

MEDI-CAL ASSUMPTIONS
November 2013
FISCAL YEARS 2013-14 & 2014-15

TABLE OF CONTENTS

Eligibility ..... 3
Affordable Care Act ..... 19
Benefits ..... 30
Home & Community Based Services ..... 41
Breast and Cervical Cancer Treatment ..... 57
Pharmacy ..... 60
Drug Medi-Cal ..... 65
Mental Health ..... 69
1115 Waiver—MH/UCD & BTR ..... 77
Managed Care ..... 94
Provider Rates ..... 105
Supplemental Payments ..... 124
Other: Audits and Lawsuits ..... 131
Other: Reimbursements ..... 136
Other: Recoveries ..... 149
Fiscal Intermediary ..... 151
Fiscal Intermediary: Medical ..... 151
Fiscal Intermediary: Health Care Options ..... 161
Fiscal Intermediary: Dental ..... 164
Information Only ..... 169
Discontinued Assumptions ..... 190

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-10)	X	<p><u>County Health Initiative Matching Program</u></p> <p>Pursuant to Assembly Bill (AB) 495 (Chapter 648, Statutes of 2001), the County Health Initiative Matching (CHIM) Program was enacted and began operations in April 2004. The Managed Risk Medical Insurance Board (MRMIB), via contracts with three counties (San Francisco, San Mateo and Santa Clara) operates CHIM. This program provides health coverage for eligible children up to age 19 in families with incomes between 250 and 400 percent of the federal poverty level that are not eligible for Medi-Cal or the Healthy Families Program. Coverage is provided through county-sponsored insurance programs, which provide comprehensive benefits similar to the Healthy Families Program. Program costs are funded by matching county expenditures with Title XXI federal funds in participating counties that have been approved by the federal government. MRMIB manages the transfer of federal funds, and the counties administer the program. Pursuant to AB 1494 (Chapter 28, Statutes of 2012), effective January 1, 2013, children with incomes at or below 250 percent of the federal poverty level in the HFP began transitioning into Medi-Cal through a phase-in methodology. Additionally beginning November 2013, infants born to mothers in the Access for Infants and Mothers (AIM) Program will begin transitioning into the Medi-Cal delivery system through a phase-in methodology. Given these transitions of children's coverage from MRMIB to DHCS, and implementation of health care reform, beginning January 1, 2014, DHCS will be vested with the duties of MRMIB in carrying out the activities of CHIM. Due to the maintenance of effort (MOE) requirements of ACA, if an applicant county elects to cease funding the nonfederal share, state general fund shall be provided until the MOE obligation is no longer applicable.</p>
E 0.2	(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 2014-15.</p>

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"PC" refers to "Policy Change".

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

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

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

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

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

**ELIGIBILITY: NEW ASSUMPTIONS**

	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
E 0.3 (PC-212)	X	<u>AIM Linked Mothers 200-300% FPL</u>
		<p>Effective July 1, 2014, Access for Infants and Mothers (AIM) linked mothers with incomes between 200-300% of the federal poverty level (FPL) will begin transitioning into the Medi-Cal delivery system. Mothers 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.</p> <p>The AIM linked mothers program is funded with Cigarette and Tobacco Surtax Revenues (Proposition 99), subscriber fees, and eligible Title XXI funding.</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		C/Y	B/Y	
E 1	(OA-10) (OA-69)	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 to 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. Effective January 1, 2013, all new applications submitted to SPE, whether paper or electronic, will be screened and forwarded to counties for a Medi-Cal determination. Effective January 1, 2013, the contract with the vendor for the HFP transition includes Single Point of Entry activities. <b><u>With the successful transition of all children from HFP to Medi-Cal, to the extent it is determined that it is an MOE violation to discontinue SPE, DHCS will explore options to continue the process.</u></b></p>
E 2	(PC-NA)	X	X	<p><u>Bridge to HFP</u></p> <p>This assumption has been moved to "Time Limited/No Longer Available" section.</p>
E 3	(PC-12)	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-11)	X	X	<p><u>New Qualified Immigrants</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 Immigrants who enter the country on or after</p>

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

August 22, 1996, for the first five years they are in the country. Most New Qualified Immigrants are only eligible for FFP for emergency services and pregnancy-related services. California is continuing to provide full-scope Medi-Cal services to immigrants who have satisfactory immigration status under the pre-Welfare Reform laws. The cost of nonemergency services provided to the New Qualified Immigrants 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.

~~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.~~

E 5    (PC-8)    X    X

Refugees

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.

The California Department of Public Health (CDPH) administers California's Refugee Resettlement Program federal grant and the Department invoices CDPH for the reimbursement of the Medical Assistance Program expenditures.

E 6    (OA-29)    X    X

SSA Costs for Health Coverage Information

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-12)    X    X

Postage & Printing

Costs for the mailing of various legal notices and the costs for forms used in determining eligibility and available third party

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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 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. 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-11)    X        X        Systematic Alien Verification Entitlement System

The federally mandated Systematic Alien Verification Entitlement (SAVE) system was implemented in California on October 1, 1988. This system allows State and local agencies to make inquiries from a federal database to obtain information on the immigration status of aliens applying for entitlement benefits. The Department conducted an evaluation of the various modes available to access SAVE, and chose the existing Income and Eligibility Verification System to provide that access. County administrative costs for using the SAVE system for Medi-Cal eligibility purposes are reimbursed 100% by the federal government.

E 9    (OA-64)    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

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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 (PC-NA) X X

Outreach – Children

This policy change has been moved to Discontinued Assumptions-Time Limited.

E 11 (CA-2) X X

Statewide Automated Welfare Systems

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).

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.

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, OSI, and the County board of supervisors have reviewed and approved the LEADER Replacement System (LRS) development contract. Development began in November 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.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

The CalWIN consortium and C-IV system are in the maintenance and operation phase.

The State and the counties in the current LEADER and C-IV consortia are working together to develop a new consortium.

E 12 (CA-4)    X    X

CalWORKs Applications

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.

E 13 (PC-6)    X    X  
 (PC-FI)

CHDP Gateway

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 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.

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.

Effective April 1, 2009, the CHIPRA eliminates counting Medicaid child presumptive eligibility costs against the Title XXI allotment,

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

so claims are no longer Title XXI funded. Children screened to HFP continue to be claimed under Title XXI.

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.

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology. All children receiving a screen through the CHDP Gateway program will be pre-enrolled into Medi-Cal. DHCS will continue to receive enhanced Title XXI funding for these children.

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

**Effective January 1, 2013, children receiving a CHDP screen are pre-enrolled in Medi-Cal for Families for up to two months of full-scope benefits, during which time the family can choose to apply for continuing Medi-Cal for Families coverage. Each child, for whom the family indicates a desire for continuing Medi-Cal coverage, is sent a CHDP cover letter and a Medi-Cal for Families application form that is used to screen for the Medi-Cal children’s percent programs.**

E 14 (OA-77) X X

Merit System Services for Counties

Federal regulations require that any government agency receiving federal funds have a civil service exam, classification, and pay process. As many counties do not have a civil service system, the Department contracts with the State Personnel Board for Merit System Services to perform as a personnel board for those counties. Merit System Services administers a civil service system for employment and retention of Medi Cal staff in 30 County Welfare Departments (CWD) and oversight in the other 28 counties.

