cal includes various Long-Term Services and Supports that allow medically needy, frail seniors, and persons with disabilities to avoid unnecessary institutionalization. The Department administers these alternatives either as State Plan benefits or through various types of waivers.

State Plan Benefits

In-Home Supportive Services (IHSS)

The IHSS Program helps eligible individuals pay for services so that they can remain safely in their own homes. To be eligible, individuals must be age 65 years of age or older, disabled, or blind. Children with disabilities are also eligible for IHSS. IHSS provides housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with a mental impairment(s).

The four IHSS programs are:

1. **Personal Care Services Program (PCSP)**
This program provides personal care services including but not limited to non-medical personal services, paramedical services, domestic services, and protective services.
2. **IHSS Plus Option (IPO)**
This program provides personal care services but also allows the recipient of services to select their provider, including family members.
3. **Community First Choice Option (CFCO)**
This program provides personal care services to those who would otherwise be institutionalized in a nursing facility.
4. **Residual (beneficiaries are not full-scope Medi-Cal; State-only program with no FFP)**

Targeted Case Management (TCM)

The TCM Program provides specialized case management services to Medi-Cal eligible individuals who are developmentally disabled. These clients can gain access to needed medical, social, educational, and other services. TCM services include:

- Needs assessment;
- Development of an individualized service plan;
- Linkage and consultation;
- Assistance with accessing services;
- Crisis assistance planning;
- Periodic review.

HOME & COMMUNITY BASED SERVICES:

Waivers

Medi-Cal operates and administers various home and community-based services (HCBS) waivers that provide medically needy, frail seniors and persons with disabilities with services that allow them to live in their own homes or community-based settings instead of being cared for in facilities. These waivers require the program to meet federal cost-neutrality requirements so that the total cost of providing waiver services plus medically necessary state plan services are less than the total cost incurred at the otherwise appropriate nursing facility plus state plan costs. The following waivers require state cost neutrality: Acquired Immune Deficiency Syndrome (AIDS) ~~Medi-Cal~~, Assisted Living (ALW), ~~Developmentally Disabled/Continuous Nursing Care (DD/CNC)~~, In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), HCBS ~~Developmentally Disabled~~ **Waiver for Persons with Developmental Disabilities**, San Francisco Community Living Support Benefit (CLSB), and Pediatric Palliative Care (PPC). A beneficiary may be enrolled in only one waiver at a time. If a beneficiary is eligible for services from more than one waiver, the beneficiary may choose the waiver that is best suited to his or her needs.

Assisted Living Waiver (ALW)

The ALW pays for assisted living, care coordination, community transition, translation/interpretation, and home modification in ~~eight~~ **seven** counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, **and** San Bernardino, ~~and Alameda~~). Waiver participants can elect to receive services in either a Residential Care Facility for the Elderly (RCFE) or through ~~a~~ home health agency ~~staff~~ while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is 2,920 in 2012 and 3,700 in 2013. The waiver is approved from March 1, 2009 through February 28, 2014.

Community-Based Adult Services (CBAS)

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program. A lawsuit was filed challenging elimination of ADHC (Darling et al. v. Douglas et al.), ~~which resulted~~ **resulting** in a settlement agreement between DHCS and the plaintiffs. The settlement agreement eliminated the ADHC program effective March 31, 2012, and replaced it with a new program called CBAS. ~~to provide~~ **CBAS provides** necessary medical and social services to individuals with intensive health care needs. CBAS became effective April 1, 2012, through an amendment to the "Bridge to Reform" 1115 Medicaid waiver. Former ADHC participants and new eligible participants who meet the more stringent CBAS eligibility standards receive CBAS ~~services~~ in approved CBAS centers. CBAS was provided through Medi-Cal FFS effective April 1, 2012. On July 1, 2012, CBAS transitioned into five County Organized Health System (COHS) managed care ~~counties~~ **health plans**. ~~Beginning~~ **On** October 1, 2012, CBAS ~~services will also transition~~ **transitioned** into Two-Plan and GMC managed care plans, as well as ~~the~~ **one** remaining COHS plan, Gold Coast Health Plan. Medi-Cal FFS ~~will continue~~ **continues to** provide CBAS to eligible participants residing in non-managed care counties, or to eligible participants who are exempted from or ineligible for enrollment in a managed care plan. There is no cap on enrollment into this waiver service.

HOME & COMMUNITY BASED SERVICES:In-Home Operations (IHO) Waiver

The IHO waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital Waiver for the participant's assessed LOC. ~~Current enrollment is 136 and the~~ **The** waiver is approved from January 1, 2010 through December 31, 2014.

Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver

Effective December 1, 2012, the Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver was merged with the Nursing Facility/Acute Hospital (NF/AH) Waiver, based on CMS approval. The newly merged waiver was renamed the Nursing Facility/Acute Hospital (NF/AH) – Transition and Diversion Waiver. Under the NF/AH – Transition and Diversion Waiver, current DD/CNC participants will continue receiving their existing services and the DD/CNC providers will continue to be reimbursed at the pre-existing DD/CNC daily per diem rates.

- **The DD/CNC Waiver, served individuals with developmental disabilities, who are medically fragile and who otherwise would reside in subacute care facilities, acute care hospitals or in developmental centers. Services were provided specifically in DD/CNC residential homes that are licensed and enrolled in the Medi-Cal program as ICF/DD-Nursing Providers.**
- The NF/AH waiver facilitates a safe and timely transition of Medi-Cal eligible beneficiaries from a medical facility to his/her home and community utilizing NF/AH Waiver services, and offers eligible Medi-Cal beneficiaries, who reside in the community, but are at risk of being institutionalized within the next 30 days, the option of utilizing the NF/AH Waiver services to develop a home program that will safely meet his/her medical care needs.

The NF/AH **– Transition and Diversion** Waiver provides Medi-Cal beneficiaries with long-term medical conditions, who met the acute hospital, adult, or pediatric subacute, nursing facility, distinct-part nursing facility (NF) Level of Care with the option of returning to and/or remaining in his/her home or home-like setting in the community in lieu of hospitalization.

~~Current enrollment is 2,206 and the~~ **The** waiver is approved from January 1, 2012 through December 31, 2016.

HOME & COMMUNITY BASED SERVICES:Developmentally Disabled/Continuous Nursing Care (DD/CNC) Waiver

The DD/CNC Waiver provides 24-hour continuous skilled nursing care in home and community-based residential settings to persons with developmental disabilities who are medically fragile. The program currently assists approximately 45 individuals who reside in homes located in Desert Hot Springs, Fresno, Gardena, San Bruno, San Jose, Santa Rosa and Sylmar. Eligibility criteria requires that DD/CNC Waiver participants be Medi-Cal eligible, enrolled in, and certified by a Regional Center as having a developmental disability, exhibit medical necessity for 24-hour continuous skilled nursing care and free of any clinically active communicable disease. Participants must also meet specific minimum medical criteria. Approved capacity of unduplicated recipients for this waiver is 84 for the 2011 fiscal year. The waiver is approved from October 1, 2009 through September 30, 2012. However, California has requested to CMS that the DD/CNC waiver be merged with the NF/AH waiver.

San Francisco Community Living Support Benefit (CLSB) Waiver

The CLSB Waiver implements Assembly Bill 2968 (Chapter 830, Statutes of 2006) and will allow the San Francisco Department of Public Health to assist eligible individuals to move into available community settings and to exercise increased control and independence over their lives. A person eligible for the CLSB Waiver must:

- Be a resident of the city and county of San Francisco.
- Be at least age 21 years or over.
- Be determined to meet nursing facility level of care as defined in relevant sections of the California Code of Regulations.
- Be either homeless and at imminent risk of entering a nursing facility, or, reside in a nursing facility and want to be discharged to a community setting.
- Have one or more medical co-morbidities.
- Be capable of residing in a housing setting with the availability of waiver services that are based on a Community Care Plan.

CLSB Waiver community settings are limited to State-approved housing, which includes community care facilities licensed by the California Department of Social Services, Community Care Licensing, and Direct Access to Housing (DAH) sites operated by SFDPH.

CLSB Waiver services consist of Care Coordination, Enhanced Care Coordination, Community Living Support Benefit in licensed settings and DAH sites, Behavior Assessment and Planning, Environmental Accessibility Adaptations in DAH sites, and Home delivered meals in DAH sites.

Approved capacity of unduplicated recipients for this waiver is 221 for 2012, 377 for 2013, and 417 for 2014. The waiver is approved from July 1, 2012 through June 30, 2017.

HOME & COMMUNITY BASED SERVICES:

Acquired Immune Deficiency Syndrome (AIDS) Medi-Cal Waiver

Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home- and community-based services as an alternative to nursing facility care or hospitalization.

Services provided include:

- Case management;
- Skilled nursing;
- Attendant care;
- Psychotherapy;
- Home-delivered meals;
- Nutritional counseling;
- Nutritional supplements;
- Medical equipment and supplies;
- Minor physical adaptations to the home;
- Non-emergency medical transportation;
- Financial supplements for foster care.

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an "Aid Code" with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE); have a written diagnosis of HIV disease or AIDS ~~with current signs, symptoms, or disabilities related to HIV disease or treatment~~; adults who are certified by the nurse case manager to be at the nursing facility level of care and score 60 or less using the Cognitive and Functional Ability Scale assessment tool, children under 13 years of age who are certified by the nurse case manager as HIV/AIDS symptomatic; and individuals with a health status that is consistent with in-home services and who have a home setting that is safe for both the client and service providers.

Approved capacity of unduplicated recipients for this waiver is 4,410 in 2013 and 4,490 in 2014. The waiver is approved from January 1, 2012 through January 31, 2016.

Multipurpose Senior Services Program (MSSP) Waiver

The California Department of Aging currently contracts with 44 local agencies statewide to provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these frail clients. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and be certified or certifiable for placement in a nursing facility. Services provided by MSSP include: adult day care / support center, housing assistance, chore and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services,

HOME & COMMUNITY BASED SERVICES:

communication services. Approved capacity of unduplicated recipients for this waiver is 16,335 in 2012 and 2013. The waiver is approved from July 1, 2009 through June 30, 2014.

Developmentally Disabled (DD) Waiver **Home and Community-Based Waiver for Persons with Developmental Disabilities (DD)**

The DD Waiver provides home and community-based services to developmentally disabled persons who are Regional Center consumers as an alternative to care provided in a facility that meets the Federal requirement of an intermediate care facility for the mentally retarded (ICF/MR); in California, they are the Intermediate Care Facility/Developmentally Disabled-type facilities, or a State Developmental Center. Approved capacity of unduplicated recipients for this waiver is 105,000 in 2012 and 110,000 in 2013. The waiver is approved from October 1, 2011 through September 30, 2016.

Pediatric Palliative Care (PPC) Waiver

The PPC provides children hospice-like services, in addition to state plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and Family Unit (siblings, parent/legal guardian, and others living in the residence). The pilot Waiver was approved for April 1, 2009 through March 31, 2012. ~~The state submitted a waiver renewal application, which is pending approval. Currently, the waiver is under extension through September 2012 as the state responds to the Centers for Medicare & Medicaid Services' Request for Additional Information.~~ **The CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years effective** Upon approval, the waiver term will be April 1, 2012 through March 31, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800.

Managed Care Programs

Program for All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers **fully** integrated services, including **PACE covered services include all** medical, **long-term services and supports**, dental, vision and other specialty services, ~~to~~ **allowing enrolled beneficiaries who would otherwise be in an intermediate care facility or in a skilled nursing facility to maintain independence in their homes and communities**. Participants must be 55 years or older and **determined by the Department to** meet the Medi-Cal regulatory criteria for nursing facility placement. PACE participants receive their services from a nearby PACE Center where clinical services, therapies, and social interaction take place. ~~There are five PACE organizations who collectively serve over 3,100 Californians at a total of 24 PACE centers.~~ **The Department has statutory authority to contract with up to 15 PACE organizations.**

HOME & COMMUNITY BASED SERVICES:

SCAN Health Plan

SCAN is a Medicare Advantage Special Needs Plan that contracts with the Department of Health Care Services to provide services for the dual eligible Medicare/Medi-Cal population subset residing in Los Angeles, San Bernardino, and Riverside counties. SCAN provides all services in the Medi-Cal State Plan; including home and community based services to SCAN members who are assessed at the Nursing Facility Level of Care and nursing home custodial care, following the member in the nursing facility. The eligibility criteria for SCAN specifies that a member be at least 65 years of age, have Medicare A and B, have full scope Medi-Cal with no share of cost and live in SCAN's approved service areas of Los Angeles, Riverside, ~~and~~ or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease. ~~The number of unduplicated participants is 7,182 in 2012. The contract will end December 31, 2013.~~ **The Department will not renew the SCAN contract that ends December 31, 2013, and has notified SCAN in accordance with contract requirements.**

Special Grant

~~Community Care Transitions (CCT)/Money Follows the Person Grant~~ **California Community Transitions/Money Follows the Person (CCT/MFP) Rebalancing Demonstration Grant**

In January 2007, the Centers for Medicare & Medicaid Services awarded the Department a Money Follows the Person (MFP) Rebalancing Demonstration Grant, called the California Community Transitions. This grant is authorized under section 6071 of the federal Deficit Reduction Act of 2005 and extended by the Patient Protection and Affordable Care Act. ~~and is effective~~ **Grant funds may be requested** from January 1, 2007, through September 30, 2016. The grant ~~was amended to require~~ **requires** the Department to develop and implement strategies ~~to assist 6,177~~ **for transitioning** Medi-Cal eligible individuals **beneficiaries** who have resided continuously in health care facilities for three months or longer ~~to transition back to a federally-allowed home and community-based settings~~ **federally-qualified residence**. ~~Approved capacity of unduplicated recipients for this waiver is 543 in 2012, 1,044 in 2013, and 1,268 in 2014. The waiver is approved from January 1, 2007, through September 30, 2016.~~

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

Applicable F/Y
C/Y B/Y

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

H 1

Home and Community Based Services

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

HCBS encompass State Plan services, including Personal Care Services provided through CDSS' In-Home Supportive Services program and Adult Day Health Care; which was eliminated on March 31, 2012 and replaced by Community-Based Adult Services. Full risk managed care services are also provided through Programs of All-inclusive Care for the Elderly (PACE) and Senior Care Action Network (SCAN); an eight-year federal demonstration to transition LTC facility residents back to their homes and communities. Several different waiver programs provide a range of services like private duty nursing, personal care, case management, habilitation, emergency response systems, respite, and home modifications for accessibility and safety.

- (PC-169) X X A. Home and Community Based Services **Waiver for Persons with Developmental Disabilities** – CDDS

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

~~CMS approved an extension of the waiver for the term of October 1, 2011 through September 30, 2016.~~

- (PC-24) X X B. Multipurpose Senior Services Program – CDA
(OA-59)

On June 23, 2009, CMS approved the renewal of the Multipurpose Senior Services Program (MSSP) Waiver for the period of July 1, 2009 through June 30, 2014. Under the waiver, CDA contracts with local government or nonprofit agencies to provide waiver services to individuals 65 years or older who are Medi-Cal eligible

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

and who, in the absence of this waiver and as a matter of medical necessity, would otherwise require care in a nursing facility. MSSP services include health care and personal care assistance, respite care, housing assistance, meal services, transportation, protective services, emergency response systems, and chore services.

The Department pays the MSSP claims. The GF is budgeted in the CDA budget and at the beginning of each fiscal year the reimbursement is transferred to the Department to pay the MSSP claims.

~~On June 1, 2013~~ **No sooner than September 1, 2013**, in the counties participating in the CCI Duals Demonstration, managed care health plans will contract with existing MSSP sites for care management services consistent with the ~~plans' Model of Care~~ **MSSP Waiver requirements**.

H 2 (PC-NA) X X

In-Home Operations Waiver

CMS approved the IHO Waiver renewal effective January 1, 2010 through December 31, 2014. The IHO Waiver "grandfathered in" Medi-Cal beneficiaries who were continuously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and continue to receive direct-care services primarily rendered by licensed nurses, and whose HCBS costs exceed the Level of Care (LOC) cost cap under the NF/AH Waiver. Each IHO participant's LOC and waiver costs will remain the same as previously authorized.

H 3 (PC-179) X X

Waiver Personal Care Services

AB 668 (Chapter 896, Statutes of 1998) requires Medi-Cal to add waiver personal care services (WPCS) to NF A/B and NF SA Levels of Care. This service is not available to those individuals at the Hospital LOC due to their extensive medical needs. WPCS is one option on the Menu of Health Services (MOHS) that NF/AH and IHO waiver participants may choose from, to the extent that waiver cost neutrality is assured.

H 4 (PC-166) X X
 (OA-52)

Personal Care Services

~~As of~~ **In** April 1993, the Medi-Cal program ~~covers~~ **began covering** personal care services as a benefit. ~~This is accomplished by~~

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

making Title XIX funds available to the IHSS program under the administrative control of CDSS. **Protective supervision and domestic and related services became IHSS-covered benefits effective August 1, 2004.**

~~CMS revised its interpretation of the State Plan Personal Care Services Program (PCSP) to include protective supervision and domestic and related services, effective August 1, 2004.~~

The State receives regular FMAP for provision services under the Personal Care Services Program and IHSS Plus Option, and 6% additional FMAP for provisions of Community First Choice Option services.

SB 1036 (Chapter 45, Statutes of 2012) requires mandatory enrollment of dual eligibles in eight counties into managed care for their Medi-Cal benefits, including their IHSS benefit. The transition will occur ~~between March 2013 and June 2013~~ **no sooner than September 2013**. As this transition occurs, IHSS costs will be paid through managed care capitation. IHSS costs related to the recipients transitioning to managed care are budgeted in the Transition of Dual Eligibles-LTC policy change.

H 5 (PC-25) X X
(PC-26)
(PC-38)
(OA-36)
(Reworded)

California Community Transitions (CCT/MFP)

As required by CMS' awarded Money Follows the Person Rebalancing Demonstration Grant, CCT/MFP is developing and implementing strategies for transitioning Medi-Cal beneficiaries with long-term inpatient health facility stays back to community living. Through CCT/MFP, the Department receives enhanced FFP for demonstration pre-transition costs and federally-qualified HCBS provided during the first 365 days post transition. There are assumed Medi-Cal savings from transitioning institutionalized Medi-Cal beneficiaries back to the community with appropriate HCBS in place.

The Department established an Interagency Agreement (IA) with the California Department of Developmental Services (CDDS) to provide transition coordination services through its local Regional Centers. IAs with CDDS and the California Department of Social Services (CDSS) cover their provision of qualified HCBS to CCT/MFP transitioned Medi-Cal beneficiaries during the first 365 days post transition. The enhanced FFP received by the

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

		Applicable F/Y			
		<u>C/Y</u>	<u>B/Y</u>		
				Department for these services is passed through to both CDDS and CDSS.	
H 6	(OA-53)	X	X	<u>Health-Related Activities-CDSS</u>	
				Health-related activities are services that aid Medi-Cal eligibles to gain access to medical services or to maintain current levels of treatment. Title XIX federal funds are passed through to CDSS for health-related activities performed by social workers in the counties.	
H 7	(OA-59)	X	X	<u>Department of Aging – Administrative Costs</u>	
				The federal government provides Title XIX federal financial participation to the California Department of Aging for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services and the Multipurpose Senior Services Program.	
H 8	(PC-115)	X	X	<u>PACE: Program of All-Inclusive Care for the Elderly</u>	
				<p>The Department contracts with five PACE organizations in various counties for risk-based capitated care of the frail elderly. PACE programs provide all medical services, home and community-based long term care (including adult day health care and in-home support) to <u>Medi-Cal state plan services (including long-term services and supports) as well as any other services determined necessary by the PACE interdisciplinary team. PACE programs enroll</u> Medi-Cal and Medi-Cal/Medicare (dual eligible) beneficiaries who are determined by the Department to be at <u>meet</u> the skilled nursing or intermediate care facility level of care.</p> <p>PACE rates are based upon historical Medi-Cal fee-for-service (FFS) expenditures for comparable populations and by law must be set at no less than 90% of the FFS Upper Payment Limits <u>(UPL). The Department has proposed Trailer Bill Language to transition from a UPL-based methodology to an actuarially sound experienced based methodology.</u> PACE rates are set on a calendar year basis, to coincide with the time period of the contracts. Four new PACE organizations will become operational in FY 2012-13 and one additional organizations will begin in FY 2013-14.</p>	

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 9	(PC-118) X (PC-129)	X	X	<p><u>Senior Care Action Network</u></p> <p>The Senior Care Action Network (SCAN) is a Medicare Advantage Special Needs Plan located in Long Beach and coordinates and provides services in designated areas of Los Angeles, San Bernardino, and Riverside counties. The Department received approval from CMS to prepare a comprehensive risk managed care contract authorized under 1915a to fund State Plan Only Medi-Cal services to its members. SCAN provides medical, social, and case management services to Medicare beneficiaries ages 65 and over in Medi-Cal's aged, disabled, and long term care aid group categories (dual eligibles). All necessary medical services are provided by SCAN. Enrollees who are certifiable for skilled nursing facility (SNF) or intermediate care facility (ICF) levels of care are eligible for additional HCBS. SCAN holds a five-year contract with the Department. The term of the current SCAN contract is January 1, 2008 through December 31, 2012. The Department does not plan to renew the SCAN contract. A one-year extension for January 1, 2013 through December 31, 2013 has been executed to facilitate transition of the SCAN Medi-Cal population to existing Medi-Cal programs.</p> <p>Rates are determined by federal law on an actuarially sound basis. In addition, California state law requires that rates be no more than the rates determined on a FFS equivalent basis. Beginning January 1, 2009, SCAN's rates are re-determined on a calendar year basis to coincide with the time period covered by its contract. To determine 2009 rates for dually eligible enrollees, SCAN provided the Department with a bid based upon its costs for Medi-Cal services rendered to this population. To determine 2009 rates for nursing home eligible participants, the Department used cost data for MSSP as a point of comparison and made adjustments to SCAN's bid. Rates through 2013 are developed based on the plans' actual experience. AB 1422 (Chapter 175, Statutes of 2009) imposed an additional tax (Gross Premium tax) on the total operation revenue of Medi-Cal Managed Care plans. Beginning January 1, 2010, the Gross Premium tax revenue was incorporated into the SCAN rates retroactive to January 1, 2009.</p>

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 10	(OA-41) <u>(PC-232)</u>	X	X	<p><u>Pediatric Palliative Care Waiver</u></p> <p>AB 1745 (Chapter 330, Statutes of 2006) required the Department to submit an application to CMS for a federal waiver for a Pediatric Palliative Care Pilot Project. The waiver was approved on December 3, 2008 for three years, beginning April 1, 2009 through March 31, 2012. The waiver was implemented and began enrollment on January 1, 2010. The Department has submitted a waiver renewal application to CMS for the period of April 1, 2012 through March 31, 2017. CMS has requested changes to the current waiver. The waiver is operating under a temporary extension through September 30, 2012. It is anticipated that the renewal will be approved after the required changes are made.</p> <p>The waiver makes available services comparable to those available through hospice that can be provided at the same time that the child would receive curative services. and</p> <p>The legislation mandates the Department to evaluate the pilot project. An independent evaluation of the waiver is also required to meet federal assurances. The evaluation began in July 2010.</p> <p><u>Effective July 2013, the participating agencies will receive reimbursement for administrative costs.</u></p>
H 11	(PC-28)	X	X	<p><u>SF Community-Living Support Benefit Waiver</u></p> <p>The San Francisco (SF) Community- Living Support Benefit Waiver implements AB 2968 (Chapter 830, Statutes of 2006), which requires the Department to develop and implement a community-living support benefit for Medi-Cal beneficiaries 21 years of age and older, residing in the City and County of SF who would otherwise be residing in nursing facilities or be rendered homeless. The Department worked with the SF Department of Public Health to develop this waiver under the <u>program as a 1915(c) HCBS waivers waiver.</u></p> <p>Eligible participants will have full-scope Medi-Cal or share-of-cost Medi-Cal for services to be rendered in Residential Care Facilities for the Elderly (RCFEs), Adult Residential Facilities, or in <u>independent</u> residency units made available by the Direct Access to Housing (DAH) program.</p>

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The City and County of San Francisco will pay for the non-federal share of the waiver costs through the utilization of CPEs to obtain federal funding for this project. On May 22, 2012, CMS approved the waiver with an effective date of July 1, 2012 through June 30, 2017.

H 12 (PC-22) X X

Additional HCBS Services for HCBS Regional Center Clients

The Department submitted a 1915(i) Home and Community-Based Services (HCBS) state plan amendment (SPA) to CMS in December 2009. The SPA requests inclusion of certain services provided by the State's Regional Center (RC) network of non-profit providers to persons with developmental disabilities. RC clients 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. Approval of the SPA is expected in FY 2012-13, with a retroactive date of October 1, 2009. ABX3 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. ~~The~~ **An additional** SPA proposes to restore reimbursement for the eliminated services ~~rendered in FY 2010-11 and forward~~ **effective October 1, 2010**. This will enable persons with developmental disabilities access to HCBS State Plan benefits, other community services, activities, and resources.

A 1915(i) SPA to add Infant Development Services was submitted to CMS in December 2011, retroactive to October 1, 2011. **Per CMS guidance, this SPA will be modified to add infant development services as an EPSDT benefit.**

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.