E 15 (CA-6) X X  
 (CA-9)

County Cost of Doing Business

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

**ELIGIBILITY: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				Department of Finance, or state employee salary increases, whichever is greater.
E 16	(CA-7)	X	X	<u>Los Angeles County Hospital Intakes</u>  Los Angeles County uses Patient Financial Services Workers (PFSWs) to provide intake services for Medi-Cal applications taken in Los Angeles County hospitals. Welfare & Institutions (W&I) Code Section 14154 limits the reimbursement amount for PFSW intakes to the rate that is applied to Medi-Cal applications processed by the Los Angeles County Department of Social Services (DPSS) eligibility workers. The federal share for any costs not covered by the DPSS rate is passed through to the county.
E 17	(CA-NA)		X	<u>Eligible Growth</u>  The county administrative cost base estimate does not include costs anticipated due to the growth in the number of Medi-Cal only eligibles. Funds are added through a policy change item based on the cost impact of the expected growth in the average monthly number of Medi-Cal only eligibles. The number is adjusted with each Estimate with updates of the latest base eligible count. The policy change presumes that counties will hire staff to process the new applications and maintain the new cases. Eligible growth <del>will not be</del> <b>was not</b> funded in FY 2013-14 <b><u>and will not be funded in FY 2014-2015.</u></b>
E 18	(OA-66)	X	X	<u>Department of Social Services Administrative Costs</u>  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: <ul style="list-style-type: none"> <li>• In-Home Supportive Services (IHSS) <b><u>programs (which include Community First Choice Option, Personal Care Services Program and the IHSS Plus Option).</u></b></li> <li>• Child Welfare Services/Case Management System (CWS/CMS), <b><u>and</u></b> the</li> <li>• Statewide Automated Welfare System (SAWS).</li> </ul>
E 19	(PC-17) (PC-15) (PC-16)	X	X	<u>Public Assistance Reporting Information System (PARIS)</u>  PARIS is an information sharing system, operated by the U.S. Department of Health and Human Services' Administration for

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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

E 20 (CA-13) X X

County Administration Reconciliation

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 ~~2013-14~~, the Department completed **plans to complete** the final reconciliation for FY 2010-11 ~~2011-12~~ and the **an** interim reconciliation for FY 2011-12 ~~2012-13~~. In FY 2013-14, the Department plans to complete an interim reconciliation for FY 2012-13. **In FY 2014-15, the Department plans to do a final reconciliation for FY 2012-13.**

E 21 (OA-56) X X

Q5i Automated Data System Acquisition

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.

E 22 (OA-21) X X

Medi-Cal Eligibility Data System (MEDS)

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.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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.

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.

**MEDS will include supporting the Advance Premium Tax Credit (APTC) and Cost Share Reduction (CSR) programs after January 2014. The MEDS system will develop unique identifiers for the new population.**

E 23 (OA-75)    X    X

Veterans Benefits

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.

E 24 (PC-13)    X    X

CHIPRA – Full-Scope Medi-Cal for New Qualified and Lawfully Present Immigrant Children and Pregnant Women

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 (referred to as New Qualified Immigrants) 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

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

years. 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). The Department received federal approval of State Plan Amendment (SPA) 09-14 on April 1, 2009 which authorizes the state to implement both of these options. **A new SPA, required for implementation of the Affordable Care Act, will revise the definition of lawful presence for purposes of providing full scope Medi-Cal to pregnant women and children who are lawfully present. Those changes are not expected to impact the cost of this coverage.**

E 25 (PC-5)    X    X  
       (PC-7)  
       (OA-39)

**Medi-Cal Inpatient Services for Inmates**

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.

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.

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

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

the Department to determine eligibility. Previously these services were funded through CDCR with 100% GF.

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 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. **The department is developing the FFP claiming requirements for these county inmate claims and expects to be able to begin processing those claims in January 2014.**

E 26 (PC-NA) X X

Lomeli, et al., v. Shewry

This policy change has been moved to Discontinued Assumptions-Time Limited.

E 27 (PC-1) X X  
 (PC-75)  
 (PC-FI)  
 (OA-10)  
 (CA-5)  
 (PC-73)

Transition of Healthy Families Children to Medi-Cal

**Pursuant to** AB 1494 (Chapter 28, Statutes of 2012) requires, effective January 1, 2013, children subscribed in the HFP **began transitioned transitioning** 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 HFP. Children with incomes at and below 150% of the FPL will not pay premiums.

**ELIGIBILITY: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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.

**In November 2012, The the Department has provided began mailing** written notices to beneficiaries enrolled in ~~Healthy Families describing HFP explaining~~ their transition to the Medi-Cal **Managed Care** program ~~and changes to anticipate prior to their movement into Medi-Cal.~~ **The mailings will continue throughout 2013. They include information notices, frequently asked questions, reminder notices, confirmation letters, and choice packets.**

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 be provided through county mental health departments. County mental health departments are eligible to claim FFP through the CPE process.

E 28 (PC-9) X X

**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 ASSUMPTIONS**

Applicable 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. These requirements will result in an increase in caseload duties for county eligibility workers and additional benefit costs. Effective January 1, 2013, the HFP subscribers began transitioning into Medi-Cal through a phase-in methodology **to be completed in calendar year 2013.** Additionally, the new screening process was implemented, and all applications submitted to SPE are sent to county eligibility workers for a Medi-Cal determination. **Effective January 1, 2014, a new single streamlined application will be used.** Petitioners have applied for an award **and were awarded payment** of attorneys' fees, **which the Department paid in FY 2012-13.**

E 29 (PC-14) X X

Incarceration Verification Program

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 30 (OA-42) X X

Vital Records Data

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 31 (PC-4) X X

AIM Linked Infants 250-300% FPL

Effective ~~October~~ **November** 1, 2013, Access for Infants and Mothers (AIM) Linked Infants will begin transitioning into the Medi-

**ELIGIBILITY: OLD ASSUMPTIONS**Applicable F/Y  
C/Y    B/Y

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.

**E 32**   **(PC-29)**   **X**  
**(CA-8)****State-Only Former Foster Care Program**

**AB 82 (Chapter 23, Statutes of 2013) extends Medi-Cal benefits to all former foster care youth who turn 21 years old between Jul 1, 2013 and December 31, 2013. Without this extension, they otherwise would have lost coverage. Costs for the extension of coverage will be 100% State funded.**

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## 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.