H 13 (OA-36) X X

CCT Enrollment – Expanded Outreach Administrative Costs

In correlation with the Money Follows the Person Rebalancing Demonstration Grant, Community Care

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Pursuant to the Patient Protection and Affordable Care Act, the Department applied for and was awarded grant funding to cover administrative costs needed to increase California Community Transitions (CCT) participation. The grant requires the Department to foster collaborations between the existing Aging and Disability Resource Connection (ADRC) programs and CCT lead organizations to increase CCT enrollment. The costs incurred for these activities are 100% federally funded.

H 14 (PC-29) X X

Quality of Life (QoL) Surveys for Money Follows the Person Program Community Care Transitions (CCT) Participants

As a condition of the Money Follows the Person Rebalancing Demonstration Grant (MFP), CMS requires the Department to conduct QoL surveys with CCT/**MFP transitioned Medi-Cal participants beneficiaries** within specified timeframes and follow a specific methodology. CCT/**MFP has participation agreements with** lead organizations, which are Medi-Cal home and community-based services ~~waiver~~ providers, **to** conduct **these** QoL surveys designed to measure seven domains: living situation, choice and control, access to personal care services, respect/dignity, community integration/inclusion, overall life satisfaction, and health status. The costs of conducting the surveys are 100% federally funded.

H 15 (PC-32) X X
(PC-FI)
(OA-25)

ADHC Transition

AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program in FY 2011-12. As a result of the settlement of the lawsuit *Darling et al. v. Douglas et al.* which challenged the elimination of ADHC services, the ADHC benefit was extended until March 31, 2012. Effective April 1, 2012, an optional Medi-Cal benefit called Community-Based Adult Services (CBAS) was made available **under the 1115 BTR Waiver**, to eligible individuals ~~under the~~ **as a** Medi-Cal Fee-For-Service (FFS) program **benefit**.

On July 1, 2012, CBAS transitioned into ~~five~~ County Organized Health Systems (COHS) managed care ~~counties~~ **health plans**. Effective **On** October 1, 2012, CBAS ~~will also transition~~ **transitioned** into Two-Plan managed care and Geographic Managed Care plans, as well as the **one** remaining COHS plan.

HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The costs ~~will be~~ **were** built into the capitation rate ~~at the actuarial equivalent.~~

For those CBAS eligible beneficiaries residing in geographic areas where managed care is not available, Medi-Cal FFS ~~will provide~~ **provides** CBAS ~~coverage~~ **benefits**. CBAS eligible beneficiaries in managed care counties who do not qualify for managed care enrollment or have an approved medical exemption ~~will be~~ **are** eligible to receive CBAS if a CBAS Center is available in their geographic area or unbundled CBAS if ~~there are no~~ CBAS Centers **became unavailable** in their geographic areas.

Beneficiaries **determined** not eligible for CBAS ~~services~~, who received ADHC services between July 1, 2011 and February 29, 2012 are eligible for Enhanced Case Management (ECM) ~~services~~ through Medi-Cal FFS or a Medi-Cal Managed Care Health Plan, **as a result of the settlement agreement.**

The Department has developed and mailed beneficiary notices informing beneficiaries of their eligibility for CBAS services, how to receive CBAS services, and for beneficiaries that are not eligible for CBAS, how to receive other services such as ECM.

There will be associated **transition** costs to the State due to ~~the~~ **Fair Hearing outcomes and penalties**, special mailings/letters, updates to informing material packets, and provider directories.

H 16

Reduction in IHSS Authorized Hours

This assumption has been moved to Discontinued Assumptions: Withdrawn.

H 17 (PC-201) X

3.6% IHSS Reduction in Service Hours

AB 1612 (Chapter 725, Statutes of 2010), enacted a 3.6% reduction of IHSS service hours. Recipients may determine which of their services will be impacted by the reduction. CDSS implemented this reduction on February 1, 2011. This reduction will sunset June 30, 2013

In March 2013, a settlement was reached in the Oster v. Lightbourne and Dominguez v. Schwarzenegger lawsuits. The settlement provides that commencing July 1, 2013, the

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

Applicable F/Y
C/Y B/Y

IHSS program will continue the 3.6% reduction of service hours with an additional 4.4% reduction, for a total of 8%.

BREAST AND CERVICAL CANCER TREATMENT: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
BC 1 (PC-3)	X	X	<u>Breast and Cervical Cancer Treatment Program</u>

The Budget Act of 2001 includes funding for the creation of the BCCTP effective January 1, 2002, for individuals with a diagnosis of breast and/or cervical cancer who need treatment and have income at or below 200% of FPL. Enhanced Title XIX funding is claimed under the federal Medicaid Breast and Cervical Cancer Treatment Act of 2000 (P.L. 106-354) for cancer treatment and full scope, no cost Medi-Cal benefits for the duration of treatment for women under age 65 who are citizens or immigrants with satisfactory immigration status and who have no other health coverage. The BCCTP also includes a state-funded program that provides cancer and cancer-related treatment services only to persons not eligible for Medi-Cal. The state-funded program is 100% GF, but may receive Safety Net Care Pool funding under the Medi-Cal Hospital/Uninsured Care Demonstration Waiver. Coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. Women with inadequate health coverage, women over the age of 65, undocumented women of any age, and males are eligible for the state funded program. Undocumented women under age 65 are also eligible for federally funded emergency services and pregnancy-related and state-only long-term care services for the duration of their cancer treatment.

Enrollment of BCCTP applicants is performed by Centers for Disease Control (CDC)-approved screening providers, which in California are Every Woman Counts and Family PACT Program providers, using an electronic Internet-based application form. Those women who appear to meet federal eligibility requirements receive immediate temporary full-scope no cost Medi-Cal coverage under accelerated enrollment. DHCS Eligibility Specialists (ES) review the Internet-based application forms and determine regular BCCTP eligibility under the state and federal components. The ES may need to request additional information from the applicant to determine appropriate eligibility under the BCCTP.

With additional staffing, the Department began processing annual redeterminations. Redeterminations are done for beneficiaries in the BCCTP federally-funded aid codes, as well as for those in the BCCTP State-funded aid codes who receive federally-funded emergency coverage. Those persons determined no longer BCCTP program eligible are referred to the counties to determine if they are eligible for any other Medi-Cal program. For those

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

determined by the counties not to be eligible for any other Medi-Cal program, a determination will be made if they are eligible for the State-funded BCCTP.

Current managed care rates fully incorporate BCCTP costs.

BC 2 (PC-3) X X

Breast and Cervical Cancer Treatment Program – Premium Payment

Effective January 1, 2002, under the state funded portion of the Breast and Cervical Cancer Treatment Program funded by the Budget Act of 2001, the Department began payment of the premium cost for individuals with breast and/or cervical cancer who have other health insurance but are underinsured. Eligibility is limited to 18 months for breast cancer and 24 months for cervical cancer. The criteria for participation in the state funded premium payment program include the following:

- Family income at or below 200% of FPL as determined by the enrolling provider,
- California resident,
- Other health coverage with premiums, deductibles and copayments exceeding \$750 in a 12-month period beginning from the month in which the Eligibility Specialist commences the eligibility determination,
- Diagnosis of breast and/or cervical cancer and in need of treatment,
- Not eligible for full-scope, no cost Medi-Cal

BC 3 (OA-8) X X

BCCTP Postage and Printing

Postage and printing costs related to the eligibility determination process for the Breast and Cervical Cancer Treatment Program are budgeted in local assistance, including postage-paid return envelopes for counties to mail copies of DRA/citizenship documentations received from BCCTP beneficiaries. Costs for the state funded component of the program are 100% General Fund, and are included in the Postage and Printing policy change. Mailings include annual redetermination packets to beneficiaries in the federal BCCTP program, retroactive Medi-Cal applications, letters to all applicants to request additional information, notices of approval or denial of eligibility, and referral packets to the counties for redetermination under other Medi-Cal programs as required

BREAST AND CERVICAL CANCER TREATMENT: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

under SB 87 when a federal BCCTP beneficiary is determined ineligible for full-scope Medi-Cal under BCCTP.

PHARMACY: NEW ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
PH 0.1(PC-220) (PC-223)	X	X	<p><u>Sunset of Specialty Drug Contracts</u></p> <p>Assembly Bill (AB) 1183 (Chapter 758, Statutes of 2008) allowed the Department to enter into contracts with providers who distribute and provide care for specialty drugs and services. This provision allows the Department to restrict payment of specialty drugs and services to a limited number of providers. The legislation included a sunset provision of July 1, 2013.</p> <p>Under AB 102 (Chapter 28, Statutes of 2011), the Actual Acquisition Cost (AAC) Medi-Cal pharmacy payment methodology was established. This payment methodology includes a provision to identify specialty drugs by means of a provider survey of services and costs and by means of the contracting provisions of W&I Code 14105.3, in order to provide an enhanced fee for services associated with the provision of specialty drugs and services.</p> <p>If the sunset occurs, the Department will lose its mechanism for reimbursing pharmacy providers for specialty drug services. Beneficiaries in need of these services would be forced to access them through more costly acute care or long-term care providers.</p> <p>The Department is proposing Trailer Bill Language to eliminate this sunset date.</p>

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 1 (PC-43)	X	X	<p><u>Non FFP Drugs</u></p> <p>Federal Medicaid rules specify that there is no FFP for drugs provided by state Medicaid Programs if the manufacturer of the drug has not signed a rebate contract with CMS. The Department has established claiming procedures to ensure that FFP is claimed correctly. Effective March 2007, an automated quarterly report identifies the costs of drugs for which there is no FFP. This report is used to reduce the FFP. In October 2010, an analysis of the non-FFP drug reports determined that these reports were not accurately capturing non-FFP drug claims. The reports were revised and then re-run for the period FY 2004-05 through FY 2009-10. As a result, a larger number of claims were identified as being ineligible for FFP. The Department will reimburse CMS for the identified non-FFP drug costs, retroactive to FY 2004-05.</p>
PH 2 (PC-47)	X	X	<p><u>Family PACT Drug Rebates</u></p> <p>The Department collects rebates for family planning drugs covered through the Family PACT program.</p>
PH 3 (PC-49)	X	X	<p><u>State Supplemental Drug Rebates</u></p> <p>The Department negotiates state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels. As with the federal drug rebates, the Department estimates the state supplemental rebate amounts by using actual fee-for-service trend data for drug expenditures and applying a historical percentage of actual amounts collected to the trend projection.</p>
PH 4 (PC-52)	X	X	<p><u>Federal Drug Rebate Program</u></p> <p>Federal law requires drug manufacturers to provide rebates to the federal government and the states as a condition of FFP in the states' coverage of manufacturers' drug products. The manufacturers have 38 days to make payment after being billed.</p>
PH 5 (PC-45)	X	X	<p><u>Medical Supply Rebates</u></p> <p>The Department negotiates diabetic medical supply rebates with diabetic supply maximum acquisition cost (MAC) and rebates with manufacturers for diabetic test strips and lancets to provide savings to the Department. Due to system limitations in</p>

PHARMACY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

the Rebate Accounting Information System (RAIS), manually created invoices are sent quarterly to manufacturers.

The product reimbursement rates for diabetic ~~supply products~~ **test strips and lancets** are based on the contracted ~~Maximum Acquisition Cost (MAC)~~ **MAC**. ~~Reimbursement on the MAC has resulted in additional savings to the Department.~~

~~On December 31, 2012, MAC contracts (those with and without rebates) for diabetic supplies will expire. The Department will negotiate terms to reduce net costs for contracts effective January 1, 2013.~~

On January 1, 2013, newly negotiated three-year contract terms went into effect and reduced the Department's net cost per claim.

PH 6 (PC-48) X X

Aged and Disputed Drug Rebates

The Department collects drug rebates as required by federal and state laws. The Department has completed its work on the oldest aged rebate disputes (1991-96) and is awaiting final agreements from a few pharmaceutical companies, which account for the majority of the amount in dispute, before closing out the time period. The Department has begun work on disputes for the 1997-2002 time period.

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

PH 7 (OA-43) X X

Epocrates

The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) in the Epocrates system. Epocrates RX™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country. Epocrates provides the Department with an opportunity to reach a large network of health professionals via a point-of-care clinical reference for physicians and other health professionals. Epocrates' formulary is free to health professional users.

PHARMACY: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 8 (PC-44)	X	X	<p><u>BCCTP Drug Rebates</u></p> <p>Enhanced Title XIX Medicaid funds (65% FFP/35% GF) are claimed for drugs under the federal Medicaid BCCTP program. The Department is required by federal law to collect drug rebates whenever there is federal participation. Beginning January 2010, the Department is collecting drug rebates for the federal BCCTP program. Manufacturers were invoiced retroactively to January 1, 2002. By agreement with CMS, rebates for beneficiary drug claims for the federal portion of the BCCTP program (emergency and prenatal services) for those without satisfactory citizenship or immigration status will not be invoiced.</p>
PH 9 (PC-46)	X	X	<p><u>Physician-Administered Drug Reimbursement</u></p> <p>The current rate of reimbursement for physician-administered drugs is the Average Wholesale Price (AWP) minus 5%. SB 853 (Chapter 717, Statutes of 2010) established a new reimbursement rate methodology for physician-administered drugs to be reimbursed consistent with the Medicare rate of reimbursement or the pharmacy rate when the Medicare rate is not available. Upon implementation of the new rates in October 2012, the new methodology is expected to generate savings. <u>The new rates were implemented on September 1, 2012, with savings being generated under this methodology.</u></p> <p>Erroneous Payment Corrections will be performed from <u>for the period of</u> September 1, 2011 forward <u>through August 31, 2012</u> on all claims that were reimbursed under the old methodology.</p>
PH 10(OA-31)	X	X	<p><u>Rate Studies for MAIC and AAC Vendor</u></p> <p>Welfare and Institutions Code, Section 14105.45, requires the Department to establish Maximum Allowable Ingredient Costs (MAIC) on certain generic drugs based on pharmacies' acquisition costs and to update the MAICs at least every three months. AB 102 (Chapter 29, Statutes of 2011) authorized the Department to develop a new reimbursement methodology for drugs based on a new benchmark, the Average Acquisition Cost (AAC), to replace the Average Wholesale Price (AWP). In order to obtain the information from providers necessary to establish the MAICs and AACs, the Department will hire a contractor in FY 2012-13 to survey drug price information from the Medi-Cal pharmacy</p>

PHARMACY: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

providers and update AACs and MAICs on an ongoing basis. Currently, the Department is subject to a court injunction which precluded implementation of the MAIC methodology, as amended by ABX4 5 (Chapter 5, Statutes of 2009). However, MAICs based on the new reimbursement benchmark, AACs, are not subject to that injunction.

PH 11(PC-42) X X

Kalydeco for Treatment of Cystic Fibrosis

This assumption has been moved to “Fully Incorporated Into Base Data/Ongoing” section.

DRUG MEDI-CAL: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
D 1	(PC-56)	X	X	<p><u>Perinatal Residential Substance Abuse Use Disorder Services</u></p> <p>The Perinatal Residential Substance Abuse Use Disorder Services program provides rehabilitation services to pregnant and postpartum women with substance use disorder diagnoses in a non-institutional, non-medical, residential setting. Each beneficiary resides on the premises and receives support in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. The cost of room and board is not reimbursed under the Medi-Cal program.</p> <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>
D 2	(PC-55)	X	X	<p><u>Day Care Rehabilitative Services</u></p> <p>Day Care Rehabilitative services provide outpatient counseling and rehabilitation services at least three hours per day, three days per week to persons with substance use disorder diagnoses,</p> <ul style="list-style-type: none"> • who are pregnant or in the postpartum period, • and/or to EPSDT eligible beneficiaries. <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>
D 3	(PC-54)	X	X	<p><u>Outpatient Drug Free Treatment Services</u></p> <p>The Outpatient Drug Free (ODF) Treatment program is designed to stabilize and rehabilitate persons with substance use disorder diagnoses in an outpatient setting when prescribed by a physician as medically necessary. Each ODF participant receives at least two group, face-to-face, counseling sessions per month. Face-to-face individual counseling is limited to intake, crisis intervention, collateral services, and treatment and discharge planning.</p> <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>

DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
D 4	(PC-53)	X	X	<p><u>Narcotic Treatment Program</u></p> <p>The Narcotic Treatment Program provides outpatient methadone or levoalphacetylmethadol (LAAM), which is not currently manufactured, services directed at stabilization and rehabilitation of persons with opioid dependency and diagnoses of substance use disorder <u>diagnoses</u>.</p> <p>The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes <u>per month</u> of face-to-face counseling sessions. The Narcotic Treatment Program does not include detoxification.</p> <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>
D 5	(PC-57)			<p><u>Naltrexone Treatment Services</u></p> <p>Naltrexone Treatment provides outpatient Naltrexone services to detoxified persons with opioid dependency and diagnoses of substance use disorder <u>diagnoses</u>. Naltrexone blocks the euphoric effects of opioids and helps prevent relapse to opioid use. Naltrexone services are not provided to pregnant women. While these benefits are available, beneficiaries are currently not utilizing the service.</p> <p>Before July 1, 2012, these services were provided by the Department of Alcohol and Drug Programs. After July 1, 2012, the Department began administering the program.</p>
D 6	(PC-59)	X	X	<p><u>Drug Medi-Cal Program Cost Settlement</u></p> <p>The Drug Medi-Cal program reimburses counties and contracted providers for the alcohol and drug treatment services that they provide to Drug Medi-Cal beneficiaries. The Drug Medi-Cal program initially pays a claim for alcohol and drug treatment at a provisional rate, not to exceed the rate cap. At the end of each fiscal year, non-Narcotic Treatment Program (non-NTP) providers must submit actual cost information. The Drug Medi-Cal program completes a final settlement <u>an interim settlement</u> after receipt and review of the provider's cost report <u>and approved units of service. Within three years of the interim settlement, the program must conduct an audit to complete a final</u></p>

DRUG MEDI-CAL: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

settlement. If the program does not complete the audit within three years, the interim settlement becomes the final settlement.

Reimbursement for non-Narcotic Treatment Program (NTP) providers is limited to the lowest of the following costs:

- Provider’s usual and customary charges to the general public for the same or similar services,
- Provider’s allowable costs, or
- Drug Medi-Cal statewide maximum allowance for each non-NTP service modality.

Reimbursement to NTP providers is limited to the lowest of the following costs:

- Provider’s usual and customary charges to the general public for the same or similar services,
- Drug Medi-Cal uniform statewide ~~daily~~ reimbursement rate for the service.

D 7 (PC-58) ✕ X

Annual Rate Adjustment

The Department annually adjusts the Drug Medi-Cal Rates. ~~based on the cumulative growth in the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies.~~ **For non-NTP services and NTP counseling services, the Department annually sets rates based on the lower of either the cost report data or the Fiscal Year 2009-10 rates adjusted by cumulative growth of the Implicit Price Deflator for the Costs of Goods and Services to Governmental Agencies as reported by the Department of Finance. For the NTP dosing service, the Department annually sets rates based on the lower of either updated component cost data or the Fiscal Year 2009-10 rates adjusted by the cumulative growth in the Implicit Price Deflator.** The annual rate adjustment is effective July 1st of each year.

MENTAL HEALTH: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MH 1(PC-224) (PC-225) (Reworded)	X	X	<p><u>Specialty Mental Health Services</u></p> <p>The Medi-Cal Specialty Mental Health Services Waiver program provides inpatient, targeted case management, and rehabilitative mental health services to adults, children, and youth under 21 who are enrolled in the Medi-Cal program and meet the medical necessity criteria.</p> <p>Adult: The mental health plan authorizes the delivery of specialty mental health services in accordance with state regulations and contract requirements for service authorization provided to adults.</p> <p>Children: The mental health plan authorizes the delivery of specialty mental health services in accordance with state regulations and contract requirements for service authorization provided to children, which includes Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specialty mental health services. EPSDT specialty mental health services include all services that are required to correct or improve medical health condition diagnosed by a doctor or mental health care provider as long as the service is covered under the federal Medicaid program.</p> <p>The Department contracts with a mental health plan in each county to provide or arrange and pay for the provision of specialty mental health services to all individuals, in that county, who are enrolled in the Medi-Cal program and meet the medical necessity criteria for the specialty mental health services.</p> <p>Effective July 1, 2012, the Department of Mental Health (DMH) program staff and associated funding was shifted to the Department.</p>
MH 2 (PC-62)	X	X	<p><u>Healthy Families Program SED</u></p> <p>The Healthy Families Program (HFP) provides low cost insurance for eligible children under the age of 19 whose families:</p> <ul style="list-style-type: none"> • Do not have insurance, • Do not qualify for zero share of cost Medi-Cal, and • Income is at or below 250 percent of the federal poverty level.

MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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

When a mental health department assumes responsibility for the treatment of the HFP enrollee’s SED condition, it claims 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.

Effective July 1, 2012, the DMH functions related to the HFP SED Benefit and associated funding was shifted to the Department.

No sooner than January 1, 2013, the HFP will cease to enroll new subscribers and HFP subscribers will transition into Medi-Cal through a phase-in methodology.

MH 3 (PC-69) X X
 (PC-70)

IMD Ancillary Services

Effective July 1, 1999, the cost of ancillary services for Medi-Cal beneficiaries who are ages 22 through 64 residing in Institutions for Mental Diseases (IMDs), was entirely state-funded. In 2008, the entire cost became a county responsibility.

MH 4 (PC-68) X X

Siskiyou County Mental Health Plan Overpayment

The Department has identified overpayments to Siskiyou County Mental Health Plan (MHP) due to inappropriate Medi-Cal billing practices. The Department must return the overpaid FFP reimbursements to the CMS. Siskiyou County and the State are currently negotiating a plan for the county to reimburse the State for the repayment.

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MH 5 (PC-72) (OA-11)	X	X	<p><u>Interim and Final Cost Settlements—Specialty Mental Health Services</u></p> <p>Within two years following the end of a fiscal year, the Department must reconcile interim settlements to MHPs for children, adults, and healthy families specialty mental health services to county cost reports and process correcting payments or recoupments.</p>
MH 6 (PC-71)	X	X	<p><u>Chart Review</u></p> <p>The Department conducts on-site chart reviews of mental health providers by comparing claims to the corresponding patient chart entries.</p>
MH 7 (PC-67)	X		<p><u>Specialty Mental Health Lawsuits</u></p> <p>Three Los Angeles MHPs have filed a writ of mandate requesting the court to direct the Department to approve certain Specialty Mental Health claims from FY 1999-00 and FY 2000-01. The cases are referred to as:</p> <ul style="list-style-type: none"> • <i>Hillsides Home for Children, et al. v. California, et al,</i> • <i>Hathaway-Sycamores Child and Family Services, et al. v. California, et al, and</i> • <i>Five Acres v. California, et al</i> <p>The claims were denied for various reasons including lack of Medi-Cal eligibility on the date of service. A proposed settlement agreement provides for Los Angeles County to pay the providers for the claims, certify the public expenditures, and submit the claims to the Department for FFP.</p>
MH 8 (PC-65)	X	X	<p><u>Solano County SMHS Realignment Carve-Out</u></p> <p>Prior to FY 2012-13, the Medi-Cal managed care program “carved in” specialty mental health services for Solano County.</p> <p>Under the 2011 Realignment, Solano County decided to exercise their right to assume responsibility for providing or arranging for the specialty mental health services from the Medi-Cal Managed Care Plan, effective July 1, 2012.</p> <p>The Medi-Cal Managed Care contract will be was reduced for the mental health services component and the mental health</p>

MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			managed-care <u>local realignment</u> funding to Solano County will <u>was</u> increase <u>increased</u> by the same amount.
MH 9 (PC-66)	X	X	<p><u>Over One-Year Claims</u></p> <p>County MHPs 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.</p>
MH 10 (OA-3)	X	X	<p><u>County Specialty Mental Health Administration</u></p> <p>Counties may obtain federal reimbursement for certain costs associated with administering a county's mental health program. Counties must report their administration costs and direct facility expenditures quarterly.</p>
MH 11 (OA-10)	X	X	<p><u>County Utilization Review and Quality Assurance</u></p> <p>County Utilization Review (UR) and Quality Assurance (QA) activities safeguard against unnecessary and inappropriate medical care. Federal reimbursement for these costs is available at 50% or 75% depending on the claim.</p>
MH 12 (OA-44) (PC-63)	X	X	<p><u>Katie A. v. Diana Bontá – Special Master</u></p> <p>On March 14, 2006, the U.S. Central District Court of California issued a preliminary injunction in <i>Katie A. v. Diana Bontá</i>, requiring the provision of EPSDT program “wraparound” and “therapeutic foster care” (TFC) mental health services under the Specialty Mental Health Services waiver to children in foster care or “at risk” of foster care placement. On appeal, the Ninth Circuit Court reversed the granting of the preliminary injunction and remanded the case to District Court in order to review each component service to determine whether they are mandated Medicaid covered services, and if so, whether the Medi-Cal program provides each service effectively. The court ordered the parties to engage in further meetings with the court appointed Special Master. On July 15, 2011, the parties agreed to a proposed settlement that was subject to court approval and on December 2, 2011, the court granted final approval of the proposed settlement. On October 13, 2011, the parties began a new series of Special Master meetings to develop a plan for, and</p>

MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

begin, settlement implementation. The Special Master is being funded by the Department and CDSS. **On December 13, 2012, the court approved the implementation plan drafted by the parties.** 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.