## AFFORDABLE CARE ACT: NEW ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
ACA 0.1 (PC-27)	X	X	<p><u>USPSTF Grade A and B Recommendations</u></p> <p>Effective January 1, 2013, the Affordable Care Act (ACA) provides states with the option to receive an additional 1% in FMAP for providing United States Preventative Services Task Force (USPSTF) recommended grade A or B preventive services and adult vaccines. Eligible preventive services must be part of the standard Medicaid benefit package and states cannot impose copayments for these services. The State provides these preventive services within the existing standard benefit package with no imposed cost sharing. To stay current with the most recent recommendations, the Department will update its coverage and billing codes to comply with recommendations made by the USPSTF.</p>
ACA 0.2 (PC-25) (OA-26)	X	X	<p><u>ACA Expansion – Presumptive Eligibility by Hospitals</u></p> <p>The ACA requires the Department to give hospitals the option, as of January 1, 2014, to determine presumptive eligibility for Medicaid. A qualified hospital may elect to make presumptive eligibility determinations on the basis of preliminary information and according to policies and procedures established by the Department. The Department will permit presumptive eligibility under this provision for:</p> <ul style="list-style-type: none"> <li>• Pregnant women;</li> <li>• Infants and children under the age of 19;</li> <li>• Parents and other caretaker relatives;</li> <li>• Childless adults 19-64; and,</li> <li>• Former foster care youth.</li> </ul> <p>The State anticipates that many of the eligible hospitals will participate. This requires the development of a simplified application form, online application and systems interfaces with MEDS or a manual process for county eligibility workers.</p>
ACA 0.3 (PC 205)	X	X	<p><u>Health Insurer Fee</u></p> <p>The ACA requires a Health Insurer Fee to be levied on all non-exempt insurers. The fee will be effective January 1, 2014, and will be collected by the federal government in September 2014. The Department will pay increased capitation rates to Medi-Cal Managed Care plans to fund the Health Insurer Fee.</p>

## AFFORDABLE CARE ACT: NEW ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
ACA 0.4 (PC 206)	X	X	<p><u>ACA Express Lane Enrollment</u></p> <p>The Centers for Medicare and Medicaid has provided several options to facilitate enrollment into the Medicaid programs. These options are designed to alleviate the influx of applications under the ACA by providing Medicaid eligibility to certain groups without conducting a separate Medicaid eligibility determination. SBx1 1 (Chapter 4, Statutes of 2013) requires the Department to seek the necessary federal waivers to implement two of these options. The targeted groups that would be provided Express Lane Enrollment into Medi-Cal are:</p> <ul style="list-style-type: none"> <li>• CalFresh adult and children eligibles; and</li> <li>• Parents/caretaker relatives of Medi-Cal income eligible children.</li> </ul>
ACA 0.5 (CA-14)	X	X	<p><u>Enhanced Federal Funding</u></p> <p>As part of guidance related to implementation of the ACA, the Centers for Medicare and Medicaid Services (CMS) has published guidance concerning federal funding for eligibility determination functions. CMS considers certain eligibility determination-related costs to fall under Medicaid Management Information Systems (MMIS) rules for approval of enhanced 75% federal funding. The enhanced 75% federal funding is available for costs of the application, on-going case maintenance and renewal functions. Funding remains at 50% for policy, outreach, and post-eligibility functions.</p>

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
ACA 1 (PC-19)	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. <b><u>CMS approved SPA 13-003 in October 2013.</u></b></p>
ACA 2 (PC-34)	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"> <li>• Geographic Managed Care (GMC) health plans</li> <li>• Two-Plan model health plans, and the</li> <li>• Health Plan of San Mateo (HPSM), a County Organized Health System (COHS).</li> </ul> <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-NA)	X		<p><u>Federal Drug Rebate Change</u></p> <p>This assumption has been incorporated into the Federal Drug Rebate assumption.</p>
ACA 4 (OA-8)	X	X	<p><u>CalHEERS Development</u></p> <p>The ACA mandates the establishment of health insurance exchanges, in California, known as <del>the Health Benefit Exchange (HBEX)</del> <b><u>Covered California</u></b> to provide competitive health care coverage for individuals and small employers. As required by ACA, States must establish 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</p>

**AFFORDABLE CARE ACT: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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-34) X    X  
(OA-40)

MEDS Interface with CalHEERS

CalHEERS will be programmed to provide Modified Adjusted Gross Income (MAGI) eligibility determinations for individuals seeking coverage through 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 CalHEERS.

The Department hired 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 project in FY 2013-14. The Department anticipates hiring contractors to assist with:

- The writing of the Request for Proposal (RFP),
- Procurement,
- Design,
- Development, and
- Implementation.

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

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

alignment with the federal Medicaid Information Technology Architecture (MITA). **The Department anticipates that the MEDS Modernization project will start in July 2014 and continue through June 2020.**

ACA 6 (OA-28)    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-20)    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.

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

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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~~ **expired on** July 6, 2013. Thus, the Department ~~must amend the~~ **submitted SPA 13-007 on May 3, 2013, with an** effective ~~July 6, 2013~~ date of July 1, 2013, to reflect updates to the State Plan that are in compliance with the final regulation.

ACA 8 (PC-FI) X	X	<p><u>Implementation of ACA Rules</u></p> <p>Effective March 2011, CMS mandated new federal rules that apply to the Medi-Cal 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.</p> <p>To <del>stay in</del> <b>work towards</b> compliance, the Dental FI needs to hire additional staff. Additional costs are expected to be incurred beginning in <del>March</del> <b>September</b> 2013.</p>
ACA 9 (PC-24) X (PC-148)	X	<p><u>Add-on for LTC (Non-AB 1629 &amp; AB 1629) Facilities</u></p> <p>Effective <del>2014</del> <b>2015</b>, 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 <del>2014</del> <b>2015</b>.</p>
ACA 10 (PC-31) X (OA-57)	X	<p><u>Recovery Audit Contractor</u></p> <p>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 providers. RACs are paid on a contingency basis based on the following terms:</p> <ul style="list-style-type: none"> <li>• 12.5% of amounts recovered after an identified overpayment, and</li> </ul>

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

- 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~~ **approved** the final contract in FY 2012-13.

ACA 11 (PC-FI) X 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-32) X X  
(PC-33)

### 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 **and \$600 million for FY 2014-15**. Reductions will increase for each fiscal year through FY 2019-20. The reduction for each state will be determined by CMS.

ACA 13 (OA-45) X X

### ETL Data Solution

The Centers for Medicare and Medicaid Services (CMS) is requesting data in a standardized format from the states, which

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

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.

ACA 14 (PC-21) X    X  
 (PC-28)  
 (OA-13)  
 (reworded)

### ACA Mandatory Expansion

Effective January 1, 2014, 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.

Enhanced FFP is not available for individuals who are currently eligible for Medi-Cal, but not enrolled.

ACA 15 (PC-30) X    X

### 1% FMAP Increase for Preventive Services

Effective January 1, ~~2014~~ **2013**, the Affordable Care Act (ACA) provides states with the option to receive an additional 1% 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.

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y		
<u>C/Y</u>	<u>B/Y</u>	
ACA 16 (PC-23)	X	<p><u>ACA Expansion-CDCR Adult Inmates Inpatient Hospital Costs</u></p> <p>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.</p>
<u>ACA 17 (CA-3)</u>	X	<p><u>Implementation of ACA</u></p> <p><u>Effective October 1, 2013, open enrollment begins for Medi-Cal beneficiaries with the new ACA mandated rules. To establish eligibility and prepare for full implementation of ACA on January 1, 2014, the Department plans to provide additional funding to counties to:</u></p> <ul style="list-style-type: none"> <li>• <u>Make changes to existing county call centers;</u></li> <li>• <u>Create new county call centers;</u></li> <li>• <u>Hire additional staff needed to handle the expected increase in workload; and,</u></li> <li>• <u>Train new and existing staff on the new rules and system changes.</u></li> </ul>
<u>ACA 18 (PC-18)</u>	X	<p><u>ACA Optional Expansion</u></p> <p><u>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. 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.</u></p> <p><u>The ACA provides California with enhanced FFP for the newly eligible adults at the following rates:</u></p> <p><u>100% FFP from 2014 to 2016,</u>  <u>95% FFP in 2017,</u>  <u>94% FFP in 2018,</u>  <u>93% FFP in 2019,</u>  <u>90% FFP in 2020 and beyond.</u></p>
<u>(PC-26)</u>		
<u>(OA-13)</u>		
<u>(OA-9)</u>		

## AFFORDABLE CARE ACT: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

Effective January 1, 2014, a percentage of the newly eligible NQA population will 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 beginning April 2014.

A percentage of the ACA optional expansion newly eligible population will utilize LTSS benefits. The Department is seeking a waiver from the Centers of Medicaid Services (CMS) for retaining the current asset test for long-term care.

ACA 19 (PC-210) X

ACA Expansion-Pregnancy Only

Effective January 1, 2015, Medi-Cal eligibles who receive pregnancy-only services under the 200% of Federal Poverty eligibility program will have the option of receiving full-scope coverage through Covered California. Medi-Cal will cover the cost of Covered California premiums, out-of-pocket expenses, and services not provided by Covered California plans.

**BENEFITS: NEW ASSUMPTIONS**

	Applicable	F/Y	
	<u>C/Y</u>	<u>B/Y</u>	
B 0.1 (OA-59)		X	<p><u>Newborn Hearing Screening Program</u></p> <p>The Department plans to shift the NHSP Support Contract to the Local Assistance Budget. Currently, the funding for NHSP services are budgeted in the Medi-Cal and Family Health Local Assistance Appropriations and the contract services are budgeted in the State Support Appropriations.</p> <p>The NHSP inpatient and outpatient hearing screens, the diagnostic hearing evaluations, and medical interventions are budgeted in the Medi-Cal and Family Health Estimates.</p> <p>In the December 1997 Budget Change Proposal, State Support costs were identified for the Hearing Coordination Centers (HCC) and the Data Management Service (DMS). The HCCs provide technical assistance and consultation to hospitals in the implementation and ongoing execution of facility hearing screening programs. The HCCs also track and monitor every infant who needs follow-up to assure they receive the needed services and referrals.</p> <p>The DMS supports the reporting, tracking, monitoring and quality assurance activities of the NHSP. The DMS also provides information and data to effectively plan, establish, monitor, and evaluate the NHSP. This includes screening, follow-up, and the comprehensive system of services of newborns and infants who are deaf or hard-of-hearing and their families.</p>
B 0.2 (PC-51)	X	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 November 1, 2013, the Department plans to:</p> <ul style="list-style-type: none"> <li>• Decrease over-utilization of emergency contraception,</li> <li>• Add clinic dispensing of ella® (emergency contraceptive)</li> <li>• Eliminate urine culture, and</li> <li>• Discontinue brand name anti-fungal drugs.</li> </ul> <p>Effective January 1, 2014, the Department plans to:</p>

**BENEFITS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

- Reduce chlamydia screening of women over 25 years of age, and
- Adopt a Medi-Cal Preferred List for oral contraceptives.

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 January 1, 2014, the Department plans to eliminate mammograms and pregnancy test only benefit to maintain compliance with Federal rules.

B 0.3 (PC-66) X X

Voluntary Inpatient Detoxification

Beginning January 1, 2014, SBX1 1 (Chapter 4, Statutes of 2013) provides for voluntary inpatient hospital detoxification services using methadone, non-narcotic drugs, or without medication. This service is included in the essential health benefits package adopted by the State. The service change affects the current Medi-Cal eligibles as well as the ACA mandatory and optional expansion population.

The Department will seek approval of a SPA to implement this new Medi-Cal service.

B 0.4 (PC-208) X X

Children's Dental Utilization

Centers for Medicare and Medicaid Services (CMS) have asked the Department to use comprehensive, coordinated treatment strategies to implement a risk-based disease prevention approach to childhood caries as a chronic disease (like asthma and diabetes). Current oral health guidelines say children should begin regular dental checkups on their first birthday or with their first tooth, the Department will identify beneficiaries ages 0-3 on their birth months that have not had a dental visit during the past 12 months and mail parents/legal guardians of these individuals a letter encouraging them to take their children to see a dental provider as well as educational information about the importance of early dental visits. Early and proper oral health care should ultimately result in better oral health care outcomes and lower future more costly restorative services.

**BENEFITS: OLD ASSUMPTIONS**

B 1 (OA-65) X X

Health Care Program for Children in Foster Care

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.

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.

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.~~ **CDSS continues to work on a timeline that will transfer the Health Care Program for Children in Foster Care to local control.**

B 2 (PC-36) X X

Local Education Agency (LEA) Providers

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-

**BENEFITS: OLD ASSUMPTIONS**

established billing allowances and audits are performed to reconcile actual costs with interim payments.

B 3 (PC-180) X X

Medi-Cal TCM Program

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-179) X X

Targeted Case Management Services – CDDS

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) X X  
(OA-7)

Medi-Cal Administrative Activities

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

Both LGAs and local educational "consortiums" (LECs) contract with the Department for reimbursement and may amend prior year contracts up to the two-year retrospective federal claiming limitation. Prior year contract amendments are generated when

**BENEFITS: OLD ASSUMPTIONS**

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-49) 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-23) 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. CCM-1 was completed with the mandatory enrollment of the SPD population into Medi-Cal managed care health plans;

**BENEFITS: OLD ASSUMPTIONS**

- CCMP-SMI (CCM-2): Persons with chronic health condition(s) and serious mental illnesses. The SMI portion ~~will expire~~ **expired** 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~~ **expired** on ~~August 31, 2014~~ **July 31, 2013**.