MH 13 (OA-48)

X

PASRR

Federal regulations mandate that the Department have an independent contractor complete all Level II Preadmission Screening and Resident Review (PASRR) Evaluations. QTC Medical Group, Inc. completes Level II evaluations for the federally mandated PASRR program. QTC provides licensed clinical evaluators to conduct a face-to-face mental status examination and psychosocial assessment for individuals identified with mental illness upon admission to a nursing facility. QTC enters Level II findings into the PASRR database.

The current contract ends in June 2014. The FY 2012-13 budget is included in support, but beginning with FY 2013-14 it will be part of the local assistance estimate.

In addition, the Department is requesting funding for a PASRR information technology (IT) project to design, test, and implement a web based automated system to bring the preadmission Level I Screening, Level II evaluation, and Level II determination processes into compliance with federally mandated regulations. The IT project will replace an inefficient mainframe database with a database that meets the Department's architecture, infrastructure, and security requirements. The Department will save money by not contracting with a consultant to support the current mainframe and by hosting the new application in-house. The project will be funded 75% FFP and 25% SGF.

MH 14(PC-204) X

X

Elimination of State Maximum Rates

Assembly Bill 1297 (Chapter 651, Statutes of 2011) eliminated the state maximum rates paid for Medi-Cal specialty mental health services. 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

MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

upper payment limit will **likely** be equal to the aggregate **of the lower of** allowable cost or customary charge for all specialty mental health services provided by the mental health plan and its network of providers.

1115 WAIVER – MH/UCD & BTR

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

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

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

1115 WAIVER – MH/UCD & BTR: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
W 0.1 (PC-216)	X		<p><u>Uncompensated Care Payments for Tribal Health Programs</u></p> <p>CMS approved an amendment to the Bridge to Reform Demonstration to make uncompensated care payments for services provided by Indian Health Service (IHS) tribal health programs to IHS eligible individuals with:</p> <ul style="list-style-type: none"> • incomes up to 133% of the FPL, and • who are not eligible for a Low Income Health Program (LIHP). <p>The demonstration will provide uncompensated care payments at the IHS encounter rate for Medi-Cal state plan primary care services and other optional services eliminated from the state plan.</p> <p>For Medi-Cal enrolled IHS eligible individuals, this demonstration will provide uncompensated care payments only for optional services eliminated from the state plan. The effective date of the demonstration is from April 5, 2013 to December 31, 2013.</p> <p>Services provided to non-IHS eligible individuals will also be eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements.</p> <p>For services provided to IHS eligible individuals, reimbursement will be 100% FFP. For services provided to non-IHS eligible individuals, reimbursement will be claimed through certified public expenditures. There will be no GF impact.</p>
W 0.2 (PC-231)	X		<p><u>Private Hospital Supplemental Fund Savings</u></p> <p>The American Recovery and Reinvestment Act of 2009 (ARRA) temporarily increased California's FMAP by 11.59% from October 1, 2008 to December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011.</p> <p>The Private Hospital Supplemental Fund includes funds received due to the increased ARRA FMAP. In FY 2013-14, the Department will redirect the ARRA funds from the Private Hospital Supplemental Fund to the GF.</p>

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

W 1 (PC-77) X X MH/UCD & BTR—Safety Net Care Pool
 (PC-90)

Effective for dates of service on or after July 1, 2005, based on the Special Terms and Conditions (STCs) of the MH/UCD, a Safety Net Care Pool (SNCP) was established to support the provision of services to the uninsured. SB 1100 authorized the establishment of the Health Care Support Fund (HCSF), Item 4260-601-7503.

The federal funds that the Department claims from the SNCP are based on the following Certified Public Expenditures (CPEs):

- The CPEs of the Designated Public Hospitals (DPHs).
- The CPEs of the following four state-only programs:
 - Medically Indigent Adult Long-Term Care Program
 - Breast and Cervical Cancer Treatment Program
 - Genetically Handicapped Person's Program
 - California Children's Services Program

Funds that pass through the HCSF are to be paid in the following order:

- Meeting the baseline of the DPHs.
- Federalizing the four state-only programs, and
- Providing stabilization funding.

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

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

The new BTR effective November 1, 2010, makes several changes to the SNCP funding. SNCP payments to DPHs are for uncompensated care provided to individuals with no source of third party coverage for the services they received. AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Department to implement the new payment methodologies under the BTR to determine (1) the federal disproportionate share hospital allotment for DPHs (2) SNCP Uncompensated Care payments, (3) DSRIP payment to DPHs. SNCP funding for the DSRIP, Designated State Health Programs (DSHP), the Low Income Health Program–Medicaid Coverage Expansion (LIHP-MCE) and the Low Income Health Program-Health Care Coverage Initiative (LIHP-HCCI) are included in separate assumptions.

W 2 (PC-74) X X

MH/UCD & BTR—DSH Payments

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

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

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

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

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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

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

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

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

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

W 3 (PC-76) X X

MH/UCD & BTR—Private Hospital DSH Replacement

Effective for dates of service on or after July 1, 2005, private hospitals receive DSH replacement payments, the non-federal share of which is funded by the GF. The DSH replacement payments, along with \$160.00 of the DSH payments (see assumption for Hospital Financing DSH Payments), will satisfy the payment obligations with respect to those hospitals under the

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Federal DSH statute. The federal share of the DSH replacement payments is regular Title XIX funding and is not claimed from the federal DSH allotment.

SB 335 (Chapter 286, Statutes of 2011) reduces Medi-Cal DSH replacement payments to private hospitals by \$75 million GF in FY 2011-12, \$10.5 million GF in FY 2012-13, and \$5.25 million GF in FY 2013-14.

W 4 (PC-79) X X

MH/UCD & BTR—Private Hospital Supplemental Payment

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, private hospitals receive payments from the Private Hospital Supplemental Fund, Item 4260-601-3097. SB 1100 provides a continuous appropriation of \$118.4 million annually from the GF to the Private Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. SB 335 (Chapter 286, Statutes of 2011) reduces this annual appropriation by \$17.5 million in FY 2012-13 and \$8.75 million in FY 2013-14. This funding replaces the aggregate amount the private hospitals received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/Voluntary Governmental Transfers (VGT)), Graduate Medical Education Supplemental Payment (Teaching Hospitals), and Small and Rural Hospital Supplemental Payment programs.

W 5 (PC-94) X X

MH/UCD & BTR—NDPH Supplemental Payment

Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, NDPHs receive payments from the Non-Designated Public Hospital Supplemental Fund, Item 4260-601-3096. SB 1100 provides a continuous appropriation of \$1,900,000 annually from the GF to the Non-Designated Public Hospital Supplemental Fund to be used as the non-federal share of the supplemental payments. This funding replaces the aggregate amount the NDPHs received in FY 2004-05 under the Emergency Services Supplemental Payment (SB 1255/VGT) program.

Effective July 1, 2012, AB 1467 (Chapter 23, Statutes of 2012) authorized NDPH payment methodology changes and eliminated this supplemental payment program.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The Department submitted a SPA to CMS, but because CMS approval has not been received timely, the Department is no longer pursuing the NDPH reimbursement change. NDPHs will continue to receive supplemental payments.

W 6 (PC-82) X X MH/UCD & BTR—DPH ~~and NDPH~~ Physician and Non-Physician Costs

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

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

Effective July 1, 2012, AB 1467 (Chapter 23, Statutes of 2012) requires the Department to change the NDPH payment methodology to a CPE methodology. The Department submitted a SPA to CMS allowing CPE-based reimbursement to be available to each NDPH for the costs incurred for physician and non-physician practitioner professional services rendered to Medi-Cal beneficiaries who are patients of the hospital or its affiliated hospital and non-hospital settings. ~~The SPA is expected to be approved in FY 2012-13 and retroactive to July 1, 2012.~~

Due to delayed CMS approval, the Department is no longer pursuing the NDPH reimbursement change. NDPHs will continue to receive payments through the current methodology and will not be eligible for uncompensated costs for physician and non-physician practitioner professional services.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

W 7 (PC-95) X

MH/UCD—Distressed Hospital Fund

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

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

On October 31, 2010, funding for the Distressed Hospital Fund ended with the expiration of the MH/UCD waiver and no separate funding is allocated under the BTR. Any residual balances from the above four prior supplemental funds are expected to be paid from the Distressed Hospital Fund in FY 2012-13.

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 DSH payments, and interim SNCP payments for each FY under the MH/UCD and budgeted in the Stabilization Funding policy change.

W 8 (PC-96) X X

MH/UCD& BTR—MIA LTC Program– Safety Net Care Pool

Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded Medically Indigent Adult Long-Term Care program.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 9	(PC-97)	X	X	<p><u>MH/UCD & BTR—BCCTP – Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on the requirements of SB 1100, the Department may claim federal reimbursement from the SNCP established by the MH/UCD and the BTR for the State-only funded portion of the Breast and Cervical Cancer Treatment Program.</p>
W 10	(PC-87)	X	X	<p><u>MH/UCD & BTR—CCS AND GHPP – Safety Net Care Pool</u></p> <p>Effective for dates of service on or after September 1, 2005, based on SB 1100, the Department may claim federal reimbursement for the CCS Program and Genetically Handicapped Persons Program (GHPP) from the SNCP established by the MH/UCD and the BTR. The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy health care services to children under 21 years of age with CCS-eligible conditions in families unable to afford catastrophic health care costs. The GHPP program provides comprehensive health care coverage for persons over 21 with specified genetic diseases including: cystic fibrosis; hemophilia; sickle cell disease and thalassemia; and chronic degenerative neurological diseases, including phenylketonuria.</p>
W 11	(PC-84)	X	X	<p><u>MH/UCD & BTR—DPH Interim and Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the Funding and Reimbursement Protocol in the STCs of the MH/UCD and BTR, each DPH's 2005-06 interim per diem rate is comprised of 100 percent federal funds, based on the reconciliation of each inpatient hospital costs for Medi-Cal beneficiaries to its filed Medi-Cal 2552-96 cost report.</p> <p>The reconciliation process for each Demonstration Year may result in an overpayment or underpayment to a DPH and will be handled as follows:</p> <ul style="list-style-type: none"> • 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

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

between the DPH's computed Medi-Cal cost, and the share of cost, third liability and Medi-Cal payments.

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

W 12 (PC-83) X X

MH/UCD—Stabilization Funding

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

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

Final reconciliations for the MH/UCD stabilization funding will begin in FY 2012-13.

W 13 (PC-92) X X

MH/UCD—Health Care Coverage Initiative

An amount of \$180 million in federal funds is available each year in Demonstration Years 3-5 to expand health care coverage to eligible low-income, uninsured persons. SB 1448 (Chapter 76, Statutes of 2006) provided the statutory framework for the Health Care Coverage Initiative (CI) and directed the Department to issue a Request for Applications to enable a county, a city and county, a

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

consortium of more than one county, or a health authority to apply for an allocation of this federal funding. A total of ten programs have been selected to participate in the CI program.

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

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

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

W 14 (PC-98) X X

MH/UCD & BTR—DPH Interim Rate

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

W 15 (PC-89) X X

MH/UCD & BTR—DPH Interim Rate Growth

Effective July 1, 2005, based on SPA 05-021, DPHs receive interim per diem rates based on the reported hospitals' Medi-Cal costs trended forward annually. The trend used is to reflect increased costs and is expected to be different from the former CMAC negotiated rate trend for some DPHs. The interim per diem rate consists of 100% FFP.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
W 16 (OA-6)	X	X	<p><u>MH/UCD—Health Care Coverage Initiative – Administrative Costs</u></p> <p>FFP is available for costs incurred on or after March 29, 2007 through October 31, 2010, that are associated with the start-up, implementation and closeout administration of approved CI programs. The federal funds will reimburse the CI counties an amount equal to 50% of their CPEs for administrative costs. The administrative activities for which FFP is being requested were submitted to CMS on December 22, 2006, and approved in October 2007.</p> <p>The required administrative cost claiming protocol was approved by CMS in October 2008 for prospective costs after the implementation of the time study. The Department implemented the time study in February 2009 for prospective costs and began reimbursement to the CI counties in FY 2009-10. The Department received CMS approval in August 2010 for the cost claiming methodologies for the administrative costs for the period prior to the implementation of the time study, along with the start-up and close-out costs. Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the Low Income Health Program. See assumption BTR-Low Income Health Program – Administrative Costs for more information.</p>
W 17 (OA-30)	X	X	<p><u>MMA –DSH Annual Independent Audit</u></p> <p>MMA requires an annual independent certified audit that primarily certifies:</p> <ul style="list-style-type: none"> • That DSH (approximately 150+ hospitals) have reduced their uncompensated care costs by the amount equal to the total amount of claimed expenditures made under section 1923 of the MMA. • That hospitals' DSH payments do not exceed the costs incurred by the hospitals in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital and payments made by uninsured patients. <p>CMS released the final regulation and criteria for the annual independent certified audit. Each year's annual report is due to CMS by December 31.</p>

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 18	(PC-74) (PC-76)	X		<p><u>MH/UCD & BTR—ARRA – DSH Allotment and DSH Replacement Payments</u></p> <p>California's annual allotment of federal funds for the Disproportionate Share Hospital (DSH) temporarily increased for FY 2008-09 and FY 2009-10 by 2.5%, due to the enactment of the ARRA. The distribution of the DSH allotment is determined by a formula specified in State statute and the State Medi-Cal Plan. When the DSH allotment is increased and more federal funds are available for distribution, the formula results in an increase in General Funds needed as the non-federal share of the DSH payments for NDPHs and DSH replacement payments to private hospitals.</p> <p>The remaining DSH ARRA payments cannot be paid to the hospitals until the entire original DSH allotment is paid out per federal rules, therefore the Department expects to continue to pay DSH ARRA payments in FY 2012-13.</p>
W 19	(PC-99)	X		<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool ARRA</u></p> <p>ARRA temporarily increased California's FMAP by 11.59% from October 1, 2008 to December 31, 2010. The Education, Jobs and Medicaid Assistance Act of 2010 increased FMAP for California by 8.77% for January 1, 2011, through March 31, 2011, and 6.88% for April 1, 2011, through June 30, 2011. The annual SNCP federal funds allotment increased accordingly. This increase in federal funds was claimed by the State through the Safety Net Care Pool via certified public expenditures. Effective November 1, 2010, under the BTR, this federal flexibility funding is no longer applicable.</p> <p>Interim claims were completed in FY 2010-11. The Department will conduct the final reconciliation for Demonstration Year 5 in FY 2012-13.</p>
W 20	(PC-103)	X	X	<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool</u></p> <p>The MH/UCD made available \$180 million in federal funds via the SNCP annually. This funding was contingent on the Department meeting specific milestones. In Demonstration Years 1 and 2, this funding was unused. The Department will utilize this funding in</p>

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				FY 2009-10, FY 2010-11, and FY 2011-12 to claim federal funds via certified public expenditures. The final reconciliation is expected to begin in FY 2012-13.
W 21	(PC-75) (PC-88)	X	X	<p><u>BTR—Delivery System Reform Incentive Pool</u></p> <p>The BTR was approved by CMS effective November 1, 2010. Based on the STCs of the demonstration, the SNCP includes a Delivery System Reform Incentive Pool (DSRIP). The DSRIP is established to support California public hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve. Funding is available in five areas:</p> <ol style="list-style-type: none"> 1. Infrastructure development 2. Innovation and redesign 3. Population-focused improvement 4. Urgent improvement in care 5. HIV Transition Projects <p>AB 1066 (Chapter 86, Statutes of 2011) provides the authority for the Department to implement the new payment methodologies under the BTR to determine DSRIP payment to DPHs.</p> <p>On June 28, 2012, CMS approved an amendment to the BTR Demonstration that authorizes HIV Transition projects to be included as a category for which additional DSRIP funding is available. DPHs that elect to implement additional DSRIP approved HIV Transition projects will receive incentive payments under the SNCP upon achievement of project milestones. These projects will be effective from July 1, 2012 through December 31, 2013.</p> <p>Intergovernmental transfers (IGTs) will be used as the non-federal share to claim the federal funding.</p>
W 22	(PC-73) (PC-78)	X	X	<p><u>BTR—Low Income Health Program</u></p> <p>The BTR was approved by CMS effective November 1, 2010. The BTR modifies modified the existing HCCI under the MH/UCD to expand health care coverage to low income adults through the Low Income Health Program (LIHP). AB 342 (Chapter 723, Statutes of 2010) and AB 1066 (Chapter 86, Statutes of 2011) authorize the local LIHPs to provide health care services to eligible individuals.</p>

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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

The counties will use ~~certified public expenditures or capitation rates through the use of intergovernmental transfers to obtain federal funding for the LIHP.~~ **the following methodologies to obtain federal funding:**

- **CPEs,**
- **IGTs for capitation rates payments, and**
- **IGTs for county-owned FQHCs (CMS approved this claiming protocol on February 5, 2013).**

If counties that participate in the HCCI under the MH/UCD elect not to participate in the HCCI component of the LIHP, they must continue to provide health care services for existing enrollees and receive federal funding for these services.

- a. MCE will cover individuals who have family incomes at or below 133% FPL. The MCE program is not subject to a federal funding cap.
- b. HCCI will cover individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to a cap of \$180 million for the first three demonstration years and \$90 million for the last year ending December 31, 2013. This cap may vary annually; see the BTR-Health Care Coverage Initiative Rollover Funds assumption.

W 23 (PC-93) X

X

BTR—SNCP Designated State Health Programs

The BTR was approved by CMS effective November 1, 2010. Under the new demonstration, the State may claim up to \$400 million federal funds for certain state-only programs. This claiming has first priority on the SNCP funds.

CPEs from the following programs may be used to draw the federal funds:

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- State Only Medical Programs
 - California Children’s 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)
 - County Medical Services Program (CMSP); effective November 1, 2010 to December 31, 2011.
- Workforce Development Programs
 - Office of Statewide Health Planning and Development (OSHPD)
 - Song-Brown Healthcare Workforce Training Program
 - Health Professions Education Foundation Steven M. Thompson Physician Corp Loan Repayment Program
 - Health Professions Education Foundation Mental Health Loan Assumption Program
 - University of California
 - California State University
 - California Community Colleges
- Miscellaneous programs.

*Separate assumptions address the federal funds for these programs.

W 24 (OA-4) X X

BTR—Low Income Health Program – Administrative Costs

Under the BTR, effective November 1, 2010, there will be new administrative costs associated with the LIHP. These costs will involve both MCE and the HCCI. FFP is available for costs incurred on or after November 1, 2010, through December 31, 2013, that are associated with the start-up, implementation and closeout administration for the LIHP. The federal funding will reimburse the programs an amount equal to 50% of their certified public expenditures for administrative costs.

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 25 (PC-86)	X		X	<p><u>BTR—Low Income Health Program – Inpatient Hospital Services Costs for CDCR Inmates</u></p> <p>AB 1628 (Chapter 729, Statutes of 2010) authorizes the Department to claim federal funding for inpatient hospital services for certain State inmates in the California Department of Corrections and Rehabilitation (CDCR) correctional facilities who are enrolled under the LIHP. The inpatient hospital services would be those that are provided at hospitals that are off the grounds of the correctional facilities and the inmates would be those determined eligible by the Department for the LIHP program operated by the counties. The CPEs incurred by the CDCR for inpatient hospital services provided to those inmates eligible for the LIHP will be certified by CDCR. The county LIHP in which the eligible inmate is enrolled will attest to the CDCR CPEs for federal reimbursement. The Department budgets the FFP based on the counties' attestation of the CDCR CPEs.</p>
W 26 (PC-106)	X		X	<p><u>Hospital Stabilization</u></p> <p>AB 1467 (Chapter 23, Statutes of 2012) provided the authority to redirect private and NDPH stabilization funding that has not yet been paid. A portion of the GF savings achieved from this legislation will be used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 through FY 2006-07.</p>
W 27 (PC-NA)				<p><u>NDPH Payments Changes</u></p> <p>This assumption has been moved to the "Discontinued Assumptions: Withdrawn" section.</p>
W 28 (PC-81) (PC-100) (PC-107)	X		X	<p><u>BTR-Health Care Coverage Initiative Rollover Funds</u></p> <p>HCCI, one component of BTR, covers individuals who have family incomes above 133% through 200% of FPL. Federal funding for HCCI is subject to an annual cap. The Department has requested received federal approval to reallocate the unspent DY 6 and DY 7 HCCI money to the SNCP uncompensated care component. The reallocated funding to SNCP will be shared 50/50 between DPHs and the State. As a condition for the DPHs receiving the reallocated funding, the DPHs are first required to utilize available CPEs to ensure the State achieves \$400 million in annual General Fund savings.</p>

1115 WAIVER – MH/UCD & BTR: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

W 29 (PC-101) X
 (PC-FI)

X

Diagnosis Related Group – Inpatient Hospital Payment Methodology

SB 853 (Chapter 717, Statutes of 2010) mandated the design and implementation of a new payment methodology for hospital inpatient services provided to Medi-Cal beneficiaries based upon diagnosis related groups (DRGs). The DRG payment methodology will replace the previous payment methods. For contract hospitals, DRGs will replace the per diem rates negotiated under the Selective Provider Contracting Program (SPCP). For non-contract hospitals, DRGs will replace the previous cost-based reimbursement methodology. DRG implementation is scheduled to begin July 1, 2013.

The Medi-Cal Fiscal Intermediary, Xerox State Healthcare, LLC (Xerox), will implement California Medicaid Management Information Systems (CA-MMIS) changes to comply with this legislation.

MANAGED CARE

Medi-Cal Managed Care Rates

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

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

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

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

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

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

Medicaid RX from UC San Diego is the Risk Adjustment Software used. Medicaid RX classifies risk by 11 age bands, gender, and 45 disease categories. Each member in the Family/Adult or SPD Medi-Cal only rate category, in a specific plan, that meets the eligibility criteria, is assigned a risk score. Member scores are aggregated to develop two risk scores for each plan operating in a county; a risk score for the Family/Adult rate and one for the SPD Medi-Cal only rate. A

MANAGED CARE

county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate. The basis for the county specific rate is the aggregate of the plan specific rates developed and each plan's enrollment for a weighted average county rate. For the 2012-13 rates, 35% of this county specific rate was taken and multiplied by each plan's respective risk score and 65% of each plan's plan specific rate was retained and added to the 35% risk adjusted rate to establish a risk adjusted plan specific rate. For FY 2013-14 rates, the percentage of county specific rates used in the risk adjustment will increase from 35% to 40% with an additional quality factor of 5%.

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

Fee-for-Service Expenditures for Managed Care Beneficiaries

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

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

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

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

2012-13 and 2013-14 Rates

Overall, the rates represent a ~~1.4%~~ **0.7%** increase in FY ~~2011-12~~ **2012-13** over the previous fiscal year rates (based on a fiscal year comparison). ~~FY 2013-14 rates have not been determined; however, a placeholder will be included based on historical rate increases, taking into consideration statutory changes, case mix changes, and health care inflation trends.~~ **Rates for 2013-14 represent an 3.74% increase over the 2012-13 fiscal year rates.**

MANAGED CARE: NEW ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 0.1 (PC-226) (PC-227) (PC-228)		X	<p><u>Sales Tax on Managed Care Plans</u></p> <p>The Administration has proposed legislation to impose the statewide sales tax on Medi-Cal managed care plans effective July 1, 2014. One half of the proceeds of the tax would be used to increase rates to the plans to reimburse them for the cost of the tax. The other half of the proceeds would be used to offset General Fund cost in the Medi-Cal program.</p>
M 0.2 (PC-233)		X	<p><u>Retroactive Managed Care Rate Adjustments for FY 2012-13</u></p> <p>Retroactive rate adjustments are due to the rate determinations 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.</p>

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y C/Y	B/Y	
M 1	(PC-108)	X	X	<p><u>Two-Plan Model</u></p> <p>Under the Two-Plan Model program, the Department contracts with two managed care plans in a county. One plan is a locally developed or designated managed care health plan referred to as the Local Initiative (LI). The other plan is a non-governmentally operated Health Maintenance Organization referred to as the Commercial Plan (CP). Currently, fourteen counties are fully operational under the Two-Plan Model.</p> <p>Capitation rates include the annual rate redeterminations.</p>
M 2	(PC-109) (PC-130)	X	X	<p><u>County Organized Health Systems</u></p> <p>Six County Organized Health Systems (COHSs) are operational in fourteen counties. Effective February 1, 2010, Health Plan of San Mateo added long term care services to their contract. Currently, all COHS plans have assumed risk for long term care services. The Partnership Health Plan of California (PHC) includes undocumented residents and documented alien beneficiaries. PHC is negotiating with the Department to remove undocumented beneficiaries from their contract. <u>The Department is currently in discussions with all COHS plans to incorporate 1115 waiver requirements related to Seniors and Persons with Disabilities.</u></p> <p>Health plans and counties currently operating under the COHS model:</p> <p>CalOPTIMA Orange County</p> <p>Santa Barbara San Luis Obispo Regional Health Authority (SBSLORHA); dba: Cen Cal Health Santa Barbara County San Luis Obispo County</p> <p>Health Plan of San Mateo (HPSM) San Mateo County</p> <p>Partnership Health Plan of California (PHC) Solano County Napa County Yolo County Sonoma County</p>

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

~~Marin County
Mendocino County~~

~~Central California Alliance for Health (CCAH)
Santa Cruz County
Monterey County
Merced County
Gold Coast Health Plan
Ventura County~~

Capitation rates include the annual rate redeterminations.