B 8	(PC-194)	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-NA)	X	X	<p><u>Physician and Clinic Seven Visits Soft Cap</u></p> <p>This assumption has been moved to the "Withdrawn" section.</p>
B 10	(PC-48)	X	X	<p><u>Hearing Aid Cap</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements a \$1,510 cap per beneficiary for hearing aid expenditures. Hearing aid reimbursements are composed of three primary categories: 1) repairs, 2) ear molds, and 3) hearing aids. The majority of the reimbursements are for the actual costs of hearing aids. Hearing aids may be dispensed individually (monaural) or as a pair (binaural). The hearing aid cap is for adults 21 years of age or older who are not in nursing facilities or pregnant women.</p>
B 11	(PC-50)	X	X	<p><u>Copayment for Non-Emergency ER Visits</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) implements mandatory copayments of <b>up to</b> \$50 for non-emergency use of the emergency rooms at the point of service. This copayment will be implemented <del>without exemptions</del> 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>

**BENEFITS: OLD ASSUMPTIONS****The following are exempted:**

- **Pregnant women**
- **Children under 18 years old, or children in foster care**
- **American Indian/Alaskan Native**
- **Dual Eligible for Medicare and Medicaid**

**An amendment to the 1115 Bridge to Reform Waiver will be submitted to CMS. Approval is not anticipated until January 2014.**

B 12	(PC-182)	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 13	(PC-184) (OA-72)	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 <del>most</del> <b>many</b> dental services for adults 21 years of age and older, CDDS has entered into an interagency agreement with the Department to have the Medi-Cal dental fiscal intermediary process and pay claims for those dental services no longer covered by Medi-Cal. The additional costs of processing claims and benefits will be reimbursed by CDDS. <b><u>With the restoration of select adult dental benefits to beneficiaries 21 years of age and older effective May 1, 2014 per AB 82 (Chapter 23, Statutes of 2013), costs will be adjusted appropriately.</u></b> Processing of CDDS claims started on January 12, 2012.</p>
B 14	(OA-74)	X	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>

**BENEFITS: OLD ASSUMPTIONS**

B 15 (PC-2) X X

Family PACT Program

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.

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.

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.

B 16 (OA-27) X X

Family PACT Evaluation

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 access by targeted populations; change in provider base for targeted geographical areas; provider compliance; claims analysis; and the cost effectiveness of the services.

~~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.~~

**BENEFITS: OLD ASSUMPTIONS**

~~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 17 (OA-32) X X  
(OA-78)

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 **for low-income women and men, including adolescents**. 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.~~

B 18 (PC-FI) X X

Family PACT Materials Distribution

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.

**BENEFITS: OLD ASSUMPTIONS**

B 19	(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 20	(OA-12)	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 and to existing enrollees when a substantial change is made to the notice. Additionally, Medi-Cal must inform all beneficiaries about how to get a copy of this Notice at least every 3 years. 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 21	(PC-47)	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>
B 22	(PC-NA)	X	X	<p><u>Family PACT Retroactive Eligibility</u></p> <p>This assumption has been moved to the "Fully Incorporated into Base Data/Ongoing" section.</p>
B 23	(PC-42)	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</p>

**BENEFITS: OLD ASSUMPTIONS**

resonance imaging (MRIs) and ultrasounds. The provisions of this bill ~~will become~~ **became** operative April 1, 2013 and **will** sunset on January 1, 2019.

B 24 (PC-40) X X

**California Children's Services Program Pilots**

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) Medi-Cal 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:~~ **The four health care delivery models considered for the Demonstration are:**

- Enhanced primary care case management model,
- Provider-based accountable care organization model,
- Existing Medi-Cal managed care plans, and
- Specialty health care plan.

~~The Health Plan of San Mateo expects to begin operation in April 2013 and receive payments beginning in May 2013~~ **began operations effective April 1, 2013.** ~~The Department anticipates other geographical location plans to be implemented in FY 2013-14.~~

**B 25 (PC-38) X X**  
**(OA-24)**

**Restoration of Select Adult Dental Benefits**

**Effective May 1, 2014, AB 82 (Chapter 23, Statutes of 2013) restores select adult dental benefits to beneficiaries 21 years of age and older.**

**The following covered medical benefits will be restored:**

- **Examinations, radiographs/photographic images, prophylaxis, fluoride treatments,**
- **Amalgam and composite restorations,**
- **Stainless steel, resin, and resin window crowns,**
- **Anterior root canal therapy,**
- **Complete dentures, including immediate dentures, and**
- **Complete denture adjustments, repairs, and relines**

**The department will seek approval for federal financial participation and coverage of the above services.**

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## HOME AND 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)

IHSS 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~~ **supervision**.
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~~ **a family member as a provider**.
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.

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## HOME AND 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), Assisted Living (ALW), In-Home Operations (IHO), Multipurpose Senior Services Program (MSSP), HCBS 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 ~~seven~~ **ten** counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, ~~and San Bernardino,~~ **Alameda, Contra Costa, and San Diego**). Waiver participants can elect to receive services in either a Residential Care Facility for the Elderly (RCFE) or through a home health agency while residing in publicly subsidized housing. Approved capacity of unduplicated recipients for this waiver is ~~2,920 in 2012 and~~ 3,700 in 2013 **and 2014**. The waiver is approved from March 1, 2009 through February 28, 2014, **and is expected to be renewed for an additional five years**.

#### 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.), 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. 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 in approved CBAS centers. CBAS was provided through Medi-Cal FFS effective April 1, 2012 **and continues to be provided 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**. On July 1, 2012, CBAS transitioned into five County Organized Health System (COHS) managed care health plans. On October 1, 2012, CBAS transitioned into Two-Plan and GMC managed care plans, as well as one remaining COHS plan, Gold Coast Health Plan. Medi-Cal FFS 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. **As of October 1, 2012, CBAS was transitioned into all managed care health plans**. There is no cap on enrollment into this waiver service.

## HOME AND 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. 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.

The waiver is approved from January 1, 2012 through December 31, 2016.

### San Francisco Community Living Support Benefit (CLSB) Waiver

The CLSB Waiver implements Assembly Bill 2968 (Chapter 830, Statutes of 2006) ~~and will allow~~ **which allows** the San Francisco Department of Public Health (**SFDPH**) 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:

## HOME AND COMMUNITY BASED SERVICES

- 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; and
- 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 SFDPH has not achieved targeted enrollment due to lack of housing in community care facilities and DAH sites. As a result, a waiver amendment has been submitted to adjust enrollment estimates.** The waiver is approved from July 1, 2012 through June 30, 2017.

### 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.

## HOME AND COMMUNITY BASED SERVICES

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 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 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~~ **individuals**. 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, and communication services. Approved capacity of unduplicated recipients for this waiver is ~~16,335 in 2012 and~~ **13,080 for 2013 and 2014**. The waiver is approved from July 1, 2009 through June 30, 2014.

### 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, **115,000 in 2014 and 120,000 in 2015**. 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 CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years

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## HOME AND COMMUNITY BASED SERVICES

effective April 1, 2012 through March 31, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800.

### **Managed Care Programs**

#### Program of All Inclusive Care for the Elderly (PACE)

PACE is a federally defined, comprehensive, and capitated managed care model program that delivers fully integrated services. PACE covered services include all medical, long-term services and supports, dental, vision and other specialty services, 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. The Department has statutory authority to contract with up to 15 PACE organizations.