M 3 (PC-110) X X

Geographic Managed Care

Under the Geographic Managed Care model, counties contract with multiple commercial plans to provide services to beneficiaries. Currently, Sacramento and San Diego counties utilize the geographic managed care model.

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

~~San Diego: GMC, as authorized by SB 2139 (Chapter 717, Statutes of 1996), was implemented in San Diego County as of August 1998. Contractors are: Health Net Community Solutions, Inc., KP Cal, LLC, Molina Healthcare of California Partnership Plan, Inc., Care 1st Partnership Plan, LLC, and Community Health Group Partnership Plan.~~

Capitation rates include the annual rate redeterminations.

M 4 (PC-119) X X

AIDS Healthcare Centers

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

All drugs used to treat HIV/AIDS approved by the federal Food and Drug Administration (FDA) prior to January 1, 2002 are included in the plan's contracted scope of services except for new drugs which do not fit into one of the current therapeutic classes and for which the Department does not have sufficient utilization

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

data to determine the financial impact of the use of those drugs will have on the managed care plan. New rates developed effective January 1, 2011, pending CMS approval, include all drugs used to treat HIV/AIDS approved by the FDA prior to January 1, 2007.

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

On January 1, 2012, the Department entered into a new five year contract with AHF. On August 2, 2012, AHF received full-risk licensure. Based upon this change in status, the Department will develop a new rate. The rate will not be effective until a new contract is signed.

M 5 (PC-122) X

Family Mosaic Capitated Case Management

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

The Family Mosaic Project contract with the Department is effective January 1, 2008 through December 31, 2012-, **and has been extended through June 30, 2014.**

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 6	(PC-112)	X	X	<u>Managed Care Rate Range Intergovernmental Transfers</u>

Counties will transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds will be used for the nonfederal share of capitation rate increases. The actuarially sound rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to but not exceeding the upper bound of the range.

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

<u>COHS</u>	<u>Effective Date of IGT</u>
San Mateo	July 1, 2005
Santa Barbara	July 1, 2009
Santa Cruz	July 1, 2009
Solano	July 1, 2009
Monterey	July 1, 2009
Sonoma	October 1, 2009
Merced	October 1, 2009
Orange	July 1, 2010
Yolo	July 1, 2010
Marin	July 1, 2011

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

M 7	(PC-125)	X	<u>Managed Care IGT Administrative and Processing Fee</u>
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Counties may transfer funds under an Intergovernmental Transfer (IGT) to the Department for the purpose of providing capitation rate increases to the managed care plans. These funds are used for the nonfederal share of capitation rate increases. Beginning

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

with FY 2010-11 rate range IGTs processed after July 1, 2011, and all subsequent rate range IGTs occurring after July 1, 2011, the Department will charge counties an administrative and processing fee for their IGTs. The fee will be 20% of each IGT and will offset the cost of medical services provided under the Medi-Cal program.

AB 102 (Chapter 29, Statutes of 2011) provides that all IGTs are subject to the fee with the exception of the IGTs related to Designated Public Hospitals (DPHs). If the IGT is replacing the CPE previously claimed in fee-for-service, no fee will be charged.

M 8 (PC-111)

X

Managed Care Public Hospital IGTs

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

M 9 (PC-126)

X

General Fund Reimbursements from DPHs

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) ~~who are not covered under other health care coverage~~ **are** assigned as mandatory enrollees in managed care plans in Two-Plan and GMC model counties. For Medi-Cal beneficiaries under the FFS program, payments to Designated Public Hospitals (DPHs) are comprised of CPEs matched with federal funds. For Medi-Cal beneficiaries under managed care, payments to DPHs are comprised of General Fund and federal funds. Therefore, as SPDs ~~are~~ **were** transitioned into managed care, GF expenditures ~~will increase~~ **increased** for DPH services.

MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				Beginning in FY 2012-13 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.
M 10	(PC-120)	X	X	<p><u>Increase in Capitation Rates for Gross Premium Tax</u></p> <p>AB 1422 (Chapter 157, Statutes of 2009) has imposed a Gross Premium Tax on the total operating revenue of Medi-Cal Managed Care plans. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. The provision pertaining to this tax is effective retroactively to January 1, 2009. The Gross Premium Tax sunsetted on June 30, 2012. The Department has proposed legislation to extend the tax through June 30, 2014. Managed Care plans affected by this new legislation are:</p> <ul style="list-style-type: none"> • Two Plan Model • County Organization Health Systems • Geographic Managed Care • AIDS Healthcare Centers • SCAN
M 11	(PC-127)	X	X	<p><u>Funding Adjustment of Gross Premium Tax Funds to GF</u></p> <p>AB 1422 (Chapter 157, Statutes of 2009) imposed an additional tax on the total operating revenue of Medi-Cal Managed Care Organizations (MCOs). The taxes are then placed in a special tax fund and are used to increase the capitation rates to reimburse the cost of the tax to the plans.</p> <p>Capitation rate increases due to the tax are initially paid from the General Fund. The Department then requests quarterly reimbursement of the General Fund through a funding adjustment from the Tax Fund.</p>
M 12	(PC-207) (PC-208) (PC-209)		X	<p><u>Extend Gross Premium Tax – Increase Capitation Rates</u></p> <p>ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through FY 2011-12. The Administration Department is proposing legislation that would extend the Gross</p>

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Premium Tax sunset date on the total operating revenue of Medi-Cal Managed Care plans through June 30, 2014 **2013**. Total operating revenue is exclusive of amounts received by a Medi-Cal Managed Care plan pursuant to a subcontract with another Medi-Cal Managed Care plan to provide health care services to Medi-Cal beneficiaries. The proceeds from the tax will be required to be used to offset, in the capitation rate development process, payments made to the State that result directly from the imposition of the tax. Managed Care plans affected by this new proposed legislation are:

- Two Plan Model
- County Organization Health Systems
- Geographic Managed Care
- AIDS Healthcare Centers
- SCAN

M 13	(PC-128)	X	X	<p><u>FFS Costs for Managed Care Enrollees</u></p> <p>Managed care contracts specify that certain services are carved out of the rates paid for managed care enrollees. These services are provided through the fee-for-service system. The most significant carve-outs for most plans are CCS services and anti-psychotic drugs. Additionally, the Department pays federally qualified health care centers and rural health clinics under the fee-for service system for certain costs associated with serving Medi-Cal managed care enrollees which are not fully paid by Medi-Cal managed care plans.</p>
M 14	(OA-29)	X	X	<p><u>San Diego County Administrative Activities</u></p> <p>The County of San Diego provides administrative services for the San Diego Geographic Managed Care program. These administrative activities include health care options presentations, explaining the enrollment and disenrollment process, customer assistance, and problem resolution. Federal funding for these activities was discontinued as of August 1, 2003.</p>
M 15	(PC-116)	X	X	<p><u>Managed Care Cost-Based Reimbursement Clinics (CBRC)</u></p> <p>The Department is required to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries.</p>

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Currently, tentative settlements are prepared by the Department after review of reconciliation requests and final settlements or recoveries are invoiced within three years after the submission of the original reconciliation reports.

Effective ~~October~~ July 1, 2011, CBRCs that provide services to Seniors and Persons with Disabilities (SPDs) who reside in Los Angeles County and are enrolled in managed care plans will be reimbursed through managed care capitation rates.

M 16	(PC-131)	X	X	<u>Managed Care Default Assignment</u>
				This assumption has been moved to the "Fully Incorporated Into Base Data/Ongoing" section.
M 17	(PC-134)	X	X	<u>Align Managed Care Benefit Policies</u>
				Medi-Cal covers the cost of medical services provided to beneficiaries during a retroactive period of 90 days before their enrollment into Medi-Cal. Previously, the COHS were responsible for covering the cost of the retroactive period and they received 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. Effective July 1, 2012, the Department eliminated the COHS' responsibility for the retroactive period and shifted this cost to FFS.
M 18	(PC-198)	X	X	<u>Transition of Dual Eligibles-Medicare Savings</u>
				This assumption has been moved to Discontinued Assumptions: Withdrawn.
M 19	(PC-113) (PC-135) (PC-192) (PC-214) (OA-19) (PC-FI) (OA-71)	X	X	<u>Transition of Dual Eligibles-Long-Term Care Savings</u>
				The Department will achieve savings from transitioning dually eligible and Medi-Cal only beneficiaries who receive Medi-Cal Long Term Care (LTC) institutional services, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multi-Purpose Senior Services Program (MSSP) and other Home and Community-Based Services (HCBS) from fee-for-service into managed care health plans. Notices and packets will be mailed to beneficiaries.

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The administrative costs to enroll beneficiaries into the managed care health plans include:

- Mailing Medi-Cal and Medicare information,
- Outreach services,
- Rate setting for newly included long-term services and supports (LTSS),
- System design and modification needs,
- Medicare and Medi-Cal data collection,
- Development of quality metrics,
- Performance measures for rapid cycle quality improvement and long-term quality assurance, and
- **Ombudsman services and reporting, and**
- Monitoring by an External Quality Review Organization (EQRO).

~~Other administrative costs include the Health Insurance Counseling and Advocacy Program (HICAP) which provides one-on-one Medicare counseling services.~~

M 20 (PC-132) X X

Managed Care Expansion to Rural Counties

Managed care is currently in 30 counties. AB 1467 (Chapter 23, Statutes of 2012) 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.

M 21 (PC-133) X X

Potentially Preventable Admissions

The Department analyzed historical encounter data to identify situations where an inpatient admission was potentially preventable and quantified the level of inefficiency and/or potentially avoidable expenses present in the base data for managed care plans. Based on the analysis, the Department imposed an adjustment to Medi-Cal Managed Care rates to account for potentially preventable admissions into hospital inpatient facilities.

M 22 (PC-114) X

Retroactive Managed Care Rate Adjustments for FY 2011-12

CMS did not approve managed care rate adjustments for FY 2011-12 in time to be paid in FY 2011-12. These adjustments will

MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

be paid in FY 2012-13. The Department will develop and CMS will approve future fiscal year managed care rate adjustments in time so that they may be paid in the same fiscal year.

M 23

Managed Care Efficiencies

This assumption has been moved to “Withdrawn” section.

M 24 (PC-212)

X

Enrollment Stabilization Program

The Department is proposing legislation to stabilize managed care enrollment. Managed care enrollees in Two-Plan and Geographic Managed Care counties would be able to switch plans once a year rather than every month. New beneficiaries will have a 90-day period from their initial enrollment date to select or change their managed care plan. On an annual basis, existing members will be provided a 60-day period to change plans.

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

PROVIDER RATES

Reimbursement Methodology and the Quality Assurance Fee for AB 1629 Facilities

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

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

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

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

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

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

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

PROVIDER RATES

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

Quality and Accountability Supplemental Payment System

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) System for SNFs by August 1, 2010. The QASP system will enable SNF reimbursement to be tied to demonstrated quality of care improvements for SNF residents. **AB 1489 (Chapter 631, Statutes of 2012) delayed the payments and required the Department to make the payments by April 30, 2014.**

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

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

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

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

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

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

Methodology by Type of LTC Facility

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

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

PROVIDER RATES

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

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

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

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

PROVIDER RATES: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

PR 0.1 (PC-229)	X	<p><u>Long Term Care Quality Assurance Fund Expenditures</u></p> <p>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.</p> <ul style="list-style-type: none"> • 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) <p>AB 1467 (Chapter 23, Statutes of 2012) established the Long Term Care Quality Assurance Fund. 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.</p>
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PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
PR 1			<u>NF-B Rate Changes and Quality Assurance (QA) Fee</u>
			AB 1629 (Chapter 875, Statutes of 2004) required the Department to change the rate methodology for freestanding skilled nursing facilities (freestanding NF-Bs and freestanding adult subacute facilities, excluding pediatric subacute services and rural swing bed days), to provide an annual cost-of-living adjustment (COLA) and to collect a QA fee from these facilities. Effective January 1, 2012, ABX1 19 (<u>Chapter 4, Statutes of 2011</u>) includes Freestanding Pediatric Subacute facilities within the QA fee provider population. The rate methodology and QA fee provisions sunset on July 31, 2013. AB 1489 (Chapter 631, Statutes of 2012) extends the QA fee, until July 31, 2015.
(PC-138)	X	X	<u>Rate Changes due to Rate Methodology</u>
			ABX1 19 (Chapter 4, Statutes of 2011) provides an allowable overall rate increase up to 2.4% for the 2011-12 rate year, and the difference between what is provided in 2011-12 and 2.4% in the 2012-13 rate year. A rate adjustment of 0.426% was provided in the 2011-12 rate year. AB 1489 (Chapter 631, Statutes of 2012) provides a rate freeze for the 2012-13 rate year and a 3% rate increase for the 2013-14 rate year <u>and 2014-15 rate years</u> .
(PC-141)	X	X	<u>Rate Adjustments due to the QA Fee</u>
			Assessment of the QA fee is based on revenues from Medi-Cal, Medicare and private pay sources. Effective October 1, 2011, the QA fee limit increased from 5.5% to 6%.
			QA fee amounts are calculated to be net of the L&C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. L&C fees shift from year to year, which impacts the amount of QA fee the Department can collect. The State uses a portion of the QA fee to draw down FFP and to fund rate increases. Rate increases due to the QA fee are expected to be cost neutral to the General Fund.
			SB 853 (Chapter 717, Statutes of 2010) requires the Department to expand the amount of revenues upon which the QA fee is assessed by including revenue from Multi-Level Retirement Communities (MLRCs) and revising the QA Fee trending methodology. This will result in rate increases to the facilities. SB 853 established an allowable overall rate increase of up to 2.4%

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

~~for rate year 2011-12. Under SB 853, the QAF fee sunsets as of July 31, 2012.~~

ABX1 19 (Chapter 4, Statutes of 2011) provides an allowable overall rate increase up to 2.4% for the 2011-12 and 2012-13 rate years, and the difference between what is provided in 2011-12 and 2.4% in the 2012-13 rate year. A rate adjustment of 0.426% was provided in the 2011-12 rate year. ABX1 19 also extended the QA fees sunset date by one year, to August 1, 2013. AB 1489 (Chapter 631, Statutes of 2012) implements a rate freeze for the 2012-13 rate year and extends the QA fees sunset date to July 31, 2015.

(PC-145) X X

Quality and Accountability Payments Program

SB 853 (Chapter 717, Statutes of 2010) implemented a quality and accountability payments program for freestanding nursing facilities (NF-Bs), with the first phase beginning in rate year 2010-11. Quality payments will be delayed a year by AB 1489 (Chapter 631, Statutes of 2012). Payments made under the program will begin in rate year 2013-14 as supplemental to the rates and will be paid through a special fund. The special fund will be comprised of penalties assessed on skilled nursing facilities that do not meet minimum staffing requirements, one-third of the AB 1629 facilities reimbursement rate increase for rate year 2013-14 (up to a maximum of 1 % of the overall rate), and the savings achieved from setting the professional liability insurance cost category at the 75th percentile. Per AB 1489 (Chapter 631, Statutes of 2012), the professional liability insurance cost category will still be set at the 75th percentile in 2012-13, but savings will be retained by the state.

(PC-138) X X

AB 1629 Add-Ons to the Rates

CMS mandated that skilled nursing facilities upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. An add-on to the rate was effective August 1, 2011, and retroactive to October 1, 2010.

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Effective October 2009, CalOSHA required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional costs was effective August 1, 2011, and retroactive to October 2009.

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 August 1, 2012, and retroactive to January 2011.

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.

Effective January 2012, CMS requires all health care organizations that submit transactions electronically to upgrade from the 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.

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.

The Federal Unemployment Tax Act (FUTA) add-on provides long term care facilities FUTA tax credit. A ~~\$0.11~~ **An** add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.

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 ~~\$0.04~~ add-on reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and 2013-14 rate year.

PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
PR 2 (PC-153)	X		X
			<u>10% Payment Reduction</u>
			<p>AB 97 (Chapter 3, Statutes of 2011) requires the Department to implement a payment reduction of up to 10% to specified providers in FFS, effective June 1, 2011. The actuarial equivalent of that amount to specified managed care providers was <u>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 impact of AB 97 for managed care will be determined on a prospective basis.</u></p> <p>On October 27, 2011, the Department received federal approval to reduce provider payments up to 10%.</p> <p>The Department submitted a State Plan Amendment on June 13, 2012, requesting <u>received</u> CMS approval <u>on September 11, 2012</u> to exempt Pediatric Day Health Care providers from the 10 percent % payment reduction, effective April 1, 2012.</p> <p><u>The Department submitted a SPA to CMS on December 24, 2012, requesting approval to exempt audiology services provided by Type C Communication Disorder Centers located in California counties of Alameda, San Benito, Santa Clara, Santa Cruz, San Francisco and Sonoma from the 10% payment reduction, effective October 19, 2012.</u></p> <p><u>A payment reduction to two Assisted Living Waiver providers, Residential Care Facilities for the Elderly (RCFE) and Care Coordinator Agencies (CCA), was implemented in January 2012. The Department has determined that 1915(c) HCBS waiver providers are not subject to the 10% payment reduction. The Department will refund the reduction amounts and submit a waiver amendment if it is determined that the 10% payment reduction will be applied to these providers.</u></p>
PR 3 (PC-143)	X		X
			<u>Annual MEI Increase for FQHCs and RHCs</u>
			<p>The Department implemented the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) included in the 2000 Benefits Improvement and Protection Act on January 1, 2001. Clinics have been given the choice of a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-</p>

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

based rate. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate adjustment is the percentage increase in the Medicare Economic Index (MEI) and is effective October 1st of each year.

PR 4

LTC Rate Adjustments and QA Fees

(PC-140) X X

Rate Adjustment

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

The following facilities are included in this assumption:

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

(PC-150) X X

Rate Freeze

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

Under *CHA v. David Maxwell-Jolly*, the Department was enjoined from freezing rates under ABX4 5 for:

- Distinct Part Nursing Facilities Level B (DP/NF-B)
- DP/NF adult
- DP pediatric subacute
- Rural swing bed providers.

The following facilities were not part of the lawsuit, and their rates continue to be frozen:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A),

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), including Habilitative and Nursing
- FS pediatric subacute facilities

AB 97 (Chapter 3, Statutes of 2011) requires the Department to freeze rates for the facilities enjoined from the original rate freeze, which was required by ABX4 5.

Under *CHA v. Toby Douglas*, the Department was enjoined from reducing the payments for DP/NF-B, as required by AB 97.

Currently the following long-term care providers are subject to the rate freeze:

- Intermediate Care Facilities (Freestanding Nursing Facilities, Level A),
- DP/NF-B
- Rural Swing Bed,
- Intermediate Care Facilities for the Developmentally Disabled, including Habilitative and Nursing, and
- FS pediatric subacute facilities

(PC-152) X X 10% Payment Reduction

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

Under *CHA v. Toby Douglas*, the Department was enjoined from reducing the payments for DP/NF-B, as required by AB 97. DP/NF adult subacute, DP and FS pediatric subacute, rural swing bed, NF-A, and ICF/DD (including Habilitative and Nursing) facilities were not part of the lawsuit.

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

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- Distinct Part Adult Subacute Facilities
- Distinct Part Pediatric Subacute Facilities
- Hospice Providers
- Hospice Room and Board Providers
- Rural Swing Bed Rate

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

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

(PC-140) X X

QA Fees

Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs) and Freestanding Pediatric Subacute Care facilities are required to pay a QA fee. The federal government allows states to assess the QA fee at 6% of total gross revenues. The fee is used to draw down FFP and fund rate increases, which are expected to be cost neutral to the GF.

(PC-140) X X

Non-AB 1629 Add-Ons to the Rates

CMS mandated that freestanding and distinct part skilled nursing facilities, **nursing facilities-level A**, including Adult and Pediatric Subacute, upgrade to the Minimum Data Set (MDS 3.0), effective October 1, 2010. Facilities are required to collect and report data specified in the MDS, such as immunization levels, rates of bed sores, and use of physical restraints. To implement the upgrade, providers are expected to incur additional costs for formal staff training resulting in an add-on to the reimbursement rates for these facilities. The rate increase was effective August 1, 2011, and retroactive to October 1, 2010.

Effective October 2009, CalOSHA required all health care facilities to offer health care workers immunization from airborne diseases. An add-on to the rates to reimburse the facilities for the additional

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

costs was effective August 1, 2011, and retroactive to October 2009.

- 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.
- 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.
- 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.
- Effective July 1, 2010, SB 183 (Chapter 19, Statutes of 2010), the Carbon Monoxide Poisoning Prevention Act, requires single-family dwelling units to have installed a carbon monoxide device that is designed to detect carbon monoxide and produce a distinct, audible alarm, which must be approved by the State Fire Marshal. An add-on to the rates to reimburse the facilities for the additional costs will be effective August 1, 2012, and retroactive to July 2011. This add-on is only applicable to ICF/DD Hs and Ns.
- 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~~ **An** add-on to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
- 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.

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

- 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.
- 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.

PR 5 (PC-144) X X

Hospice Rate Increases

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

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

PR 6 (PC-NA) X X

Alternative Birthing Centers

Pursuant to W & I Code Section 14148.8, the Department is required to provide Medi-Cal reimbursement to alternative birthing centers (ABCs) for facility-related costs at a statewide all-inclusive rate per delivery. This reimbursement must not exceed 80% of the average Medi-Cal reimbursement received by general acute care hospitals with Medi-Cal contracts. The reimbursement rates must be updated annually and must be based on an average hospital length of stay of 1.7 days. The ABC rates will increase each year by the same percentage as the average acute care hospital contract rate. Effective July 1, 2013, rates will increase each year by the same percentage as the average increase in Diagnosis Related Groups base prices.

PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
PR 7 (PC-149)	✕		X	<u>Reduction to Radiology Rates</u>
<p>SB 853 (Chapter 717, Statutes of 2010) reduced Medi-Cal rates for radiology services to 80% of Medicare rates, effective October 1, 2010. It is expected that the rate methodology will be implemented in January July 2013 with rate reductions retroactive to July 1, 2012 in order to protect beneficiary access to needed radiology services.</p>				
PR 8 (PC-142)	X		X	<u>Air Ambulance Medical Transportation</u>
<p>AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 upon every conviction involving a vehicle violation, effective January 1, 2011. The bill requires the county treasurers to transfer the money collected each quarter, after payment of county administrative costs, to the State Controller's Emergency Air Medical Transportation Act (EMATA) Fund.</p> <p>AB 215 (Chapter 392, Statutes of 2011) removed a county's ability to retain a portion of moneys collected from the penalties to administer the EMATA and deletes the requirement that counties submit an annual report to the Department on the funds the county retained for administration costs.</p> <p>After the payment of the Department's administrative costs, 20% of the fund will be allocated to the General Fund. The remaining 80% in the EMATA fund will be matched with federal funds and will be used to increase payments for Medi-Cal emergency air medical transportation services.</p>				

The Department submitted two SPAs to CMS:

- **SPA 12-001A, approved by CMS in November 2012, allows the Department to disburse the EMATA funds to air medical transportation providers in lump sum supplemental payments on a per transport basis for services provided between January 7, 2012 and June 30, 2012.**
- **SPA 12-001B, pending CMS approval, allows the Department to implement ongoing payment augmentations for services provided by air medical transportation providers retroactive to July 1, 2012.**

PROVIDER RATES: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
PR 9	(PC-138) X (PC-139)	X	X
<u>10% Payment Reduction Restoration and Supplemental Payments</u>			
Under ABX1 19 (Chapter 4, Statutes of 2011), the 10% payment reduction for AB 1629 facilities ended July 31, 2012. ABX1 19 requires the Department to:			
<ul style="list-style-type: none"> • Provide a one-time supplemental payment in FY 2012-13 that is equivalent to the reduction applied from May 1, 2012 through July 31, 2012, • Provide an allowable rate increase up to 2.4% for the 2011-12 rate year. Under ABX1 19, a rate adjustment of 0.426% was provided for the 2011-12 rate year. 			
AB 1489 (Chapter 631, Statutes of 2012) freezes rates and eliminates the hold harmless for 2012-13 rate year and provides a 3% rate increase in 2013-14 <u>and 2014-15</u> .			
PR 10	(PC-151) X	X	X
<u>Eliminate 2012-13 Rate Increase & Supp. Payment</u>			
AB 1489 (Chapter 631, Statutes of 2012) authorizes the Department to:			
<ul style="list-style-type: none"> • Redirect funding for rate increases and <u>the Quality and Accountability Payments Program</u> supplemental payments for AB 1629 facilities to the GF in 2012-13, and • Allow for the savings associated with the Professional Liability Insurance (PLI) cost category capped at the 75th percentile to remain in the General Fund rather than being transferred to the Quality and Accountability Supplemental Payment (QASP) Fund. 			
PR 11	(PC-NA)		
<u>Preserving Contract Hospitals</u>			
This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.			
PR 12	(PC-148) X	X	X
<u>Clinical Laboratory Reimbursement Methodology</u>			
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 implemented pursuant to AB 97 (Chapter 3, Statutes of 2011), AB 1494 allows payments to be reduced by an additional 10% for			

PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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 CMS. The Family Planning, Access, Care, and Treatment Program shall be exempt from the payment reduction as specified in AB 1494.

SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

SP 1 (PC-158) X X Capital Project Debt Reimbursement

SB 2665 (Chapter 1310, Statutes of 1990) and SB 1732 (Chapter 1635, Statutes of 1988) authorize Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. To qualify, a hospital must be a disproportionate share hospital, must have either a SPCP or County Organized Health Systems contract with the State of California, and must meet other specific hospital and project conditions specified in Section 14085.5 of the W&I Code.