#### 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, or San Bernardino counties. SCAN does not enroll individuals with End Stage Renal Disease. The Department ~~will not renew the SCAN contract that ends December 31, 2013, and has notified SCAN in accordance with contract requirements~~ **has renewed the SCAN contract through December 31, 2014.**

### **Special 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 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. Grant funds may be requested from January 1, 2007, through September 30, 2016. The grant requires the Department to develop and implement strategies for transitioning Medi-Cal beneficiaries who have resided continuously in health care facilities for three months or longer back to a federally-qualified residence.

**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 the California Department of Social Services' In-Home Supportive Services program, **additional HCBS for Regional Center Clients**, 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 long-term care 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-174) 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.

(PC-39) X    X    B. Multipurpose Senior Services Program – CDA  
(OA-70)

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, the California Department of Aging (CDA) contracts with local government or nonprofit agencies to provide waiver services to individuals 65 years or older who are Medi-Cal eligible and who, in the absence of this waiver and as a matter of medical necessity, would

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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.

No sooner than ~~September 1, 2013~~ **April 1, 2014**, 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 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-181) 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-171) X X  
(OA-61)

### Personal Care Services

In April 1993, the Medi-Cal program began covering personal care services as a benefit, making Title XIX funds available to the IHSS program under the administrative control of CDSS. Protective

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

Applicable F/Y  
C/Y B/Y

supervision and domestic and related services became IHSS-covered benefits 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 no sooner than ~~September 2013~~ **April 2014**. 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-37) X X  
(PC-43)  
(PC-52)  
(OA-44)

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 Department for these services is passed through to both CDDS and CDSS.

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
H 6	(OA-62)	X	X	<p><u>Health-Related Activities - CDSS</u></p> <p>Health-related activities are services that aid Medi-Cal eligibles to gain access to medical services or to maintain current levels of treatment. Title XIX federal funds are passed through to CDSS for health-related activities performed by social workers in the counties.</p>
H 7	(OA-70)	X	X	<p><u>Department of Aging – Administrative Costs</u></p> <p>The federal government provides Title XIX federal financial participation to the California Department of Aging (<b>CDA</b>) for administrative costs related to services provided to Medi-Cal eligibles in Community-Based Adult Services and the Multipurpose Senior Services Program.</p> <p><b><u>The Department also provides enhanced federal funding to CDA for administrative costs related to services provided to eligibles utilizing Aging and Disability Resource Centers (ADRC).</u></b></p>
H 8	(PC-122)	X	X	<p><u>PACE: Program of All-Inclusive Care for the Elderly</u></p> <p>The Department contracts with PACE organizations in various counties for risk-based capitated care of the frail elderly. PACE programs provide all 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 Medi-Cal and Medi-Cal/Medicare (dual eligible) beneficiaries who are determined by the Department to meet 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 (UPL). The Department <del>has proposed Trailer Bill Language</del> <b><u>is working with PACE organizations and proposing changes to current law</u></b> to transition from a UPL-based methodology to an actuarially sound experienced based methodology <b><u>in alignment with the Department’s goal for standardization of managed care rate methodologies</u></b>. PACE rates are set on a calendar year basis, to coincide with the time period of the contracts. <b><u>The anticipated effective date of the new rate methodology will be in FY 2015-16.</u></b></p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		C/Y	B/Y	
H 9	(PC-126) X (PC-141)	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 <del>holds</del> <b><u>had</u></b> a five-year contract with the Department <b><u>that ended on December 31, 2012, but was extended for two additional years through December 31, 2014.</u></b> 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. <b><u>The extension of the contract facilitates the transition of the SCAN Medi-Cal population into existing Medi-Cal programs, including the Cal MediConnect health plan.</u></b></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. <del>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.</del> <b><u>To determine 2014 rates, SCAN will submit a bid based upon costs for Medi-Cal services rendered to its respective population, with the Department using Medi-Cal costs of equivalent populations as comparison points to make adjustments to the bid.</u></b> AB</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				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.
H 10	(OA-49) (PC-44)	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 and mandates the Department to evaluate the pilot project. An independent evaluation of the waiver is also required to meet federal assurances.</p> <p>Effective July 2013, the participating agencies will receive reimbursement for administrative costs.</p>
H 11	(PC-45)	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 program as a 1915(c) HCBS waiver.</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 independent residency units made available by the Direct Access to Housing (DAH) program.</p> <p>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.</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 12	(PC-35)	X	X	<p><u>Additional HCBS for Regional Center Clients</u></p> <p>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. <del>Approval of the SPA is expected in FY 2012-13, with a retroactive date of October 1, 2009.</del> <b><u>The SPA was approved April 25, 2013, retroactive to October 1, 2009.</u></b> ABX3 5 (Chapter 20, Statutes of 2009), eliminated non-emergency medical transportation and various optional services for adults in September 2009. An additional SPA proposes to restore reimbursement for the eliminated services effective October 1, 2010. This will enable persons with developmental disabilities access to HCBS State Plan benefits, other community services, activities, and resources.</p> <p>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.</p> <p>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.</p>
H 13	(OA-44)	X	X	<p><u>CCT Enrollment – Expanded Outreach Administrative Costs</u></p> <p>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.</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
H 14	(PC-46)	X	X	<p><u>Quality of Life (QoL) Surveys for Community Care Transitions (CCT) Participants</u></p> <p>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 beneficiaries within specified timeframes and follow a specific <b>survey</b> methodology. CCT/MFP has participation agreements with lead organizations, which are Medi-Cal home and community-based services 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.</p>
H 15	<del>(PC-32)</del> <del>(PC-FI)</del> (OA-20)	X	X	<p><u>ADHC Transition</u></p> <p>AB 97 (Chapter 3, Statutes of 2011) eliminated Adult Day Health Care (ADHC) services from the Medi-Cal program in FY 2011-12. <del>As a result of</del> <b><u>Resulting from</u></b> the settlement of the lawsuit <i>Darling et al. v. Douglas et al.</i> which challenged the elimination of ADHC services, the ADHC benefit was extended until 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 as a Medi-Cal Fee-For-Service (FFS) benefit.</p> <p><del>On July 1, 2012, CBAS transitioned into five County Organized Health Systems (COHS) managed care health plans. On October 1, 2012, CBAS transitioned into Two-Plan managed care and Geographic Managed Care plans, as well as one remaining COHS plan. The costs were built into the capitation rate. <b><u>As of October 1, 2012, CBAS was transitioned into all managed care health plans.</u></b></del></p> <p>For those CBAS eligible beneficiaries residing in geographic areas where managed care is not available, Medi-Cal FFS provides CBAS benefits. CBAS eligible beneficiaries in managed care counties who do not qualify for managed care enrollment or have an approved medical exemption are eligible to receive:</p>

## HOME & COMMUNITY BASED SERVICES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- CBAS if a CBAS Center is available in their geographic area, or
- Unbundled CBAS if CBAS Centers became unavailable in their geographic areas.