The SPCP contracts will end on June 30, 2013, due to the implementation of the DRG payment methodology. A SPA is being drafted to obtain authority to continue these payments and will be submitted to CMS in FY 2012-13. Only hospitals that met eligibility requirements set forth in Section 14085.5 of the W&I Code will be eligible to participate.

SB 1128 (Chapter 757, Statutes of 1999) authorizes a Distinct Part (DP) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP must meet other specific hospital and project conditions specified in Section 14105.26 of the W&I Code. Two DP facilities began submitting claims and received payments in FY 2011-12.

SP 2 (PC-155) X X Hospital Outpatient Supplemental Payments

AB 915 (Chapter 747, Statutes of 2002) creates a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. The supplemental amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal share used to draw down FFP will be paid exclusively with funds from the participating facilities and will not involve General Fund dollars. Interim payments are expected to be made every year in June. Interim payment adjustments are made upon receipt and review of amended claims.

The reconciliation mandated by AB 915 against audited cost reports is scheduled to begin in FY 2012-13. Adjustments to interim payments, or recoupment of overpaid funds, are expected

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				during FY 2012-13. Reconciliation of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.
SP 3	(PC-161)	X	X	<p><u>IGTs for Non-SB 1100 Hospitals</u> <u>IGT Payments for Hospital Services</u></p> <p>W&I Code, Section 14164, 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. The IGT will be used as the non-federal share of cost in order to draw down FFP, which will then be distributed to the hospitals designated by the county or health care district.</p>
SP 4	(PC-156)	X	X	<p><u>FFP for Local Trauma Centers</u></p> <p>The Budget Act of 2003 provided authority for Los Angeles County and Alameda County to submit IGTs to the Medi-Cal program to be used as the non-federal share of costs in order to draw down federal funds. The combined funds will be used to reimburse specified hospitals for costs of trauma care provided to Medi-Cal beneficiaries.</p>
SP 5	(PC-160)	X	X	<p><u>Certification Payments for DP-NFs</u></p> <p>AB 430 (Chapter 171, Statutes of 2001) allows Nursing Facilities (NF) that are Distinct Parts (DP) of acute care hospitals to claim FFP on the difference between their projected costs based on the hospital's prior year data and the maximum DP-NF rate Medi-Cal currently pays. The acute care hospitals must be owned and operated by a public entity, such as a city, county, or health care district.</p> <p><u>CMS approved the SPA allowing eligible DP-NFs to claim FFP on the difference between their actual costs and the maximum DP-NF rate Medi-Cal currently pays, effective August 1, 2012. The actual costs are derived from the hospital's as-filed or audited cost report for the reporting year.</u></p>

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
SP 6	(PC-162)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient DSH</u></p> <p>SB 2563 (Chapter 976, Statutes of 1988) created a supplemental program for hospitals providing a disproportionate share of outpatient services. The Department reimburses eligible DSH providers on a quarterly basis through a Payment Action Notice (PAN) to the Fiscal Intermediary (FI). The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
SP 7	(PC-163)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient Small and Rural Hospitals</u></p> <p>AB 2617 (Chapter 158, Statutes of 2000) requires the Department to increase reimbursement rates for outpatient services rendered to Medi-Cal beneficiaries by small and rural hospitals (SRH). The Department reimburses eligible SRH providers on a quarterly basis through a PAN to the FI. The payment represents one quarter of the total annual amount due to each eligible hospital.</p>
SP 8	(PC-157)	X	X	<p><u>Freestanding Outpatient Clinics</u></p> <p>AB 959 (Chapter 162, Statutes of 2006) adds eligible freestanding outpatient clinics to the current Medi-Cal outpatient supplemental program. Under this program, clinics that are enrolled as Medi-Cal providers and are owned or operated by the state, city, county, city and county, the University of California, or health care district would be eligible to receive supplemental payments.</p> <p>The non-federal match is paid from public funds of the participating facilities.</p> <p>Supplemental payments to freestanding outpatient clinics will be effective retroactively beginning July 1, 2006. pending an approved State Plan Amendment. The SPA is expected to be approved in 2012-13. <u>The SPA for freestanding outpatient clinics was approved October 14, 2012.</u></p>
SP 9	(PC-164)	X	X	<p><u>State Veterans' Home Supplemental Payments</u></p> <p>AB 959 (Chapter 162, Statutes of 2006) adds state veterans' homes to the current Medi-Cal outpatient supplemental program. State veterans' homes that are enrolled as Medi-Cal providers and are owned or operated by the State are eligible to receive</p>

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

supplemental payments. The non-federal match is paid from public funds of the participating facilities.

The SPA for state veterans' homes was approved March 3, 2011. ~~Supplemental payments were effective retroactively beginning with the rate year starting August 1, 2006.~~

SP 10(PC-61) X X Specialty Mental Health Services Supplemental Reimbursement

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

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

The Department submitted a SPA to CMS to obtain approval for the new supplemental payment program. The Department is providing additional information to CMS. Upon approval, supplemental payments will be authorized retroactive to January 2009, with payments expected to be made beginning FY 2012-13.

The Supplemental Payment Program will be included in the Specialty Mental Health Services (SMHS) Waiver.

SP 11(PC-159) X X NDPH IGT Supplemental Payments

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

Effective July 1, 2012, AB 1467 (Chapter 23, Statutes of 2012) authorized NDPH payment methodology changes and eliminated this supplemental payment program.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

The Department submitted a SPA to CMS, but because CMS approval has not been received timely, the Department is no longer pursuing the NDPH reimbursement change. NDPHs will continue to receive supplemental payments.

SP 12(PC-154) X X

Hospital QAF – Hospital Payments

AB 1383 (Chapter 627, Statutes of 2009) authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 1, 2009 through December 31, 2010. AB 1653 (Chapter 218, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383 by:

- Altering the methodology, timing, and frequency of supplemental payments,
- Increasing capitation payments to Medi-Cal managed health care plans, and
- Increasing payments to mental health plans.

AB 188 (Chapter 645, Statutes of 2009) established the Hospital Quality Assurance Revenue Fund to:

- Provide supplemental payments to hospitals,
- Provide direct grants to DPHs,
- Increase capitation payments to managed health care,
- Increase payments to mental health plans,
- Offset the state cost of providing health care coverage for children, and
- Pay for staff and related administrative expenses required to implement the QAF program.

SB 90 (Chapter 19, Statutes of 2011) 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 (Chapter 286, Statutes of 2011) 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.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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,
- Reducing managed care payments for private hospitals in FYs 2012-13 and 2013-14, and
- Eliminating grant payments to DPHs in FY 2013-14.

SP 13(PC-80) X X

~~Low Income Health Program Out Of Network Fund~~ **LIHP MCE Out-of-Network Emergency Care Services Fund**

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

SP 14(PC-165) X X

GEMT Supplemental Payment Program

AB 678 (Chapter 397, Statutes of 2011) provides supplemental payments to publicly owned or operated ground emergency medical transportation (GEMT) service providers. Supplemental payments combined with other reimbursements cannot exceed 100% of the costs. Governmental entities provide the non-federal share through CPEs. Once the SPA is approved by CMS, the supplemental reimbursement program will be retroactive to January 30, 2010. The SPA is expected to be approved in FY 2012-13.

SP 15(PC-190) X X

Hospital QAF – Children's Health Care

SB 335 (Chapter 286, Statutes of 2011) extended the Hospital QAF program from July 1, 2011 through December 31, 2013, which will provide 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. AB 1467 (Chapter 23, Statutes of 2012) increases the amount of QAF allocated for children's health care coverage.

SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
SP 16 (PC-205) (PC-206)	X	<u>Extend Hospital QAF</u>
		The current Hospital QAF program will end on December 31, 2013. The Department proposes to extend the program from January 1, 2014 through December 31, 2016.

OTHER: AUDITS AND LAWSUITS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

A 1 (PC-184) <u>Lawsuits/Claims*</u>	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
a. <u>Attorney Fees of \$5,000 or Less</u>		
Total	\$0	
Fund Balance \$50,000	\$50,000	\$50,000
b. <u>Provider Settlements of \$75,000 or Less</u>		
1. Daughters of Charity Health System	\$8,433	
2. CFHS Holdings, Inc.	\$16,945	
3. Daughters of Charity Health System	\$9,510	
4. Brotman Medical Center	\$2,318	
5. Alameda Hospital	\$709	
6. CHA Hollywood Medical Center L.P.	\$1,003	
7. Good Samaritan Hospital	\$30,150	
8. Providence Health System	\$19,771	
9. Catholic Healthcare West	\$13,341	
10. Country Oaks Partners, LLC	\$36,551	
11. Alta Los Angeles Hospitals	\$27,600	
12. Alta Hospitals System	\$3,764	
13. Catholic Healthcare West	22,336	
14. CHA Hollywood Medical Center L.P.	\$9,173	
15. Daughters of Charity Health System	\$475	
16. Daughters of Charity Health System	\$3,177	
17. Avanti Health System, LLC	\$23,342	
18. Cedars-Sinai Medical Center	\$15,555	
19. Daughters of Charity Health System	\$49,719	
20. CFHS Holdings, Inc.	\$13,099	
21. Providence Health System-Southern Calif.	\$19,934	
22. Community Hospitals of Central California	\$34,064	
23. CFHS Holdings, Inc.	\$3,122	
24. Alta Hospitals Systems	\$3,728	
25. Good Samaritan Hospital	\$19,264	
26. Comm. Hospital of Huntington Park Mgmt	\$17,388	
27. Cedars-Sinai Medical Center	\$8,419	
28. Long Beach Memorial Medical Center	\$31,649	
29. Daughters of Charity Health System	<u>\$38,604</u>	
Total	<u>\$483,142</u>	
Fund Balance \$1,116,858	\$1,600,000	\$1,600,000
c. <u>Beneficiary Settlements of \$2,000 or Less</u>		
Fund Balance	\$15,000	\$15,000

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

Applicable F/Y

C/Y B/Y

d.	<u>Small Claims Court Judgments of \$5,000 or Less</u>			
	Fund Balance	\$200,000	\$200,000	
e.	<u>Other Attorney Fees</u>			
	1. Western Center on Law and Poverty	\$131,816		
	2. Helen Rose Griffin	\$40,700		
	3. California Association of Rural Health	\$35,585		
	4. Rosemary Carpendale	\$7,653		
	5. CJ Harris	\$48,077		
	6. Esther Darling	\$29,955		
	7. Maternal and Child Health Access	\$704,768		
	8. Pablo Carranza	\$69,500		
	9. Winton and Geraldine O'Neill	<u>\$64,092</u>		
	Total	\$1,132,147		
f.	<u>Other Provider Settlements / Judgments</u>			
	1. Country Oaks Partners, LLC	\$79,912		
	2. Molina Healthcare of California	\$1,100,000		
	3. Cedars-Sinai Health Systems	<u>\$400,000</u>		
	Total	\$1,579,912		
g.	<u>Other Beneficiary Settlements</u>			
	Amounts may exclude interest payments.			
A 2	(PC-121)	X	X	<u>Notices of Dispute / Administrative Appeals – Settlements</u>
				Settlement agreements for disputes between the Department and the managed care plans are estimated to be \$2,000,000 for possible settlements for each fiscal year.
A 3	(OA-15)	X	X	<u>Litigation-Related Services</u>
				The Department continues to experience significant and increasing litigation costs in defense of the Medi-Cal program. The number of open cases has increased, and the Department of Justice rates for litigating these cases have increased.
				Ongoing litigation filed by managed care plans against the Department regarding their capitation rates has resulted in increased work and costs for the Department's consulting actuaries to comply with the requirements of the court rulings.

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

A 4 (PC-50) X

Litigation Settlements

The Department continues to work collaboratively with the Office of the Attorney General to pursue charges related to the illegal promotion of drugs, kickbacks, overcharging, and overpayments. Settlements are expected to be received in FY 2012-13 from Seaciff Diagnostics Medical Group; Serono; Merck; Maxim; GlaxoSmithKline, LLC; Bioscrip; Boehringer Ingelheim Pharmaceuticals, Inc.; McKesson; A-Med Pharmacy; Dava Pharmaceuticals, Inc.; Walgreen's Pharmacy; Senior Care Action Network; and KV Pharmaceuticals, **Amgen, and Bio-Med Plus.**

A 5 (PC-171) X X

AB 97 Injunctions

The U.S. District Court, Central District of California, issued a preliminary injunction in the following cases related to AB 97:

- December 28, 2011 – *California Hospital Association v. Douglas, et al.*: The Department is prohibited from implementing **the rate freeze and 10%** reductions ~~for~~ **to** hospital-based nursing facilities. 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 exclude from its effect services rendered June 1, 2011 through December 27, 2011** ~~prior to December 28, 2011, that were not reimbursed prior to~~ **December 28, 2011 at the unreduced level.** ~~that date. Both DHCS and plaintiffs have appealed. The parties have completed their appellate briefs regarding the issuance and modification of the injunction, and the hearing is set for October 10, 2012.~~
- December 28, 2011 – *Managed Pharmacy Care, et al. v. Sebelius, et al.*: The Department is prohibited from implementing **the 10% payment** reductions for **prescription drugs.** ~~pharmacy services.~~ 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** ~~services rendered from~~ **June 1, 2011 through December 27, 2011, that were not** are reimbursed **prior to December 28, 2012 at the unreduced level.** ~~for the first time on or after December 28, 2011. Both DHCS and plaintiffs have appealed. The parties have completed their briefs regarding the issuance and modification of the injunction, and the hearing on that issue is set for October 10, 2012.~~

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

- January 10, 2012 – *California Medical Transportation Association v. Douglas, et al.*: The Department is prohibited from implementing **the 10% payment** reductions for non-emergency medical transportation (NEMT) 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** prior to January 10, 2012, that had not been reimbursed **prior to January 10, 2012 at the unreduced payment level** prior to that date. Both DHCS and plaintiffs have appealed. The parties have completed their appellate briefs regarding the issuance and modification of the injunction, and the hearing is set for October 10, 2012.
- January 31, 2012 – *California Medical Association v. Douglas, et al.*: The Department is prohibited from implementing **a 10% payment** reductions for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment **except for services rendered on or after June 1, 2011 through January 30, 2012 that had not been reimbursed prior to January 31, 2012 at the unreduced payment level.** DHCS appealed. The parties have completed and filed their appellate briefs regarding the issuance of the injunction, and the hearing is set for October 10, 2012.

On December 13, 2012, the United States Court of Appeals for the Ninth Circuit issued a decision in which it reversed the injunctions against the AB 97 payment reductions issued in all four of the above cases. The plaintiffs requested a rehearing on January 28, 2013.

The Department has filed Notices of Appeals in the first three cases and will do so in the fourth case as well.

A 6 (PC-180)

X

Audit Settlements

Payments for audit settlements with the federal government are budgeted in the Audit Settlements policy change.

Federal audits A-09-11-02040 and A-09-12-02077 determined that several claims from October 1, 2008 through September 30, 2010 in San Diego County were ineligible for 90% federal

OTHER: AUDITS AND LAWSUITS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Medicaid reimbursement for family planning services provided under the Family PACT program. The audit identified that the majority of the ineligible claims were for primarily non-family planning services. The Department plans to refund the federal government in FY 2013-14.

OTHER REIMBURSEMENTS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

R 0.1 (PC-219) X X Youth Regional Treatment Centers

The Department will implement the enrollment and reimbursement of the Youth Regional Treatment Centers (YRTCs) under the Indian Health Service program. YRTCs provide American Indian youths culturally appropriate inpatient substance abuse treatment. The Department will receive Title XIX reimbursement for services provided to eligible American Indian Medi-Cal beneficiaries under the age of 21.

R 0.2 (PC-218) X Cost Shift of CCS State-Only to Medi-Cal EPC

In June 2012, the Department identified payment problems for CCS State-Only services:

- The system erroneously paid Medi-Cal claims with CCS State-Only 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.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

R 1 (PC-NA) X X

FMAP Changes

The Federal Medical Assistance Percentage (FMAP), which determines the federal Medicaid sharing ratio for each state, was 50% for the Medi Cal program effective for the federal fiscal year beginning October 1, 2002. Public Law 108-27, the federal Jobs and Growth Tax Relief Reconciliation Act of 2003, increased the FMAP to 54.35% from April 1, 2003, to September 30, 2003, and to 52.95% from October 1, 2003, to June 30, 2004.

On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period.

On August 10, 2010, the President signed the Education, Jobs and Medicaid Assistance Act of 2010 that included a six-month extension through June 2011 of Medicaid's temporary enhanced FMAP for the states. California received an 8.77% FMAP increase for January 1, 2011 through March 31, 2011 and a 6.88% FMAP increase for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date payment occurs, there will be some expenditures made in FY 2011-12 that receive ARRA. Expenditures may receive the applicable FMAP based on date of service, such as SNCP payments, or based on the date another department paid the initial expenditure and Medi-Cal draws the federal funds in a subsequent fiscal year.

R 2 (PC-172) X X

Dental Contract

~~The dental rates are:~~

	Refugees	All Others
Effective August 1, 2011 — June 30, 2012	\$3.35	\$6.03

The dental rates are based on historical cost data and updated once a year.

AB 97 requires a 10% provider payment reduction. CMS approved the reduction, effective June 1, 2011. The current rates

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

remain in effect until the new rates, reflecting the reduction, are negotiated and approved by control agencies through the change order process.

R 3	(PC-117) X (PC-147)	X	<p><u>Dental Geographic Managed Care</u></p> <p>The Geographic Managed Care (GMC) project in Sacramento County covers dental services for eligibles with mandatory aid codes and SSI/SSP on a voluntary basis. Since April 1994, dental managed care services to beneficiaries have been delivered through several dental plans. Currently, there are four dental GMC plans.</p> <p>The four GMC contracts are in effect through December 31, 2012. The Request for Proposal process for a new contract, effective January 1, 2013, began in January 2012. <u>In October 2012, the Department awarded contracts to GMC dental plans, which took effect on January 1, 2013.</u></p>
R 4	(PC-117) X (PC-147)	X	<p><u>Dental Managed Care within Medi-Cal Two-Plan Model Counties</u></p> <p>The 1997-98 Budget Act made a provision for the Department to enter into contracts with health care plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis.</p> <p>The Department has contracted with seven six dental plans that are providing services as voluntary PHPs in Los Angeles County. These contracts end on June 30, 2013. The Request for Proposal process for a new contract, effective July 1, 2013, began in January 2012. <u>In October 2012, the Department awarded contracts to PHP dental plans, which take effect on July 1, 2013.</u></p>
R 5	(PC-194)	X	<p><u>FI Cost Containment Projects – Program Savings</u></p> <p>The Department has approved implementation of proposals developed by the Fiscal Intermediary to contain Medi-Cal costs. The cost containment proposals result in savings to the Medi-Cal program. The Fiscal Intermediary will share in the achieved savings for two years after implementation of each proposal.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
R 6	(OA-14)	X	X	<u>MIS/DSS Contract</u>
				<p>The Management Information System and Decision Support System (MIS/DSS) houses a variety of data and incorporates it into an integrated, knowledge-based system. It is used by the Department, including the Medi-Cal Managed Care Division in its monitoring of Health Plan performance, the Third Party Liability and Recovery Division in its collection efforts, and the Audits and Investigations Division in its anti-fraud efforts.</p> <p>Ongoing operation and maintenance of the MIS/DSS is accomplished through a multi-year contract with <u>Optum Government Solutions, Inc. (formerly</u> Integris, Inc. DBA OptumInsight), which is effective through February 14, 2014. The Department plans to continue contracting for MIS/DSS services with Integris beyond the current contract end date of June 30, 2015. <u>The Department plans to continue contracting for MIS/DSS services after February 14, 2014.</u></p>
R 7	(PC-186)	X	X	<u>Indian Health Services</u>
				<p>The Department implemented the Indian Health Services (IHS) memorandum of agreement (MOA) between the federal IHS and 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 <i>Federal Register</i>.</p>
R 8	(OA-66)	X	X	<u>Kit for New Parents</u>
				<p>Beginning in November 2001, Title XIX FFP has been claimed for the "Welcome Kits" distributed by the California Children and Families Commission (Proposition 10) to parents of Medi-Cal eligible newborns.</p>
R 9	(PC-175)	X	X	<u>Developmental Centers/State Operated Small Facilities</u>
				<p>The Medi-Cal budget includes the estimated federal fund cost of the CDDS Developmental Centers (DCs) and two State-operated small facilities.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 10	(OA-54)	X	X	<p><u>CDDS Administrative Costs</u></p> <p>The Medi-Cal budget includes FFP for CDDS Medi-Cal-related administrative costs. Beginning in FY 2001-02, CDDS began budgeting the General Fund in its own departmental budget.</p>
R 11	(PC-187) (OA-57)	X	X	<p><u>CLPP Case Management Services</u></p> <p>The Childhood Lead Poisoning Prevention (CLPP) Program provides case management services utilizing revenues collected from fees. The revenues are distributed to county governments, which provide case management services. To the extent that local governments provide case management to Medi-Cal eligibles, federal matching funds can be claimed.</p>
R 12	(PC-188)	X	X	<p><u>Cigarette and Tobacco Products Surtax Funds</u></p> <p>Cigarette and Tobacco Products Surtax (CTPS/Proposition 99) funds have been allocated to aid in the funding of the <i>Orthopaedic Hospital</i> settlement and Medi-Cal hospital outpatient services via the Hospital Services Account and the Unallocated Account. The amounts available to Medi-Cal vary from year to year.</p>
R 13	(OA-68)	X	X	<p><u>California Health and Human Services Agency HIPAA Funding</u></p> <p>A HIPAA office has been established at the California Health and Human Services Agency to coordinate implementation and set policy regulations for departments utilizing Title XIX programs. Title XIX FFP is available for qualifying HIPAA activities related to Medi-Cal.</p>
R 14	(OA-5)	X	X	<p><u>EPSDT Case Management</u></p> <p>Medi-Cal provides funding for the county administration of the CHDP Program for those children that receive CHDP screening and immunization services that are Medi-Cal eligible. These services are required for Medi-Cal eligibles based on the Title XIX Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
R 15 (OA-2) (OA-45)	X	X	<p><u>CCS Case Management Costs</u></p> <p>Medi-Cal provides funding for the county administration of the California Children's Services (CCS) Program for those children who receive CCS services who are Medi-Cal eligible. The CMS Net automated eligibility, case management, and service authorization system is used by the CCS program to provide administrative case management for CCS clients in the CCS Medi-Cal, CCS State Only, and CCS-Healthy Families programs. The costs for CCS clients in Medi-Cal are budgeted in the Medi-Cal Estimate.</p> <p>County funds expended above the allocations on administrative activities in support of a county's CCS/Medi-Cal caseload may be used as certified public expenditures to draw down Title XIX federal financial participation.</p>
R 16 (OA-33)	X	X	<p><u>Postage and Printing – Third Party Liability</u></p> <p>The Department uses direct mail and specialized reports to identify Medi-Cal beneficiaries with private health insurance, determine the legal liabilities of third parties to pay for services furnished by Medi-Cal, and ensure that Medi-Cal is the payer of last resort. The number of forms/questionnaires printed and mailed and report information received correlates to the Medi Cal caseload.</p>
R 17 (OA-46)	X	X	<p><u>TAR Postage</u></p> <p>Postage costs related to mailing treatment authorization request-related documents are budgeted in local assistance.</p>
R 18 (PC-185)	X	X	<p><u>HIPP Premium Payouts</u></p> <p>The Department pays the premium cost of private health insurance for high-risk beneficiaries under the Health Insurance Premium Payment (HIPP) program when payment of such premiums is cost effective.</p>
R 19 (PC-167)	X	X	<p><u>Medicare Part A and Part B Buy-In</u></p> <p>The Department pays CMS for Medicare Part A (inpatient services) and Part B (medical services) premiums for those Medi-Cal beneficiaries who are also eligible for Medicare. Part B beneficiaries with an unmet share of cost are not eligible.</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

These premiums allow Medi-Cal beneficiaries to be covered by Medicare for their cost of services, thus saving Medi-Cal these expenditures. The premium amounts are set by CMS effective January 1st of each year.

R 20 (OA-74) X X PIA Eyewear Courier Service

The Prison Industries Authority (PIA) fabricates the eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an interagency agreement with PIA to reimburse them for one-half of the costs of the courier service that delivers orders between the optical providers and PIA.

R 21 (OA-64) X X FFP for Department of Public Health Support Costs

Title XIX federal Medicaid funding for Medi-Cal-related CDPH support costs are budgeted in the Medi-Cal local assistance budget and are shown as a reimbursement in the CDPH budget.

R 22 (PC-174) X X ICF-DD Transportation and Day Care Costs - CDDS

Beneficiaries that reside in Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) also receive active treatment services from providers located off-site from the ICF/DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.

On April 15, 2011, CMS approved a SPA that allows FFP to be paid for these services retroactive back to July 1, 2007.

R 23 (PC-183) X X Non-Contract Hospital Inpatient Cost Settlements

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

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

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.

R 24 (PC-137) X X

FQHC/RHC/CBRC Reconciliation Process

The Medi-Cal reimbursement policy for Federally Qualified Health Centers/Rural Health Clinics and Cost-Based Reimbursement Clinics (FQHC/RHC/CBRCs) participating in the Medi-Cal PPS is applied as follows:

Each FQHC/RHC has an individual PPS rate for its Medi-Cal clinic visits. For the FQHC/RHC visits from beneficiaries enrolled in managed care plans or dual eligible beneficiaries, an interim rate is established in order for the clinic to be reimbursed the difference between the Medi-Cal PPS rate and the payments received from managed care plans and Medicare. There is no established interim rate for CHDP visits.