Beneficiaries determined not eligible for CBAS, who received ADHC services between July 1, 2011 and February 29, 2012 are eligible for Enhanced Case Management (ECM) 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~~ **Associated** transition costs to **have been incurred by** the State due to Fair Hearing outcomes and penalties, ~~special mailings/letters, updates to informing material packets, and provider directories.~~

H 16 (PC-201) X

### 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~~ **expired** 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 IHSS program will continue the 3.6% reduction of service hours with an additional 4.4% reduction, for a total of 8%. **The reduction decreases to 7% in FY 2014-15 and may be offset if a provider assessment is developed.**

**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

Breast and Cervical Cancer Treatment Program

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. The Department's 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-12)    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 under SB 87 when a federal BCCTP beneficiary is determined ineligible for full-scope Medi-Cal under BCCTP.

**PHARMACY: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

PH 0.1(PC-211)

X

MCO Supplemental Drug Rebate

The Department has proposed legislation to negotiate state supplemental drug rebates with drug manufacturers to provide additional drug rebates over and above the federal rebate levels for drugs provided through Medicaid MCOs. Effective July 1, 2014, the Department will include Medicaid MCO outpatient covered drug utilization data for the purposes of determining additional state supplemental rebates. MCO supplemental drug rebates shall be payable retroactive to July 1, 2014.

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PH 1 (PC-54)	X	X	<u>Non FFP Drugs</u>  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. <del>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.</del>
PH 2 (PC-57)	X	X	<u>Family PACT Drug Rebates</u>  The Department collects rebates for family planning drugs covered through the Family PACT program.
PH 3 (PC-60)	X	X	<u>State Supplemental Drug Rebates</u>  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.
PH 4 (PC-61)	X	X	<u>Federal Drug Rebate Program</u>  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. 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

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			percentage for most drugs and retains the GF share at the current FMAP rate, for all rebates collected.
PH 5 (PC-56)	X	X	<p><u>Medical Supply Rebates</u></p> <p>The Department negotiates 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 the Rebate Accounting Information System (RAIS), manually created invoices are sent quarterly to manufacturers.</p> <p>The product reimbursement rates for diabetic test strips and lancets are based on the contracted MAC.</p> <p>On January 1, 2013, newly negotiated three-year contract terms went into effect and reduced the Department's net cost per claim.</p>
PH 6 (PC-59)	X	X	<p><u>Aged and Disputed Drug Rebates</u></p> <p>The Department collects drug rebates as required by federal and state laws. The Department has completed its work on the oldest aged rebate disputes (1991-96) and <del>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</del> <b>is working</b> on disputes for the 1997-2002 time period. <b><u>for more recent periods.</u></b></p> <p>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.</p>
PH 7 (OA-51)	X	X	<p><u>Epocrates</u></p> <p>The Department entered into a contract with Epocrates to place Medi-Cal's Contract Drug List (CDL) in the Epocrates system. Epocrates RX™ contains important drug list and clinical information for commercial health plans and Medicaid programs throughout the country. Epocrates 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.</p>

**PHARMACY: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
PH 8 (PC-55)	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-NA)	X	X	<p><u>Physician-Administered Drug Reimbursement</u></p> <p>This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.</p>
PH 10(OA-60)		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 <del>will</del> <b>must</b> hire a contractor <del>in FY 2012-13 to survey drug price information from the Medi-Cal pharmacy providers and update AACs and MAICs on an ongoing basis.</del> Currently, the Department is subject to a court injunction which precluded implementation of the MAIC methodology, as amended by ABX4 5 (Chapter 5, Statutes of 2009). However, MAICs based on the new reimbursement benchmark, AACs, are not subject to that injunction.</p> <p><b><u>The procurement is anticipated to occur in FY 2014-15 following the settlement of litigation and approval of the State Plan Amendment.</u></b></p>

**PHARMACY: OLD ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
PH 11 (PC-NA)	X	X	<u>Sunset of Specialty Drug Contracts</u>
			This assumption has been moved to "Fully Incorporated Into Base Data/Ongoing" section.
<b><u>PH 12 (PC-53)</u></b>	<b>X</b>	<b>X</b>	<b><u>Restoration of Enteral Nutrition Benefit</u></b>
			<b><u>The Omnibus Health Trailer Bill, AB 82 (Chapter 23, Statutes of 2013), added Section 14132.86 to the Welfare and Institutions Code and removes the tube feeding restriction to enteral nutrition products benefit coverage for adult beneficiaries, and broadens the covered benefit subject to a Medi-Cal list and utilization controls.</u></b>

**DRUG MEDI-CAL: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
D 0.1 (OA-58)		X	<p><u>Drug Medi-Cal County Administration</u></p> <p>Effective July 1, 2014, counties may claim reimbursement for administrative costs related to Drug Medi-Cal (DMC) services through a new quarterly invoicing process. As a result of this change, the Department reimbursement rate-setting methodologies will exclude county administrative expenses to reimburse counties for the federal share of the county-certified direct service costs.</p>
D 0.2 (OA-80)	X	X	<p><u>Third Party Validation of Certified Providers</u></p> <p>The Department will procure a vendor, from the California Multiple Award Schedule, to conduct a third party validation of all Drug Medi-Cal program service providers, pre and post certification.</p> <p>The third party validation will enhance anti-fraud activities that will enable the Department to assess program providers, provider risk, demographic coverage, and generate alerts of changes in status by matching providers through various sources of information. Matching sources will include but are not limited to: (a) Federal Exclusion Records; (b) State Exclusion Records; (c) Federal Death Records; (d) State Licensure Sanctions; and (e) National Provider Identification (NPI) Deactivations.</p>
D 0.3 (PC-203)	X	X	<p><u>Provider Fraud Impact to DMC Program</u></p> <p>Fraudulent Medi-Cal billing practices have been determined to have primarily occurred in the DMC Outpatient Drug Free Treatment Services program. The Department has taken significant steps to address fraud in the Drug Medi-Cal program.</p> <p>A statewide enforcement sweep was launched in July. As of August, 30, 2013, the Department has issued temporary suspensions for 139 out of the 1,063 certified DMC providers and lodged 51 Credible Allegations of Fraud with the California Department of Justice for potential prosecution.</p>

## DRUG MEDI-CAL: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
D 1	(PC-63)	X	X	<p><u>Perinatal Residential Treatment Services</u></p> <p>The <del>Perinatal</del> Residential Treatment Services program provides rehabilitation services to <del>pregnant and postpartum women</del> <b>beneficiaries</b> with substance use disorder diagnoses in a non-institutional, non-medical, residential setting. Each beneficiary resides on the premises and receives support in her effort 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><del>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</del> <b><u>Beginning January 1, 2014, as a result of California's adoption of the ACA, the previous limitation on this service to only pregnant and postpartum beneficiaries will be removed and all Medi-Cal beneficiaries who meet the service criteria may receive the service.</u></b></p>
D 2	(PC-65)	X	X	<p><u>Day Care Rehabilitative Intensive Outpatient Services</u></p> <p><del>Day Care Rehabilitative</del> <b><u>Intensive Outpatient</u></b> 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"> <li><del>• who are pregnant or in the postpartum period,</del></li> <li><del>• and/or to EPSDT eligible beneficiaries.</del></li> </ul> <p><del>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.</del> <b><u>Beginning January 1, 2014, as a result of California's adoption of the ACA, the previous limitation to only pregnant, postpartum or EPSDT eligible beneficiaries will be removed and all Medi-Cal beneficiaries who meet the service criteria may receive the service.</u></b></p>
D 3	(PC-64)	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</p>

## DRUG MEDI-CAL: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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.