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

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

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

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 25	(OA-28) (Reworded)	X	X	<p><u>HIPAA Capitation Payment Reporting System</u></p> <p>Prior to the HIPAA Capitation Payment Reporting System (CAPMAN), the Department paid contracted managed care health plans through a manual process. The manual process limited the reporting of capitation amounts at the aid code level or above. HIPAA mandates that the Department report these types of payments with a standard HIPAA transaction. The Department implemented the new HIPAA transaction requirements on July 1, 2011.</p> <p>The new HIPAA transaction requirements (5010):</p> <ul style="list-style-type: none"> • Make significant improvements to the capitation calculation process, • Allow detailed reporting at the beneficiary level, • Increase the effectiveness of monthly reconciliation between Medi-Cal and the contracted managed care plans, and • Support research efforts to perform recoveries. <p>Due to the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN. The Department anticipates that a new five-year contract is required to bring vendor staff to work with the Department on CAPMAN system changes.</p>
R 26	(OA-23) (PC-170) (PC-FI) (Reworded)	X	X	<p><u>ARRA HITECH Incentive Program</u></p> <p>The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of ARRA of 2009, authorizes federal funds for Medicare and Medicaid incentive programs from 2011 through 2021. To qualify, health care providers must adopt, implement or upgrade (AIU), and meaningfully use (MU) Electronic Health Records (EHR) in accordance with the HITECH Act. The HITECH Act pays provider incentive payments at 100% Federal Financial Participation (FFP).</p> <p>The Department received approval of the State Medicaid Health Information Technology Plan (SMHP) and Implementation Advance Planning Document (IAPD) on September 30, 2011. The SMHP and IAPD authorized implementation of the EHR Incentive Program, which occurred on October 3, 2011. CMS approved an IAPD Update (IAPD-U) on December 11, 2012. The</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

authorization provides additional funds for MU measures specific to immunization registries.

The Medical 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. The Department anticipates the incentive payments will accelerate the AIU and MU of certified EHR technology.

The Department plans to expand the current Medicaid Management Information System (MMIS) to integrate a State Level Registry (SLR) payment functionality, allowing for more seamless and efficient participation and payment for eligible providers (EPs).

CMS requires the Department to assess the usage of and barriers to AIU and MU by EPs; the assessments require multiple contractors.

The HITECH Act of 2009 allows a 90/10 FFP for administrative activities. The enhanced funding supports further advancement and maintenance of the EHR program.

R 27 (OA-37) X X

Encryption of PHI Data

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

The encryption of these tapes will:

- Secure and protect Department information assets from unauthorized disclosure,
- Protect the privacy of Medi-Cal beneficiaries,
- Prevent lawsuits from citizens for privacy violations,
- Avoid costs to notify millions of people if a large breach does occur, and
- Maintain its public image and integrity for protecting confidentiality and privacy of information that it maintains on its customers.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 28	(PC-182)	X	X	<p><u>ICF-DD Administrative and QA Fee Reimbursement - CDDS</u></p> <p>The Department of Developmental Services (DDS) will make supplemental payments to Medi-Cal providers that are licensed as Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), ICD-DD Habilitative, or ICF-DD Nursing, for transportation and day treatment services provided to Regional Center consumers. The services and transportation are arranged for and paid by the local Regional Centers, which will bill DDS on behalf of the ICF-DDs. A State Plan Amendment (SPA) was approved April 15, 2011. DDS will provide payment, retroactive to July 1, 2007, to the ICF-DDs for the cost of reimbursing the Regional Centers for the cost of arranging the services plus a coordination fee (administration fee and the increase in the QA fee).</p> <p>On April 8, 2011, the Department entered into an interagency agreement with DDS for the reimbursement of the increased administrative expenses due to the addition of active treatment and transportation services to beneficiaries residing in ICF-DDs.</p>
R 29	(PC-189)	X	X	<p><u>CLPP Funds</u></p> <p>Medi-Cal provides blood lead tests to children who are at risk for lead poisoning and are full-scope Medi-Cal beneficiaries or are pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program. The CHDP State-Only program provides lead screenings to Medi-Cal beneficiaries who are eligible for emergency and pregnancy related services. The lead tests are funded by the CLPP Fund which receives revenues from a fee accessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of Equalization. The expenditures for the lead testing are in Medi-Cal's FFS base trends and this policy change adjusts the funding.</p>
R 30	(PC-195)	X	X	<p><u>Overpayments – Interest Rate Change</u></p> <p>This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.</p>
R 31	(PC-131) (PC-132) (PC-133) (PC-134) (PC-135)	X		<p><u>Payment Deferral</u></p> <p>Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. The Department is proposing language to delay an additional</p>

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

checkwrite for FY 2012-13. From then on, two checkwrites would be delayed at the end of each fiscal year.

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

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

R 32 X

First 5 California Funding

This assumption has been moved to the "Withdrawn" section.

R 33 (PC-168) X X

Part D—Phased-Down Contribution

With the implementation of Medicare Part D, the federal government requires a phased down contribution from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal program. In 2006, the phased-down contribution was 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015. An annual inflation factor is also applied to the phased-down contribution. The phased-down contribution, annual CMS-determined inflation factor, and PMPM are adjusted annually.

R 34 (OA-61) X X

CDPH I&E Program and Evaluation

AB 1762 (Chapter 301, Statutes of 2003) authorized the Department to require contractors and grantees under the Information and Education (I&E) program to establish and implement clinical linkages to the Family PACT program, effective in the 2003-04 fiscal year. This linkage includes planning and development of a referral process for program participants, to ensure access to family planning and other reproductive health care services.

The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.

OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 35	(PC-193)	X	X	<u>Operational Flexibilities</u>

The Department will establish policies to improve Medi-Cal processes through operational flexibilities.

OTHER RECOVERIES: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

OTHER: RECOVERIES: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
RC 1 (PC-202)	X	X	<p><u>Base Recoveries</u></p> <p>Medi-Cal recoveries are credited to the Health Care Deposit Fund and used to finance current obligations of the Medi-Cal program. Medi-Cal recoveries result from collections from estates, providers, and other insurance to offset the cost of services provided to Medi-Cal beneficiaries in specified circumstances. Recoveries are based on trends in actual collections.</p>
RC 2 (PC-199)	X	X	<p><u>FQHC/RHC Audit Staffing</u></p> <p>The Department received three limited-term positions to perform audit activities for FQHC/RHC providers to account for the increasing number of providers and to fulfill statutory audit deadlines. In the past five years, the number of FQHC/RHC providers has increased from 460 to 1,000, while the number of audit staff has remained the same. The positions were filled in December 2011, but expired on June 30, 2012. The Department redirected existing staff to continue to perform these audit activities.</p>
RC 3 (OA-17)	X	X	<p><u>Medi-Cal Recovery Contracts</u></p> <p>The Department contracts with vendors to identify third party health insurance and workers compensation insurance. When such insurance is identified, the vendor retroactively bills the third party to recover Medi-Cal paid claims. Payment to the vendor is contingent upon recoveries.</p>
RC 4 (PC-197)	X	X	<p><u>Anti-Fraud Activities for Pharmacy and Physicians</u></p> <p>In FY 2011-12, the Department expanded its anti-fraud activities. The activities focus on pharmacy and physician services.</p>
RC 5 (PC-196) (OA-35)	X	X	<p><u>Medicare Buy-In Quality Review Project</u></p> <p>On October 1, 2010, the Department entered into a three-year contract with the University of Massachusetts (UMASS) to identify potential overpayments to CMS or Medicare providers related to the buy-in process for Medicare/Medi-Cal dual eligibles. UMASS will assist assists the Department in by auditing the invoices received from CMS to pay the Medicare premiums. The Department anticipates it will begin realizing realized savings beginning in FY 2012-13 October 2012. Payments to UMASS are contingent upon recovery of overpayments from CMS and</p>

OTHER: RECOVERIES: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

Medicare providers. **The Department extended the contract through June 30, 2015.**

FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 1	(PC-FI) (PC-194)	X	X	<p><u>Cost Containment Proposals – Savings Sharing</u></p> <p>The Department continues to review and approve the Fiscal Intermediary-initiated cost containment proposals, implementing as appropriate to contain Medi-Cal costs. Savings are achieved, with the Fiscal Intermediary continuing to receive a share of the savings.</p> <p>Additionally, the Contractor continues the process of identifying fraudulent claims activity in two areas – outpatient (physician, DME, lab, pharmacy, etc.) and prepayment review. As other areas are identified, they will be further developed. The savings methodology is linked to actual cost avoidance and/or realized recovery of fraudulent payments to providers. The Contractor has developed a program to formalize the identification of fraudulent claims activity, facilitate appropriate intervention with various audit organizations, recommend system or policy modifications, if appropriate, and support regulation development, if necessary, to support efforts by the Department to expeditiously stop illegal and inappropriate payment activity. The staffing is provided by the Contractor.</p>
FI 2	(PC-FI)	X	X	<p><u>HIPAA UPN Exception Request</u></p> <p>Implementation of the original scope of the Universal Product Number (UPN) pilot project was cancelled in March of 2006 because it was determined that the modifications to the current CA-MMIS infrastructure would be too costly and could not be implemented in an efficient manner. Further analysis determined that in order to implement the use of the UPN into a claims processing environment, it would be necessary to bring forth new technology in order to allow for the system to be flexible, cost effective, and easily modified for future requirements.</p> <p>The Department received 90% funding approval from CMS to revise the scope of the UPN pilot in order to reduce costs and to leverage system changes needed to comply with the Federal Deficit Reduction Act of 2005 which mandates the collection of rebates for physician administered drugs using the National Drug Code (NDC). CMS is requiring a two-year evaluation of the project to substantiate the possible adoption of the UPN as a HIPAA standard. The Department completed the two-year evaluation of the UPN and submitted findings to CMS in September 2011. There will be a FY 2012-13 cost if the Federal</p>

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

				government requires the Department to discontinue the use of the UPN.
FI 3	(PC-FI)	X	X	<p><u>HIPAA – CA-MMIS</u></p> <p>HIPAA requires uniform national health data standards, unique identifiers and health information privacy and security standards that apply to all health plans and health care providers who conduct specified transactions electronically. Additional technical staff is required to provide for remediation/implementation of HIPAA changes to the CA-MMIS and for assessing the impact of each new published rule and any proposed changes to previously published rules (addenda and errata). The advance planning document updates (APDUs) have been submitted to CMS and were approved for enhanced funding for Transactions and Code Sets, and high level work on other rules. APDUs APDs will continue to be submitted as new rules are published to continue to secure enhanced funding.</p> <p>The necessary work is associated with the following HIPAA regulations:</p> <ul style="list-style-type: none"> • Privacy (Completed) • Transactions and Codes (Completed) • Unique Employer Identifier (Completed) • Security (In Progress) • National Provider Identifier (Completed) • Electronic Signature (Future Project) • Enforcement (Completed) • National Health Plan Identifier (Future Project) • Claims Attachments (Future Project) • First Report of Injury (Future Project) • Transactions and Code Sets Revisions (In Progress) <p>Due to the complexity of the HIPAA requirements and their impact on the Medi-Cal Program, the Department has developed a phased-in approach to implement the most critical (in terms of provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation began in October 2003 and the remaining transactions and code conversions will continue to be phased-in and implemented. The January 16, 2009 published HIPAA rules will require MMIS changes in order to incorporate updated transactions for Medi-Cal and prescription drug claims by</p>

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

				<p>the federal compliance date of January 1, 2012. The final rules also require the implementation of a new diagnosis and inpatient hospital procedure coding standard, ICD-10, by October 1, 2013. <u>CMS recently extended the October 1, 2013 deadline to October 1, 2014 for ICD-10.</u></p>
FI 4	(PC-FI)	X	✕	<p><u>Extension of the HP Contract</u></p> <p>The Department contracts with HP up to June 30, 2012 to allow for the completion of all post operation activities. The Department extended the HP contract one year, up to June 30, 2013, for the sole purpose of providing payment to HP for a cost containment proposal. The payment is for services performed during the original term of the contract.</p>
FI 5	(OA-40)	X		<p><u>Medicaid Information Technology Architecture</u></p> <p>The CMS is requiring the Department to create frameworks and technical specifications for the MMIS of the future. CMS is requiring the Department to move toward creating flexible systems, which support interactions between the federal government and their state partners. Through Medicaid Information Technology Architecture (MITA) the Department will develop the ability to streamline the process to access information from various systems. CMS will not approve APDs or provide federal funding to the Department without adherence to MITA.</p> <p>The Department completed the CMS-required MITA State Self-Assessment (SS-A) of business processes to determine the current and long-term business requirements. The Department must complete an annual SS-A that contains a roadmap that demonstrates progression along the MITA model. The Department is currently developing Enterprise Architecture (EA) at the Agency level to address MITA EA activities.</p>
FI 6	(OA-18)	X	X	<p><u>CA-MMIS Takeover and Replacement Oversight</u></p> <p>CA-MMIS is the claims processing system used for Medi-Cal. This system has changed considerably over the past 30 years to incorporate technological advances as well as address new business and legislative requirements and, as a result, is extremely complex, difficult to maintain, and nearing the end of its useful life cycle. CA-MMIS is a mission critical system that must assure timely and accurate claims processing for Medi-Cal providers. Given the business critical nature of CA-MMIS, a</p>

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

detailed assessment was completed by a specialty vendor which recommends that modernization of CA-MMIS begin immediately. The Department contracts with various vendors to assist with FI oversight activities, documentation of business rules, project management, change management and IV&V services during transition and replacement of the CA-MMIS.

FI 7 (PC-FI) X

CA-MMIS Takeover by New FI Contractor

CA-MMIS is the claims processing system used for Medi-Cal and is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal providers. The Department extended the term of the previous contract to June 30, 2012 to continue uninterrupted support of operations until a successful Assumption of Operations (AOO) by the new FI contractor's Takeover phase. An RFP was issued to establish a new FI contract. The bids were evaluated and the Notice of Intent to Award was published on December 8, 2009. The Takeover activities of the new FI contractor began on May 3, 2010. In the Takeover Phase, the new FI ~~is required to complete~~ completed contractually required activities necessary for the AOO from the ~~current~~ previous contractor. These activities include the following expansion items:

- On-line and Computer-Based Interactive Training,
- Post-Service Prepayment Audit,
- Contingency Payments,
- Caller Satisfaction Evaluation Tool,
- Encounter Data Processing,
- Geographic Mapping,
- Contract Management,
- CA-MMIS Enterprise Project Management Office,
- Project and Portfolio Management,
- Additional Software Licenses,
- Additional Office Space,
- Security for Data "At Rest",
- Additional 32-Bit Processors,
- Payment Methodology Modification,
- Sensitive Information Redaction.

Takeover plans were ~~expected to be~~ completed in FY 2011-12; however, final documentation of Takeover is still being finalized. ~~As a result, the final~~ and payment for Takeover will occur in FY 2012-13.

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/YFI 8 (OA-20) X X CA-MMIS Takeover/Replacement Other State Transition Costs

CA-MMIS is the claims processing system used for Medi-Cal. The previous FI contract will expire on June 30, 2013. Additional costs will be incurred for CA-MMIS Takeover and Replacement activities which include interfacing with other Departmental mission critical systems such as MEDS, EMBER, SCO, MIS/DSS and PCES applications that will require coordination and resources with other Department Divisions and Agencies. The existing production and test regions will be needed to continue to support the current contract. Network configurations, testing environments (including system and parallel), support for expansion enhancements, and new communication interfaces will be needed to run a parallel system. This transition began in FY 2009-10. The Department will also be required to obtain additional consultative contractor resources for set-up, testing activities, and management of these new environments in support of transition activities during the Takeover and Replacement phases. The CA-MMIS system must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during both phases. The Takeover activities are expected to be completed in FY 2012-13, and Replacement activities are underway. Consultative contractors and other resources are required to continue the CA-MMIS replacement phase.

FI 9 (PC-FI) X X ~~Business Rules Extraction Enhancement~~ CA-MMIS System Replacement Project
(Reworded)

The Department plans to replace the 30-year old CA-MMIS. CA-MMIS is a mission critical system that must ensure timely and accurate claims processing for Medi-Cal providers. The Department continues to update the current system to incorporate technological advances. The updates address new business and legislative requirements. Because of the updates, CA-MMIS is extremely complex, difficult to maintain, and near the end of its useful life cycle. A specialty vendor completed a detailed assessment of the current system. Due to the business critical nature, the vendor recommends that modernization of CA-MMIS begin immediately. The Department scheduled the CA-MMIS System Replacement Project in four phases.

Business Rules Extraction (BRE) will occur at the beginning of each phase. The objective of the BRE Enhancement is to define a comprehensive rules base for the Legacy CA-MMIS and to store

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

the confirmed rules in a requirements traceability database. The traceability database is for tracking future testing, management, and updates. Business rules link to requirements, which are the key building blocks of a system development project. The Department expects BRE related costs to begin in FY 2012-13.

In Phase I, Pharmacy Benefits Manager and Drug Rebate, the Department plans to implement a new pharmacy claims system. This includes three major components:

- Real-time Point-of-Service (POS) and batch claims processing;
- The rebate collection and tracking system; and
- The drug utilization review (both prospective and retrospective).

Planning work on the system began in January 2012. The Department plans to implement Phase I in February 2015.

In Phase II, TARS-RX Authorizations, the Department plans to:

- Replace the existing Treatment Authorization Request (TAR) System for pharmacy services only,
- Establish two TAR Processing Centers, and
- Consolidate existing Field Office Automation Group (FOAG) activities.

The Department scheduled Phase II to begin in February 2013. Based on the existing pay schedule, actual costs will be incurred in FY 2013-14

In Phase III, TARS-Medical Authorizations, the Department plans to implement a new Medical Authorizations system. This involves replacing:

- The remainder of the SURGE system,
- The Medical Treatment Authorization Requests (MeTARS), and
- The TAR Appeals Process.

The Department scheduled Phase III to begin in FY 2013-14.

In Phase IV, CMSNet, TPL, ACMS, CalPOS, and RTIP Full Replacement, the Department plans replace:

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

- The Children's Medical Services Network (CMSNeT),
- Third Party Liability (TPL) system,
- Automated Collection Management System (ACMS),
- The remaining pieces of the California Point of Service (CalPOS) system, and
- The Real Time Internet Pharmacy (RTIP) system.

The Department scheduled the final phase to begin in FY 2013-14.

FI 10 (PC-FI) X X CA-MMIS Re-Procurement–HIPAA ICD-10 Legacy Enhancement

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt the use of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM) for diagnosis coding, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD–10–PCS) for inpatient hospital procedure coding. Medi-Cal currently uses ICD-9 coding, as does the majority of the national health care industry, as critical data for claims processing, prior authorization, fraud investigation, and other program operations. The Final Rule for ICD-10 indicates an expectation that efforts to begin addressing these requirements begin no later than January 2011; ~~the compliance deadline is October 1, 2013.~~ **In August 2012, Centers for Medicare and Medicaid Services (CMS) changed the compliance date from October 1, 2013 to October 2, 2014.**

The new contract for the CA-MMIS was awarded to Xerox, and includes an enhancement of the existing system to address ICD-10 requirements, **and the acquisition and utilization of software tool for code management.** Planning, analysis, development and implementation of the CA-MMIS ICD-10 enhancement is in process.

FI 11 (PC-FI) X X CA-MMIS Re-Procurement – 5010/D.0 Legacy Enhancement

As part of the HIPAA, the federal government issued a Final Rule on January 16, 2009, requiring that Medi-Cal and other HIPAA-covered entities adopt new versions of the standards for electronically exchanging critical administrative health care transactions, including health care claims, eligibility information, prior authorizations, and payment information. These changes will

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

impact the vast majority of Medi-Cal providers and managed care plans. These new versions are maintained by two national standards organizations; X12 and the National Council for Prescription Drug Programs (NCPDP). The X12's transactions are part of the standard called "5010," while NCPDP's standard is called "D.0". The federal compliance deadline ~~is~~ was January 1, 2012; however, the activities ~~will continue~~ **continued** until December 31, 2012.

The new contract for the CA-MMIS was awarded to Xerox, and includes an enhancement of the existing system to address the 5010/D.0 transaction requirements. The planning, analysis, and development of the CA-MMIS 5010/D.0 ~~has been~~ **was** completed, **with** implementation **implementation** into CA-MMIS **was occurring on** July 1, 2012. The Department will allow Medi-Cal providers to continue to submit claims in the old format for a **limited** period of time **and will continue to make additional modifications that are anticipated to result in additional costs carrying over into FY 2013-14.**

FI 12 (PC-FI)	X	<u>TAR/System Replacement (pharmacy-only)</u>	<p>This assumption has been incorporated into the "CA-MMIS Replacement System Project" assumption.</p>
FI 13 (PC-FI)	X	X <u>Pharmacy Claims/DUR/Rebate Accounting Replacement</u>	<p>This assumption has been incorporated into the "CA-MMIS Replacement System Project" assumption.</p>
FI 14 (PC-FI)	X	X <u>Rebate Accounting and Information System Hardware and Software Refresh</u>	<p>The Rebate Accounting and Information System (RAIS) supports invoicing of pharmaceutical drugs, physician-administered drugs, and medical supply rebates.</p> <p>RAIS is built upon technology that is client server oriented. Since the hardware technology is constantly changing and expanding, the hardware has a limited life span. In order to avoid memory storage reaching maximum capacity and hardware components failing due to the age of the equipment, the FI Contractor is required to evaluate RAIS hardware and software every five years. The last refresh of the RAIS platforms was completed in 2005. The FI Contractor's review of RAIS determined that the</p>

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

				RAIS hardware has reached its end of life. The refresh is expected to begin in FY 2012-13.
FI 15 (PC-FI)	X	X	<u>Point of Service Refresh</u>	<p>Medi-Cal providers are currently able to use the Point of Service (POS) devices to verify Medi-Cal recipients' eligibility, and perform claims-related transactions including: decrement Share of Cost (SOC), submit pharmacy transactions for immediate on-line adjudication, access the Child Health and Disability Prevention Gateway, and submit Family Planning, Access, Care and Treatment transactions.</p> <p>The devices that support the POS network are out-of-date and need to be replaced to comply with the new HIPAA transactions standards. Implementation of the POS refresh is scheduled to be completed in June 2013 <u>March 2014</u>.</p>
FI 16 (OA-38)	X	X	<u>MIS/DSS Contract Reprocurement Services</u>	<p>The contract for ongoing development, maintenance, and operation of the Management Information System and Decision Support System (MIS/DSS) is scheduled to end on February 14, 2014. The Department will contract with a vendor to provide assistance with the reassessment of the scope of services to be included in the reprocurement of the MIS/DSS contract beginning in FY 2012-13. Resources are needed to develop the Feasibility Study Report and APD to achieve required state and federal level approvals.</p>
FI 17 (PC-FI)	X	X	<u>Clarity Software</u>	<p>The federal health reform initiatives require the Department to effectively and efficiently initiate, manage, monitor and report human and cost resources.</p> <p>Clarity is a portfolio management tool designed for prioritization, efficiency, and analysis. This tool will help the Department manage the various technology undertakings that are required to make improvements to the Medi-Cal fiscal intermediary process and for implementing the new California Medicaid Management Information System (CA-MMIS), which will bring additional efficiencies and functionality to support the Medi-Cal program.</p>

FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 18	(PC-FI)	X		<p><u>Additional CA-MMIS Office Space</u></p> <p>The Department has decided to locate all CA-MMIS staff in one location and has directed Xerox to provide additional office space within the new Medi-Cal Operations Center (MOC) facility in West Sacramento, CA. This office space exceeds the FI's contractual office space requirements. The build out of additional office space is expected to be completed by FY 2012-13.</p>
FI 19				<p><u>Cost Reasonableness Contractor</u></p> <p>This assumption has been moved to the "Withdrawn" section.</p>
FI 20	(OA-49)	X	X	<p><u>SDMC System M&O Support</u></p> <p>The Department has started procuring a contract for ongoing operation and maintenance of the Short-Doyle/Medi-Cal (SDMC) system. The SDMC system adjudicates Medi-Cal claims for specialty mental health and substance use disorder services. This contract will be for a two year period beginning June 29, 2013, with three one-year optional extensions.</p>
FI 21	(OA-50)	X	X	<p><u>Annual EDP Audit Contractor</u></p> <p>The Department plans to procure an independent Certified Public Accounting firm to provide a contractually required annual Electronic Data Processing (EDP) audit of the Medi-Cal fiscal intermediary. The Department will use the findings and recommendations of the audit as part of its ongoing CA-MMIS monitoring process.</p>

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
HO 1 (PC-FI)	X	X	<p><u>Personalized Provider Directories</u></p> <p>HCO currently prints and mails health plan Provider Directories that provide information for every Medi-Cal managed care provider in the beneficiary's county of residence. AB 203 (Chapter 188, Statutes of 2007) authorized the implementation of a Personalized Provider Directory (PPD) as a pilot project in one Two-Plan Model county (Los Angeles) and one GMC county (Sacramento). The content and format of the Personalized Provider Directories were determined in consultation with health plans and stakeholders. The pilot project began on February 27, 2009 and continued for a period of two years. At the end of the pilot project period (March 2014), the Department, in consultation with health plans and stakeholders, performed an assessment to determine if Personalized Provider Directories provide more accurate, up-to-date provider information to Medi-Cal managed care beneficiaries, in a smaller, standardized, and user-friendly format that results in a reduction of default assignments, and if they should be implemented statewide in all managed care counties. This determination will be based on the outcomes set forth in the evaluation provided to the Legislature. The pilot project will continue beyond the initial two-year period until this determination is made. <u>Based upon the assessment, the Department decided to continue the pilot.</u></p>
HO 2 (OA-42)	X	X	<p><u>Health Care Options Consultant Costs</u></p> <p>The Department will contract with a health care consultant <u>to</u> develop policies, make recommendations, and provide assistance in aligning its Health Care Options Program with Health Care Reform and the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) solution.</p> <p>Operations for the current enrollment broker contracts ends on September 30, 2012, with three one-year extension options. <u>The Department exercised a one-time extension option of the current contract for the period of September 30, 2012 through September 30, 2013.</u></p>
HO 3 (PC-FI)	X	X	<p><u>Updates to Existing HCO Informing Materials</u></p> <p>All existing HCO informing materials will be reviewed and revised to reflect changes associated with the current health care environment. This includes, but is not limited to:</p>

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

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

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

HO 4 (PC-FI) X
 (Reworded)

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

Previously, Stanislaus County designated Anthem Blue Cross as the Local Initiative (LI) health plan. Beginning January 1, 2013, Health Plan of San Joaquin (HPSJ) became the new designated LI through a request for proposal. In September 2012, the Department mailed notices and packets to all beneficiaries. The mailing coincided with the HPSJ start date of January 1, 2013.

FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS

Applicable F/Y
C/Y B/Y

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

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

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

The work necessary is associated with the following HIPAA regulations:

- Electronic Signature (Completed)
- Enforcement (Completed)
- ~~National Health Plan Identifier Standard~~ **Adoption of Rules for a Unique Health Plan Identifier (HPID)** (Pending) **(In Progress)**
- Claims Attachments (Pending)
- First Report of Injury (Completed)
- ~~Transaction and Code Sets Revisions (In Progress)~~ **(Completed)**
- Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claims **Status** Transactions (In Progress)
- Adoption of Standards for Health Care Electronic Funds Transfers (EFTs) and Remittance (In Progress)

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

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

				<p><u>January 1, 2013 Transactions and Companion Guides and had a compliance date of January 1, 2013. The September 5, 2012 published HIPAA rules adopted the standard for a national unique health plan identifier (HPID) and requires changes to CD-MMIS in order to meet the federal compliance date of November 7, 2016.</u></p>
DD 2 (PC-FI)	X	X	<p><u>Medi-Cal Dental FI Contract Turnover</u></p> <p><u>CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department is seeking approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The extension begins July 1, 2013 through June 30, 2015. The Department plans to develop a Planning Advanced Planning Document (PAPD) and procure a new dental MMIS contract that meets CMS's requirements.</u></p> <p><u>The Department has instructed the FI contractor to resume turnover support services and all activities in accordance with the contract requirements.</u> The Turnover period ensures an orderly transfer of the Medi-Cal Dental FI contract from the current contractor to the successor contractor, in addition to supporting the Department's procurement effort by ensuring that all required data and documentation was included in the Office of Medi-Cal Procurement's data library. Turnover support services and all activities in accordance with the contract requirements are being delayed due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013.</p>	
DD 3 (PC-FI) (Reworded)	X	X	<p><u>CD-MMIS Takeover by New Dental FI Contractor</u></p> <p>The dental FI operates CD-MMIS, which is the Medi-Cal dental claims processing system. It is a mission-critical system that must ensure timely and accurate claims processing for Medi-Cal dental providers. The Department issued a RFP to establish a new FI contract. In August 2011, the Department evaluated the bids and published the Notice of Intent to Award.</p> <p>In February 2012, the new dental FI began takeover activities. However, CMS determined the new Medi-Cal Dental FI contract failed to meet the regulatory criteria and conditions as a MMIS. Subsequently, the Department exercised the one-time extended operations option of the current Dental FI Contract for the period</p>	

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONSApplicable F/Y
C/Y B/Y

				of June 1, 2012 through June 30, 2013. The Department instructed the FI contractor to stop all Takeover activities. The FI contractor filed a Notification of Claim to recoup costs already expended for Takeover activities.
DD 4 (PC-FI)		X		<u>CD-MMIS Business Rules Extraction Enhancement</u> This assumption has been moved to the "Withdrawn" section.
DD 5 (PC-FI)	X		X	<u>Dental Managed Care Encounter Data Enhancement</u> This assumption has been moved to the "Withdrawn" section.
DD 6 (PC-FI)			X	<u>Medi-Cal Dental FI Contract - Runout</u> This assumption has been moved to the "Withdrawn" section.
DD 7 (PC-FI)	X		X	<u>Extension of the Current Medi-Cal Dental FI Contract</u> CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. Consequently, this prohibits the contract from receiving enhanced FFP. <u>The Department is seeking approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The Department plans to develop a Planning Advanced Planning Document (PAPD) and procure a new dental MMIS contract that meets CMS's requirements.</u> exercised a one-time extended operations option of the current contract for the period of July 1, 2012 through June 30, 2013, to work with CMS in developing a planning document to make the system certifiable as an MMIS and compliant with the Federal Register Vol. 76, No. 75. All Runout and Underwriting Periods will be adjusted accordingly and all related activities for the new FI contract will be delayed. <u>Dental APD- PAPD Project Manager</u> The Department completed the procurement for the CD-MMIS Fiscal Intermediary and published the Notice of Intent in August 2011. CMS determined the new dental contract no longer meets the regulatory criteria and conditions as a MMIS acquisition. Therefore, the contract is not eligible for enhanced FFP at 75%. The Department plans to procure a Certified Project Manager (CPM) to develop and obtain CMS approval of an a Advanced
DD 8 (OA-34)	X		X	

FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS

Applicable F/Y
C/Y B/Y

~~Planning Document (APD)~~ **PAPD**. The Project Manager's responsibilities include:

- Provide project management expertise,
- Provide status reporting, and
- Advise the Department to ensure CMS approval of the dental FI contract as an MMIS at the enhanced level.

INFORMATION ONLY:**REVENUES**1. Revenues

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

FY 2011-12: \$ 23,037,000	ICF-DD Quality Assurance Fee
\$ 466,978,000 <u>\$470,285,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629) (The revenues for this is now included in the revenues for AB 1629.)
\$ 28,640,000	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ 999,000 <u>\$1,090,000</u>	Freestanding Pediatric Subacute Quality Assurance Fee
\$ 265,213,000	Gross Premium Tax (AB 1422)
\$2,634,924,000	Hospital Quality Assurance Revenue Fund (4260-610-3158)
\$ 7,151,000 <u>\$11,718,000</u>	Emergency Medical Air Transportation Fund (EMATA)
\$3,426,942,000 <u>\$3,434,907,000</u>	Total
FY 2012-13: \$ 23,170,000	ICF-DD Quality Assurance Fee
\$ 526,707,000 <u>\$510,264,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 6,620,000	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ 1,256,000 <u>\$1,090,000</u>	Freestanding Pediatric Subacute Quality Assurance Fee
\$ 0	Gross Premium Tax
\$2,915,076,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
\$ 7,151,000 <u>\$12,806,000</u>	Emergency Medical Air Transportation Fund (EMATA)
\$ 3,479,980,000 <u>\$3,673,720,000</u>	Total
FY 2013-14: \$ 23,153,000	ICF-DD Quality Assurance Fee
\$ 526,510,000 <u>\$494,096,000</u>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 6,620,000	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ 1,258,000 <u>\$1,257,000</u>	Freestanding Pediatric Subacute Quality Assurance Fee
\$ 0	MCO Tax

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\$1,567,380,000	<u>\$3,181,559,000</u>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
\$ 7,151,000	<u>\$12,806,000</u>	Emergency Medical Air Transportation (EMATA) Fund
\$2,132,072,000	<u>\$4,603,945,000</u>	Total

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

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

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

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

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

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

The California Department of Public Health (CDPH) lowered Licensing and Certification (L&C) fees for long-term care providers for FY 2010-11. The aggregate amount of the

INFORMATION ONLY:

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

Effective January 1, 2011, AB 2173 (Chapter 547, Statutes of 2010) imposes an additional penalty of \$4 for convictions involving vehicle violations.

2. Redevelopment Agency and Local Government Funds

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

ELIGIBILITY**3. Qualifying Individual Program**

The Balanced Budget Act of 1997 provided 100% federal funding, effective January 1, 1998, to pay for Medicare premiums for two new groups of Qualifying Individuals (QI). QI-1s have their Part B premiums paid and QI-2s receive an annual reimbursement for a portion of the premium. The QI programs were scheduled to sunset December 31, 2002, but only the QI-2 program did sunset December 31, 2002. HR 3971, enacted as Public Law 109-91, extended the program through September 30, 2007. The current sunset date has been extended to December 31, ~~2012~~ **2013** by HR 3630, the Middle Class Tax Relief and Job Creation Act of 2012.

4. Transitional Medi-Cal Program

As part of Welfare Reform in 1996 (PRWORA of 1996, P.L. 104-193), the Transitional Medi-Cal Program (TMC) became a one-year federal mandatory program for parents and children who are terminated from the Section 1931(b) program due to increased earnings and/or hours from employment. Prior to this current twelve month program, TMC was limited to four months for those discontinued from the Aid to Families with Dependent Children program due to earnings. Since 1996, it has had sunset dates that Congress has continually extended. The current sunset date has been extended February 29, 2012 by HR 3765, the Temporary Payroll Tax Cut Continuation Act of 2011.

INFORMATION ONLY:5. Lomeli, et al., v. Shewry

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

The Department implemented the changes in August 2011. ~~The petitioners claim that the Department is required to pay for their attorney fees in excess of \$168,000. The Department, through the Attorney General's Office, is in negotiations with the petitioners.~~ **and through the Attorney General's Office, successfully negotiated attorney fees of \$130,000 with the petitioners.**

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

Section 4 of SB 708 (Chapter 148, Statutes of 1999) reauthorizes state-only funded long-term care for eligible aliens currently receiving the benefit (including aliens who are not lawfully present). Further, it places a limit on the provision of state-only long-term care services to aliens who are not entitled to full-scope benefits and who are not legally present. This limit is at 110% of the FY 1999-00 estimate of eligibles, unless the legislature authorizes additional funds. SB 708 does not eliminate the uncodified language that the *Crespin* decision relied upon to make the current program available to eligible new applicants. Because the number of undocumented immigrants receiving State-only long-term care has not increased above the number in the 1999-00 base year, no fiscal impact is expected in FY 2012-13 and FY 2013-14 due to the spending limit.

7. Ledezma v. Shewry Lawsuit

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

8. Electronic Asset Verification Program

Due to the requirements imposed by H.R. 2642 of 2008, the Department is required to implement electronic verification of assets for all Aged, Blind or Disabled (ABD)

INFORMATION ONLY:

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

9. Lanterman Developmental Center Closure

On April 1, 2010, the California Department of Developmental Services (CDDS) submitted a plan to the Legislature for the closure of Lanterman Developmental Center. CDDS is working with consumers, families, and the regional centers to transition residents to community living arrangements ~~beginning in FY 2011-12~~. If eligible for Medi-Cal, residents moving into the community will be enrolled in a Medi-Cal managed care health plan or will receive services through the fee-for-service (FFS) system. **It is not known when the transitions will begin.**

AFFORDABLE CARE ACT**BENEFITS****10. State-Only Anti-Rejection Medicine Benefit Extension**

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

11. CDSS IHSS Share-of-Cost Buyout

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

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

INFORMATION ONLY:

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

HOME & COMMUNITY BASED-SERVICES**12. AB 398—Traumatic Brain Injury**

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

13. Assisted Living Waiver Expansion

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

14. IHSS Provider Tax

AB 1612 (Chapter 725, Statutes of 2010) mandates that IHSS providers be taxed at the State sales tax rate. In exchange, the providers will receive a supplementary payment through CDSS equal to the amount of the tax, plus the federal income, Social Security and Medicare tax liabilities on that supplementary payment. The Department will provide the Title XIX federal funds for the supplementary payments for services provided to Medi-Cal beneficiaries. The SPA is pending CMS approval and the clock is stopped.

BREAST AND CERVICAL CANCER TREATMENT**PHARMACY****15. Average Acquisitions Cost as the New Drug Reimbursement Benchmark**

Average Wholesale Price (AWP) is currently the pricing benchmark used to reimburse drug claims to Medi-Cal FFS pharmacy providers. First Databank, the Department's primary drug price reference source ceased publishing AWP as of September 2011. AB 102 (Chapter 29, Statutes of 2011) gave the Department the authority to establish and implement a new methodology for Medi-Cal drug reimbursement that is based on average acquisition cost

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(AAC). If CMS provides guidelines for an alternative national benchmark, such a benchmark could be used under the new statute. To ensure the benchmark is in compliance with certain provisions of federal law, the Department must perform a study of the new reimbursement methodology.

16. Federal Upper Limit

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

1115 WAIVER—MH/UCD & BTR**17. South LA Preservation Fund – Deferral**

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

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

The Department responded on May 2, 2011 discussing the rationale for concluding that claiming for the contract payments counties have with private providers is appropriate under the 1115 Waiver. In January 2012, CMS approved the contract payments with private providers issue. The Department anticipates the deferral to be officially lifted upon CMS notification. In addition, CMS allowed the Department to make final payments of the remaining SLAMSP funds in FY 2011-12.

In January 2013, the Department resolved the deferral.

MANAGED CARE

INFORMATION ONLY:**PROVIDER RATES****SUPPLEMENTAL PAYMENTS****18. Designated Public Hospitals – Seismic Safety Requirements**

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

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

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

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

19. Hospital Inpatient Rate Freeze

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

OTHER: AUDITS AND LAWSUITS**20. Mission Hospital Regional Medical Center and Kaiser Foundation Hospitals et al. v. Douglas**

Plaintiffs are approximately 100 California hospitals that filed litigation in 2005 to challenge the validity of a limit on Medi-Cal reimbursement for FY 2004-05 for non-contract hospitals, which was enacted by SB 1103 (Chapter 228, Statutes of 2004). Plaintiffs contend the SB 1103 reimbursement limit violates the federally approved State Plan and various federal Medicaid laws, including 42 United States Code (U.S.C.) section 1396a(a)(30)(A), as well as the due process clause and contracts clause of both the United States and California constitutions.

The trial court issued an order June 19, 2009 that required the Department to recalculate the rates for the plaintiff hospitals for FY 2004-05 without applying the SB 1103 limit and pay them the additional money they would be owed. The Department appealed, and the Court of Appeal reversed the trial court's order. At a hearing on April 27, 2012, the trial court denied the plaintiffs' motion to amend their lawsuit to state a claim for money based on the

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state recalculating their rates for FY 2004-05 without applying the SB 1103 limit. A judgment is expected soon that will deny the plaintiffs the recalculated rates they seek. However, the plaintiffs filed a new lawsuit in November 2011 in which they again challenge the validity of the SB 1103 reimbursement limit and the new lawsuit specifically seeks a court order to require the Department to recalculate rates for FY 2004-05 without applying the SB 1103 reimbursement limit.

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

Plaintiffs (an association of home health care providers, a home health care provider, and a disability rights advocacy group) filed a lawsuit on April 27, 2004 seeking reimbursement, injunctive, and declaratory relief premised upon the Department's alleged violation of the Medicaid Act's "reasonable promptness" requirement; the Medicaid Act's "access" and efficiency, economy, and quality of care ("EEQ") provisions; federal regulation (42 C.F.R. § 447.204) and the State Plan.

In March 2007, following an appeal of a trial court decision, the Court of Appeal issued a published decision holding that:

- The Department was required to review reimbursement rates for home health services annually for years 2001 through 2005 to ensure that they comply with the former State Plan provision incorporating 42 U.S.C. 1396a(a)(30)(A), and
- The Department was not obligated to set new rates - i.e., for years after 2005.

Following the appellate decision, the Department completed a rate review and concluded that rates **paid to home health care providers for 2001-2005** were consistent with section 1396a(a)(30)(A). After the rate review was filed with the trial court, plaintiffs objected. On September 25, 2009, the trial court held that the Department did not perform a proper rate review in light of the standard set forth in *Orthopaedic Hospital v. Belshe*. The court ordered the Department to perform a further rate review.

The Department appealed the trial court's ruling. On March 26, 2012, the appellate court issued a published decision, affirming in part and reversing in part, holding:

- The Department was not required to consider provider costs under section 30(A) when performing the rate review,
- Section 30(A)'s requirement of "efficiency" and "economy" did not impose a minimum limit for, Medi-Cal reimbursement rates,
- Lack of complaints was sufficient to establish quality of care under section 30(A), and
- Sufficient ~~There was insufficient~~ evidence supported **to support** the Department's finding ~~that~~ of access to care under **home health care services during the period 2001-2005 complied with** section 30(A).

The case was remanded to the trial court, which issued an order on October 29, 2012, requiring the Department to conduct a further rate review for 2001-2005 for the purpose of further evaluating whether rates were sufficient for beneficiaries to have

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adequate access consistent with the March 2012 Court of Appeal decision. The Department is currently completing a supplemental conducting the further rate review consistent with the appellate court decision required by the court.

22. California Hospital Association v. Shewry

The California Hospital Association (Plaintiff) is a trade association representing nursing facilities that are a distinct part of a hospital (DP/NFs). Plaintiff contends the Department's policy of excluding the projected costs of facilities with less than 20% Medi-Cal days in determining the median rate results in rates that violate various laws, including 42 U.S.C. section 1396a(a)(30)(A). Plaintiff also contends that the freeze in rates during rate year 2004-05 violated section 1396a(a)(30)(A). Plaintiff seeks an injunction against the continued use of the 20% exclusion policy and a writ of mandate requiring the Department to recalculate rates for rate years 2001-02 through 2005-06 and pay DP/NFs the additional amount owed based on the recalculations.

On August 20, 2010, the Court of Appeal issued a decision reversing the trial court's judgment in favor of the Department. The Court of Appeal held that the Department violated section 1396a(a)(30)(A) by failing to evaluate whether rates were reasonable relative to provider costs. The case has been remanded back to the trial court for further litigation concerning the plaintiff's challenge to the rates paid for rate years 2001-02 through 2005-06. So far, there has been some additional discovery, but no other activity has occurred since the remand.

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

Plaintiffs are 17 hospitals that contend that the 10% Medi-Cal payment reductions the Department implemented for non-contract hospital inpatient services, pursuant to ABX4 5 (Chapter 5, Statutes of 2009), violate various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(8) and 1396a(a)(30), the Supremacy Clause and Equal Protection Clause of the United States Constitution, the State Plan, and state law. ~~Plaintiffs seek declaratory relief and a permanent injunction against the payment reductions.~~ The status of the case is as follows:

- On February 20, 2009, the federal court denied plaintiffs' motion for preliminary injunction,
- On June 1, 2009, the Ninth Circuit dismissed the plaintiffs' appeal. Plaintiffs filed an amended motion for preliminary injunction with respect to the 10% payment reductions mandated by W&I Code section 14166.245,
- On November 18, 2009, the district court issued a preliminary injunction with respect to the ~~90% of allowable cost standard mandated by Section 14166.245~~ 10% payment reduction for non-contract hospital inpatient services rendered on or after that date. The Department appealed,
- On May 27, 2010, the Ninth Circuit issued a decision affirming the preliminary injunction,

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- On January 18, 2011, the United States Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy Clause to sue states over whether provider rates comply with 42 U.S.C. section 1396a(a)(30)(A), ~~and~~
- On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case back to the Ninth Circuit to reconsider the Department's appeal of the preliminary injunction, and
- **Appellate briefing has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.**

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

This lawsuit challenges the 10% reduction required by ABX4 5 (Chapter 5, Statutes of 2009) in Medi-Cal payments that took effect on July 1, 2008. These reductions are mandated by W&I Code sections 14105.19 and 14166.245. Plaintiffs contend that these reductions violate 42 U.S.C. section 1396a(a)(30)(A) and the Americans with Disabilities Act. The status of this case is as follows:

- On August 18, 2008, the district court issued a preliminary injunction against the 10% reduction for physicians, dentists, optometrists, adult day health care centers, clinics, and for prescription drugs for services on or after August 18, 2008,
- On November 17, 2008, the district court issued a preliminary injunction against the 10% reduction for home health and non-emergency medical transportation (NEMT) services for services on or after November 17, 2008,
- On July 9, 2009, the Ninth Circuit issued a decision affirming the district court's August 18, 2008, preliminary injunction. The Ninth Circuit further granted plaintiffs' appeal with respect to their claim that the district court's August 18, 2008, injunction should have applied to service back to July 1, 2008,
- On August 7, 2009, the Ninth Circuit issued a decision affirming the district court's preliminary injunction with respect to NEMT and home health services,
- On January 22, 2010, the district court issued an order requiring the Department to pay additional money due for July 1, 2008 through August 17, 2008 to providers in the 6 categories covered by the August 18, 2008 injunction,
- On January 18, 2011, the U.S. Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy clause to sue states over whether provider rates comply with 42 U.S.C. section 1396(a)(30)(A), ~~and~~
- On February 22, 2012, the Supreme Court issued a ruling that vacates the Ninth Circuit decision and remanded the case to the Ninth Circuit to reconsider the Department's appeals of the two injunctions. ~~This will require a new appellate court briefing, which has been postponed to allow the parties to first explore possible settlement of the litigation.~~ and
- **Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.**

INFORMATION ONLY:25. AB 1183 Litigation

Two lawsuits challenged provider payment reductions that were mandated by AB 1183 (Chapter 758, Statutes of 2008) effective October 1, 2008 for non-contract hospital inpatient services, and March 1, 2009 for prescription drugs, adult day health care center (ADHC) services, and other hospital services. **The plaintiffs in these cases contend that the reductions violate 42 US Code Section 1396(a)(30)(A).**

- In the *Independent Living Center of Southern California* (formerly *Managed Care Pharmacy*) v. *Maxwell-Jolly* case, the federal district court issued a preliminary injunction on February 26, 2009 against the 5% payment reduction for prescription drugs. The Department appealed, and the Ninth Circuit affirmed the preliminary injunction. ~~On January 18, 2011, the U.S. Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy clause to sue states over whether provider rates comply with 42 U.S.C. section 1396a(a)(30)(A).~~
- In the *California Pharmacists Association, et al. v. Maxwell-Jolly* case, the federal district court issued a preliminary injunction on March 6, 2009 against the 5% payment reduction for ADHC services. The district court denied a preliminary injunction against the AB 1183 payment reductions for hospitals. On April 6, 2009, the United States Court of Appeal for the Ninth Circuit granted the plaintiffs' motion for a stay of the district court's denial of a preliminary injunction concerning the hospital payment reductions, pending their appeal of that ruling, which effectively enjoined the AB 1183 payment reductions for hospitals beginning April 6, 2009.

On March 3, 2010, the Ninth Circuit issued ~~two~~ **three** decisions that affirmed preliminary injunctions against the AB 1183 payment reductions for **prescription drugs**, ADHC and hospital services. **On January 18, 2011, the U.S. Supreme Court granted the Department's petition for certiorari on the issue of whether providers and recipients have a cause of action under the Constitution's Supremacy Clause to sue states for violation of section 1396a(a)(30)(A).** On February 22, 2012, the Supreme Court issued a ruling that vacated the Ninth Circuit decisions and remanded both cases back to the Ninth Circuit to reconsider the Department's appeals of the three injunctions in the above cases. ~~This will require a new appellate court briefing, which has been postponed to allow the parties to first explore possible settlement of the litigation.~~ **Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.**

26. AB 97 Litigation

Four lawsuits challenge the 10% rate reductions enacted by AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011.

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- *California Hospital Association v. Douglas, et al.*

Plaintiffs include the California Hospital Association and Medi-Cal beneficiaries, who contend that payment reductions enacted by AB 97 for nursing facilities that are distinct parts of hospitals (DP/NFs) violate the takings clause of the U.S. Constitution and 42 U.S.C. sections 1396a(a)(8), (19), and (30). AB 97 provides that rates to DP/NFs effective June 1, 2011 shall be the rates paid in the 2008-09 rate year reduced by 10%. The federal government (Secretary of the Department of Health and Human Services, Kathleen Sebelius), which recently approved a State Plan Amendment (SPA) concerning these reductions, has been named as a co-defendant.

On December 28, 2011, the district court issued a preliminary injunction against the AB 97 reductions for DP/NFs. The Department appealed. On March 8, 2012, the district court issued an order modifying the injunction to exclude from its effect services rendered prior to December 28, 2011 that were not reimbursed prior to that date. Plaintiffs appealed that ruling. ~~On March 22, 2012, the Ninth Circuit denied the Department's request for stay of the injunction pending its appeal. The parties have completed their appellate briefs and the hearing is set for October 10, 2012.~~ **On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On January 28, 2013, the plaintiffs requested a rehearing of the decision.**

- *Managed Pharmacy Care, et al. v. Sebelius, et al.*

Plaintiffs, a Medi-Cal beneficiary, five pharmacies, a statewide pharmacy member group, an independent living center, and the state association of independent living centers, challenge the October 27, 2011 action of defendant Secretary of the U.S. Department of Health and Human Services (HHS), approving a SPA of defendant California Department of Health Care Services for a 10% Medi-Cal payment reduction. Plaintiffs allege that Medi-Cal payment reductions mandated by AB 97 (as amended by AB 102) violate requirements set forth in 42 U.S.C. section 1396a(a)(30)(A), and that HHS violated the Federal Administrative Procedure Act in approving the SPA. Plaintiffs also allege violation of the due process clause of the 14th Amendment, the Fifth Amendment, and the Privileges and Immunities Clause of the U.S. Constitution.

On December 28, 2011, the district court issued ~~an~~ **a preliminary** injunction ~~enjoining implementation of the reduction on Medi-Cal reimbursement to providers of pharmacy services in the Medi-Cal fee for service program on or after June 1, 2011.~~ **against the 10% reduction for prescription drugs.** All requests for stay have been denied. On March 12, 2012, the district court issued an order modifying the preliminary injunction to allow the Department to apply the payment reduction **for prescription drugs provided** to services rendered from June 1, 2011 through December 27, 2011 that are reimbursed for the first time on or after December 28, 2011. ~~The parties have completed their appellate briefs and the hearing is set for~~

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~~October 10, 2012.~~ **On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On January 28, 2013, the plaintiffs requested a rehearing of the decision.**

- *California Medical Transportation Association v. Douglas, et al.*

Plaintiffs filed a Complaint for Injunctive and Declaratory Relief challenging the validity of the 10% reduction under AB 97 for reimbursements to providers of NEMT services in the Medi-Cal fee-for-service system. Plaintiffs allege that the implementation of the AB 97 reductions for NEMT services violates 42 U.S.C., section 1396a(a)(30)(A). Additionally, Plaintiffs allege that Defendant Secretary Kathleen Sebelius' approval of the SPA that sets forth the 10% reduction for NEMT services violates 5 U.S.C., sections 701-706.

On January 10, 2012, the district court issued an injunction enjoining implementation of the reduction on reimbursement for NEMT services on or after June 1, 2011. The court subsequently modified the injunction to allow the Department to implement the 10% reduction for NEMT services rendered prior to January 10, 2012, that had not been reimbursed prior to that date. Defendants appealed. Plaintiffs appealed the court's decision allowing some retroactive implementation of the reduction. ~~The parties have completed their appellate briefs and the hearing is set for October 10, 2012.~~ **On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction with respect to the AB 97 rate freeze and reduction for DP/NFs. On January 28, 2013, the plaintiffs requested a rehearing of the decision.**

- *California Medical Association v. Douglas, et al.*

Plaintiffs include the California Medical Association, California Dental Association, and California Pharmacy Association. Plaintiffs challenge the validity of a 10% reduction in Medi-Cal payments for physician, dental, pharmacy, and other services, authorized by AB 97. The federal government (Kathleen Sebelius, Secretary of Health and Human Services), which recently approved a SPA concerning the 10% reductions, is also named as a co-defendant. Plaintiffs contend the reductions violate 42 U.S.C. section 1396a(a)(30)(A).

On January 31, 2012, the court issued an injunction prohibiting implementation of the payment reductions for physicians, dentists, clinics, non-drug pharmacy services, emergency medical transportation, medical supplies, and durable medical equipment, except for services rendered prior to January 31, 2012 that are not reimbursed at the unreduced rates prior to that date. The Department appealed, and Plaintiffs appealed that portion of the district court's order excluding some services from the injunction. On March 22, 2012, the Ninth Circuit denied the Department's request for a stay of the injunction pending appeal. ~~The parties have completed their appellate briefs and the hearing is set for October 10, 2012.~~ **On December 13, 2012, the Ninth Circuit issued a decision reversing the preliminary injunction**

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with respect to the AB 97 rate freeze and reduction for DP/NFs. On January 28, 2013, the plaintiffs requested a rehearing of the decision.

- California Hospital Association v. David Maxwell-Jolly

This lawsuit seeks to enjoin a “freeze” in rates for the 2009-10 rate year (i.e. freeze rates at the 2008-09 rate levels) for hospital based nursing facility and sub-acute care services and the extension to some small and rural hospitals of the 10% reduction for non-contract hospital inpatient services. Plaintiff alleges violations of various federal Medicaid laws, including 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30), and that implementation of these statutory changes is preempted by the Supremacy clause of the United States Constitution.

On February 24, 2010, the district court issued a preliminary injunction against the 10% reduction for small and rural hospitals and the freeze in rates for hospital based nursing facility and sub-acute services. On appeal, the Ninth Circuit granted the Department’s motion for a stay of appellate proceedings pending petitions for certiorari in Maxwell-Jolly v. Independent Living Centers and Maxwell-Jolly v. California Pharmacists Association. On March 30, 2012, the Ninth Circuit ordered an end to the stay. This case has been referred to non-binding mediation in the Ninth Circuit, so there will be no further briefs submitted by the parties until the mediation is complete.

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

Plaintiffs, an individual Federally Qualified Health Center (FQHC) and an association representing multiple Rural Health Clinics (RHCs), allege that the Department illegally applied the 2009 elimination of certain optional Medi-Cal benefits required by ABX3 5 (Chapter 20, Statutes of 2009) to FQHCs and RHCs. Plaintiffs contend that certain benefits are mandatory when provided by an FQHC and seek to compel the Department to continue to reimburse FQHCs for these services. Plaintiffs contend that W&I Code section 14131.10 is preempted via the Supremacy Clause of the US Constitution as to Departmental payment to FQHCs and RHCs for the provision of these eliminated benefits.

On October 20, 2010, the district court issued an order enjoining the Department from disallowing certain optional benefits to RHCs and FQHCs until the applicable SPA was approved by CMS. Both the Department and Plaintiffs appealed. The SPA was approved by CMS on May 23, 2011. Plaintiffs are still challenging the elimination of optional benefits based on “new evidence” they allege they have discovered. The Department is requesting that this issue be sent back to the district court for consideration. In the meantime, the issue of whether the Department can implement a reduction of services prior to CMS’ approval of a SPA remains in front of the Ninth Circuit Court of Appeals.

INFORMATION ONLY:**27. Managed Care Potential Legal Damages**

Four health plans filed lawsuits against the Department challenging the Medi-Cal managed care rate setting methodology for the rate years from 2002 through 2005. The cases are referred to as:

- *Santa Clara Family **County** Health Authority dba Santa Clara Family Health **Plan** v. DHCS*
- *Health Net of California, Inc. v. DHCS*
- *Blue Cross of California, Inc., dba Anthem Blue Cross v. DHCS*
- *Molina Healthcare of California, Inc., v. DHCS*

On April 20, 2011, the trial court issued a judgment in favor of the plaintiff in the Santa Clara County Health Authority case and on June 13, 2011, judgment was issued in favor of the plaintiffs in the Health Net, Blue Cross, and Molina Healthcare cases. In all of the cases, the trial court determined that the Department had breached its contract with the managed care plans for the years in question. The Department is in appellate mediation on damages and interest for each of these cases, but mediation has not been completed.

On November 2, 2012, the Department and Health Net reached a settlement agreement for capitation rate disputes regarding rate years 2003-04 through 2010-11. In the settlement, Health Net agreed to seek dismissal of its 2006-07 through 2010-11 rate litigation and the Department agreed to seek dismissal in its appeal of the adverse Superior Court ruling in the 2003-04 and 2004-05 rate litigation. Additionally, the Department agreed to extend contracts:

- **#03-76182: Extension through March 31, 2019, for Los Angeles County,**
- **#12-89334: A) Extension through June 30, 2020, for San Diego County,**
B) Extension through December 31, 2018, for Sacramento County,
and
C) Extension through December 31, 2022, for Kern, Stanislaus,
Tulare, and San Joaquin Counties. This is the recently awarded
Central Valley Two-Plan Model Commercial Health Plan contract (as
evidenced in the Notice of Intent to Award dated May 4, 2012, award
such contract to Health Net).

The Department also agreed to make contract revisions regarding audits, operational efficiencies, and encounter data submissions, as well as the limitations regarding retroactive rate reductions as they pertain to the imposition of copayment policies, elimination of covered benefits and/or services, and/or future DHCS initiated provider rate reductions. The settlement will terminate of its own accord between 2020 and 2023; the Department may be required to make a payment pursuant to the settlement agreement to Health Net at that time.

- *Molina Healthcare of California v. Toby Douglas*

This assumption has been moved to "Other: Audits and Lawsuits: Old Assumptions" section.

INFORMATION ONLY:*AIDS Healthcare dba Positive Healthcare*

Plaintiff seeks declaratory and injunctive relief to prohibit the Department from complying with W&I Code section 14105.46. The complaint alleges that section 14105.46 violates State and federal law, because that State statute illegally compels AIDS Healthcare Foundation (AHF) to accept payment under the methodology set forth in the federal 340B program for the drugs it provides to persons with HIV and AIDS.

As the result of a Motion to Dismiss filed by the Department, on March 15, 2010, the court dismissed this case in its entirety, with prejudice. Plaintiff filed an appeal, and argument was held on October 12, 2011. On November 3, 2011, the Ninth Circuit U.S. Court of Appeals issued an unpublished decision affirming in part and reversing in part the lower court's dismissal of the case. Plaintiff's claims for violations of equal protection, 42 U.S.C. section 1396a(a)(30)(A), and failure to obtain federal approval of a SPA will proceed. ~~The Court ordered a pre-trial conference on September 24, 2012 and trial on October 23, 2012.~~ **In October 2012, the U.S. District Court stayed this case pending a ruling in the AB 97 consolidated appeal. On December 13, 2012, the Ninth Circuit Court of Appeal issued a decision in the AB 97 consolidated cases, but the decision is not yet final. The Department has filed a motion to continue the stay in the AIDS Healthcare case to be heard on February 25, 2013.**

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

This lawsuit sought to enjoin the elimination of Medi-Cal coverage of adult day health care (ADHC) services, as required by AB 97 (Chapter 3, Statutes of 2011). Plaintiffs contend that elimination of Medi-Cal covered ADHC services violates various federal laws, including the Americans with Disabilities Act. The Department and plaintiffs entered into a settlement agreement, which was approved by the court in January 2012. The settlement ended ADHC services effective February 29, 2012, and established Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective March 1, 2012. The settlement agreement will be in effect until August 2014, with the court retaining jurisdiction during the pendency of the settlement.

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

This lawsuit seeks to enjoin a freeze in the Medi-Cal rates paid to intermediate care facilities for the developmentally disabled (ICF/DDs), including ICF/DD-Hs (habilitative) and ICF/DD-Ns (Nursing), and freestanding pediatric sub-acute care facilities (W&I Code section 14105.191 (f)(2)). Plaintiffs contend that the state violated 42 U.S.C. sections 1396a(a)(13) and 1396a(a)(30)(A) in enacting and implementing the rate freeze, and that the freeze statute is therefore preempted by federal law under the supremacy clause of the United States Constitution. The status of the case is as follows:

- On May 6, 2011, the court issued a preliminary injunction against the rate freeze,
- On June 28, 2011, the United States Court of Appeals (Ninth Circuit) granted the Department request for a stay of the preliminary injunction pending appeal,

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- On November 30, 2011, the Ninth Circuit issued a decision reversing the preliminary injunction, and
- On March 21, 2012, the district court granted plaintiffs' motion for leave to amend their complaint to state a claim under the "takings" clause of the Constitution, and to name HHS Secretary Sebelius as a defendant. The district court stayed further litigation pending a decision by the Ninth Circuit on remand in the Independent Living litigation.

30. California Pharmacists Association v. David Maxwell-Jolly

This lawsuit challenges the legality of a new upper billing limit provision concerning maximum allowable ingredient costs (MAICs) and the use of recently reduced average wholesale prices (AWPs) in reimbursing drugs. Plaintiffs claim that the State has not complied with 42 U.S.C. section 1396a(a)(30)(A) in enacting and implementing these changes.

On May 5, 2010, the district court issued an order granting preliminary injunction concerning the new upper billing limit and new MAICs, but denying preliminary injunction concerning the AWP reductions. The Department and plaintiff both appealed. On April 2, 2012, the Ninth Circuit lifted a stay of the appellate litigation that had been in effect. The preliminary injunction remains in effect. The Ninth Circuit has postponed appellate court briefing to allow the parties time to first explore possible settlement.

31. Centinela Freeman Emergency Medical Associates, et al. v. Maxwell-Jolly

This 2009 class action lawsuit was brought by five physician groups who allege that the Medi-Cal reimbursement rates for emergency room physicians are inadequate and that the Department has the duty to review these rates annually. Plaintiffs allege the following causes of action:

- Violation of the Equal Protection Clause,
- Violation of 42 U.S.C. section 1396a(a)(30)(A) of the Federal Medicaid Act, and
- Violation of Welfare & Institutions Code section 14079 (duty to review rates annually).

The third cause of action (duty to review rates annually) was transferred to a different judge to be heard separately from the other two causes of action. Based on the hearing on the third cause of action, the Court ordered the Department to conduct an annual review of reimbursement rates for all physician and dental services. The Rate Review was filed with the court on December 16, 2011. On March 15, 2012, the court ordered the parties to proceed on the two remaining causes of action. On April 30, 2012, the Department filed a demurrer to the (a)(30)(A) cause of action. The hearing on the demurrer was held on June 28, 2012, and the demurrer was sustained without leave to amend, which disposed of the second cause of action. The Department intends to file a motion for summary judgment on the remaining Equal Protection cause of action.

INFORMATION ONLY:**32. Family Planning Services – Los Angeles County Claims Reviewed by the OIG**

The Office of the Inspector General (OIG) plans to conduct an audit of family planning services claimed under the Family PACT program in Los Angeles County. The audit will determine whether the Department complied with Federal and State requirements when claiming Federal reimbursement at the 90% rate for family planning services provided under the Family PACT program. The audit period covers payments made during the period October 1, 2010 through September 30, 2011.

33. Marquez v. California Department of Health Care Services, David Maxwell-Jolly Lawsuit

In this pending litigation, the petitioners seek a writ of mandate that would require the Department to provide a Medi-Cal beneficiary with a due process notice (Notice of Action) and the right to appeal (Fair Hearing) when other health coverage (OHC) is added to a Medi-Cal beneficiary's record. Alternatively, petitioners contend that the Medi-Cal program should change from a cost avoidance system to a "pay and chase" recovery process.

OTHER: REIMBURSEMENTS**34. Federal Upper Payment Limit**

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

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

35. Selective Provider Contracting Program Waiver Renewal

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

On July 1, 2013, the Department will implement a new payment system, which will replace the SPCP and existing non-contract payment system.

INFORMATION ONLY:**36. Accrual Costs Under Generally Accepted Accounting Principles**

Medi-Cal has been on a cash basis for budgeting and accounting since FY 2004-05. On a cash basis, expenditures are budgeted and accounted for based on the fiscal year in which payments are made, regardless of when the services were provided. On an accrual basis, expenditures are budgeted and accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. Under Generally Accepted Accounting Principles (GAAP), the state's fiscal year-end financial statements must include an estimate of the amount the state is obligated to pay for services provided but not yet paid. This can be thought of as the additional amount that would have to be budgeted in the next fiscal year if the Medi-Cal program were to be switched to accrual. For the most recently completed fiscal year (FY 2011-12), the June 30, 2012 Medi-Cal accrual amounts were estimated to be \$1.95 billion state General Fund and \$7.42 billion federal funds, for a total of \$9.37 billion.

37. Freestanding Clinic – Former Agnews State Hospital

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

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

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

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

38. Refund of Recovery

CMS requested the Department prepare reconciliations of Grant awards vs. federal draws for all fiscal years. The Department determined FFP was overpaid on some recovery activities. As a result of this determination, the Department is correcting the reporting of overpayments on the CMS 64 report. The Department expects a one-time refund of \$240 million FFP for federal FY 2007 through 2011 and \$34 million FFP ongoing each month.

OTHER: RECOVERIES

INFORMATION ONLY:

FISCAL INTERMEDIARY: MEDICAL

39. Fiscal Intermediary (FI) Notification of Claims - Pending

In the FI Contract with Xerox State Healthcare, LLC (Xerox), Xerox uses a Notification of Claims (NOC) to report to the Department any conduct that may result in or require a change in the contract and/or to the original bid amount. The NOC details work that is beyond the normal scope of services. The Department assesses Xerox's NOCs and either approves, denies or requests additional information. If approved, the Department issues negotiated payment to Xerox. Xerox submitted the following NOCs:

- HIPAA 5010/DO
- Diagnosis Related Grouping (DRG)
- Affordable Care Act Primary Care Physician Rate Increase
- Operating Rules for Eligibility and Claim Status Transactions
- Data Elements Not Present on 835 Transaction

The Department is reviewing the above-mentioned NOCs. If the Department approves the NOCs and they result in additional payment, costs may occur in FY 2013-14

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS**Fully Incorporated into Base Data/Ongoing****ELIGIBILITY**1. 250% Working Disabled Program (WDP) Changes

The WDP, established in April 2000, allows for employed individuals with disabilities to earn up to 250% of the federal poverty level and receive full scope Medi-Cal benefits. All eligible individuals and couples are required to pay a monthly premium based on their countable income.

AB 1269 (Chapter 282, Statute of 2009) requires the Department to implement changes to the program 30 days after ARRA enhanced federal funding ends on June 30, 2011. The provisions are:

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

However, under the Maintenance of Effort (MOE) requirements of the Affordable Care Act (ACA) 2010, states cannot implement more restrictive Medicaid eligibility policies, procedures or methodologies without the possibility of losing federal funding for their Medicaid programs. The MOE provisions are in effect until January 1, 2014 for adults and 2019 for children. Therefore, the Department will not be able to implement provision four at this time, since it would be more restrictive. The first three provisions were implemented effective August 1, 2011.

BENEFITS2. Elimination of OTC Cough and Cold Products

AB 97 (Chapter 3, Statutes of 2011) eliminated selected nonprescription cough and cold products as Medi-Cal benefits for adults and children. Children eligible for EPSDT are exempt from this provision.

HOME & COMMUNITY-BASED SERVICES**BREAST AND CERVICAL CANCER****PHARMACY**

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

3. Kalydeco for Treatment of Cystic Fibrosis

Effective January 31, 2012, the U.S. Food and Drug Administration approved Kalydeco for the treatment of patients, six years and older, with cystic fibrosis (CF) who have a specific mutation in the CF regulator gene.

1115 WAIVER—MH/UCD & BTR

MANAGED CARE

4. Managed Care Default Assignment

AB 1467 (Chapter 23, Statutes of 2012) requires beneficiaries in the Family or Seniors and Persons with Disabilities (SPD) aid categories who do not choose a plan to be defaulted in a plan based on default ratios which consider health plan quality of care and cost.

PROVIDER RATES

5. Preserving Contract Hospitals

SB 90 (Chapter 19, Statutes of 2011) included a provision that required a reduction in amount of any QAF supplemental payment for a contract hospital that converts to non-contract status. This reduction is equal to the amount by which the hospital's overall payment for Medi-Cal services was increased during the program period by reason of it becoming a noncontract hospital.

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

6. Overpayments – Interest Rate Change

The Department assesses interest on overpayments made to Medi-Cal providers at a rate equal to the monthly average received on investments in the Surplus Money Investment Fund (SMIF). AB 1467 (Chapter 23, Statutes of 2012) authorizes the Department to update the interest rate to the California Constitution rate or the SMIF rate, whichever is higher.

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

DISCONTINUED ASSUMPTIONS

Fully Incorporated into Base Data/Ongoing

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Time Limited/No Longer Available

ELIGIBILITY

BENEFITS

HOME & COMMUNITY-BASED SERVICES

BREAST AND CERVICAL CANCER

PHARMACY

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MANAGED CARE

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

DISCONTINUED ASSUMPTIONS

Withdrawn

ELIGIBILITY

BENEFITS

1. Cervical Cancer Screening

Currently, women age 25 and older receive a Papanicolaou (Pap) test every year. If the Pap test is abnormal, additional tests may be allowed. The clinician determines the frequency of the Pap test based on the woman's risks and the need to follow-up abnormal results.

The United States Preventive Services Task Force (USPSTF) guideline for cervical cancer screening was revised on March 2012.

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

- Before Age 21: No Pap test
- Age 21 – 29: Pap test every three years
- Age 30 – 65: Pap test every three years or Pap test and HPV test every five years
- After Age 65: No Pap test

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

HOME & COMMUNITY-BASED SERVICES

1. Reduction in IHSS Authorized Hours

SB 73 (Chapter 34, Statutes of 2011) imposed a 20% service hour reduction on IHSS recipients effective January 1, 2012, when the 2011-12 Budget "Trigger Reductions" became operative. Individuals receiving IHSS hours through a 1915(c) waiver would be exempt. The bill also established an IHSS Care Supplement process for any individual who is notified of a reduction in service hours, but is believed to be at serious risk of out-of-home placement unless all or part of the reduction was restored. The IHSS Care Supplement process requires the individual to submit an application to the county to determine risk. The county would determine whether IHSS hours will be partially or fully restored to avoid risk of out-of-home placement.

The Department submitted to CMS a SPA with an effective date of November 1, 2013. A court order issued on March 2, 2012 (*David Oster et al. v. Lightbourne and Douglas*) enjoined the Department and CDSS from implementing provisions of SB 73.

DISCONTINUED ASSUMPTIONS

Withdrawn

In March 2013, a settlement was reached in the *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger* lawsuits. The settlement provides that commencing July 1, 2013, the IHSS program will continue the 3.6% reduction of service hours with an additional 4.4% reduction, for a total of 8%.

BREAST AND CERVICAL CANCER

PHARMACY

1115 WAIVER—MH/UCD & BTR

1. NDPH Payments Changes

Prior to FY 2012-13, NDPHs received either SPCP negotiated per diem rates for contract facilities or cost-reimbursement for non-contract facilities with 50% FFP and 50% GF for Medi-Cal hospital inpatient services. AB 1467 (Chapter 23, Statutes of 2012) provides the authority to:

- Replace the current reimbursement with CPEs based reimbursement,
- Eliminate NDPH SB 1100 and AB 113 IGT supplemental payments, and
- Request federal approval to increase Safety Net Care Pool (SNCP) and DSRIP funding available for NDPHs.

MANAGED CARE

1. Transition of Dual Eligibles-Medicare Savings

The Department identified demonstration projects to integrate Medicare and Medicaid services under a new 1115 Demonstration Project Waiver. The new waiver includes providing long-term care services and supports for dual eligible beneficiaries. The goals of the pilot projects include:

- Coordinating Medi-Cal and Medicare benefits across health care settings to improve continuity and access to acute care, long-term care, and HCBS,
- Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services, and
- Increasing the availability of and access to home and community-based alternatives.

The Department has identified demonstration projects in Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara counties. Implementation will begin between March 2013 and June 2013. The demonstration assumes shared savings between Medicare and Medicaid. A blended rate for health care costs split between Medicare and Medicaid is yet to be determined.

DISCONTINUED ASSUMPTIONS

Withdrawn

2. Managed Care Efficiencies

The Department continues to seek efficiencies in the provision of services in the Medi-Cal program in order to reduce costs and improve outcomes. Instituting efficiency adjustments in the managed care rate development provides the appropriate financial incentives to health plans to seek efficiencies and avoid unnecessary costs.

PROVIDER RATES

SUPPLEMENTAL PAYMENTS

OTHER: AUDITS AND LAWSUITS

OTHER: REIMBURSEMENTS

1. First 5 California Funding

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

OTHER: RECOVERIES

FISCAL INTERMEDIARY: MEDICAL

2. Cost Reasonableness Contractor

In accordance with the Xerox contract, the Department plans to procure a Cost Reasonableness contractor. The contractor will evaluate the reasonableness and accuracy of any Systems Development Notice, Change Order, or Enhancement cost estimates submitted by the FI Contractor. The Department anticipates completing the procurement in October 2012.

FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

FISCAL INTERMEDIARY: DENTAL

3. CD-MMIS Business Rules Extraction Enhancement

The Business Rules Extraction (BRE) enhancement will identify and extract the business rules in the current legacy CD-MMIS and store the rules in a requirements traceability tool for tracking, future testing, managing and updating.

The Department will hire a contractor to develop a traceability matrix of forward and backward contextual links between the various requirements and the work products

DISCONTINUED ASSUMPTIONS

Withdrawn

developed for implementation, as well as to verify the completeness and accuracy of the requirements. All requirements will be captured including: business, user, functional and test requirements for the entire system.

The CD-MMIS Business Rules Extraction enhancement activities will be delayed due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013.

4. Medi-Cal Dental FI Contract – Runout

The Medi-Cal Dental FI contract was scheduled to end on June 30, 2012; however, since the Department is exercising the one-time extended operations option of the current Dental FI Contract for the period of July 1, 2012 to June 30, 2013, all Runout activities will be delayed.

5. Dental Managed Care Encounter Data Enhancement

The federal government is requiring that HIPAA-covered entities adopt new versions of the transaction requirements (5010) for electronically exchanging critical administrative health care data. The Medical FI, Xerox is enhancing CA-MMIS to address the 5010 requirement. The Dental Managed Care Plans will submit encounter data to the Medical FI in the new standard transaction formats. The Medical FI will pass the encounter data to the Dental FI, consequently CD-MMIS must be enhanced to accept the new format from CA-MMIS.

However, the DMC encounter data enhancement activities will be delayed due to the Department exercising the one-time extended operations option of the current Dental FI Contract for the period of June 1, 2012 through June 30, 2013.