~~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 .~~

D 4 (PC-62) X X

### Narcotic Treatment Program

The Narcotic Treatment Program provides outpatient methadone or levorphanol (LAAM), which is not currently manufactured, **maintenance** services directed at stabilization and rehabilitation of persons with opioid dependency and diagnoses of substance use disorder diagnoses.

The program includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions. ~~The Narcotic Treatment Program does not include detoxification.~~

~~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.~~

D 5 (PC-NA)

### Naltrexone Treatment Services

This assumption has been moved to the "Info Only" section.

D 6 (PC-67) X X

### Drug Medi-Cal Program Cost Settlement

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 an interim settlement after receipt and review of the provider's cost report and approved units of service. Within three years of the interim settlement, the program must conduct an audit to complete a final settlement. If the program does not complete

**DRUG MEDI-CAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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-68)    X        X

Annual Rate Adjustment

The Department annually adjusts the Drug Medi-Cal rates. 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.

**Effective July 1, 2014, Drug Medi-Cal reimbursement rate setting methodologies will exclude county administrative expenses. The Department will reimburse counties quarterly for Drug Medi-Cal county administration expenses.**

**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-69) (PC-70)	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 and children <del>and youth under 21 who are</del> 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 <del>service authorization</del> <b>services</b> 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 <del>service authorization</del> <b>services</b> 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 <del>plan in each county</del> <b>plans</b>, to provide or arrange and pay for the provision of specialty mental health services to all individuals, <del>in that county, who are</del> enrolled in the Medi-Cal program and <del>and</del> <b>that</b> meet the medical necessity criteria for <del>the</del> specialty mental health services.</p> <p><del>Effective July 1, 2012, the Department of Mental Health (DMH) program staff and associated funding was shifted to the Department.</del></p>
MH 2 (PC-75)	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"> <li>• Do not have health insurance,</li> <li>• Do not qualify for zero share of cost Medi-Cal, and</li> <li>• Income is at or below 250 percent of the federal poverty level.</li> </ul>

**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 managed care 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 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 **Beginning** January 1, 2013, the HFP will cease **ceased** to enroll new subscribers and **the current** HFP subscribers will transition **were phased** into **the** Medi-Cal **program** through a phase-in methodology.~~

MH 3 (PC-80) X X  
 (PC-82)

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-79) 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~~ **negotiated** a plan for the county to reimburse the State for the repayment.

## MENTAL HEALTH: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
MH 5 (PC-83) (OA-5)	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 <del>must reconcile interim settlements</del> <b><u>reconciles interim payments</u></b> to MHPs for children, adults, and healthy families <b><u>and adults</u></b> specialty mental health services to county <b><u>via interim</u></b> cost report <b><u>settlements</u></b>. <del>and process</del> <b><u>The Department processes</u></b> correcting payments or recoupments <b><u>depending on each</u></b> <b><u>county’s interim cost report settlement amount</u></b>. <b><u>Subsequent to the interim settlement, the Department conducts a final cost settlement audit resulting in a final audit payment or recoupment</u></b>.</p>
MH 6 (PC-81)	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. <b><u>When documentation of a specialty mental health service does not meet medical necessity or other criteria, the FFP portion of the paid claim is recouped</u></b>.</p>
MH 7 (PC-NA)	X		<p><u>Specialty Mental Health Lawsuits</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
MH 8 (PC-78)	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 was reduced for the mental health services component and the local realignment funding to Solano County was increased by the same amount.</p>

**MENTAL HEALTH: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
MH 9 (PC-77)	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-14)	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-55) (PC-74)	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 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.</p>

## MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

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. **In this context, these existing services are referred to as Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) and were effective beginning January 1, 2013. Also as a result of the lawsuit, a new service called Therapeutic Foster Care (TFC) will be implemented beginning January 1, 2014 or after CMS approval of the TFC service type.**

MH 13 (OA-25)    X    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 **was** included in support, but beginning with FY 2013-14 it **will** be **is** 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-72)    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

## MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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 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.

**MH 15(PC-76)**    **X**    **X**

### **Investment in Mental Health Wellness**

**SB 82 (Chapter 34, Statutes of 2013) created the Investment in Mental Health Wellness Act of 2013. SB 82 adds 25 mobile crisis support teams and 2,000 crisis stabilization and crisis residential treatment beds over the next two years to expand community-based resources and capacity. The Act also adds 600 triage personnel over the next two years to assist individuals with gaining access to medical, specialty mental health care, alcohol and other drug treatment, social, educational, and other services.**

**MH 16(PC-18)**    **X**    **X**

### **Parole Mental Health and Medi-Cal Expansion**

**SB 82 (Chapter 34, Statutes of 2013), establishes the Investment in Mental Health Wellness Act of 2013. Through the Act, the Legislature increased federal funding to the Department to provide services for mentally ill inmates released after January 1, 2014. The State expands eligibility to additional parolees under the ACA.**

**MH 17(PC-71)**    **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.

## MENTAL HEALTH: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

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 2013-14.

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

## 1115 WAIVER-MH/UCD & BTR

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

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

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

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

Applicable F/Y  
C/Y    B/Y

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

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
W 1	(PC-88) (PC-104)	X	X	<u>MH/UCD &amp; BTR—Safety Net Care Pool</u>

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); and
- 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; and
  - 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 (DY) 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 Department to implement the new payment methodologies under

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

Applicable F/Y  
C/Y    B/Y

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-85) 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 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; and
- 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-87) 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 Federal DSH statute. The federal share of the DSH replacement

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

Applicable F/Y  
C/Y    B/Y

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-89)	X	X	<p><u>MH/UCD &amp; BTR—Private Hospital Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, private hospitals receive payments from the Private Hospital Supplemental Fund, Item 4260-601-3097. SB 1100 provides a continuous appropriation of \$118.4 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.</p>
W 5	(PC-103)	X	X	<p><u>MH/UCD &amp; BTR—NDPH Supplemental Payment</u></p> <p>Effective for dates of service on or after July 1, 2005, based on the requirements of SB 1100, NDPHs receive payments from the Non-Designated Public Hospital Supplemental Fund, Item 4260-601-3096. SB 1100 provides a continuous appropriation of \$1,900,000 annually 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.</p>
W 6	(PC-94)	X	X	<p><u>MH/UCD &amp; BTR—DPH Physician and Non-Physician Costs</u></p> <p>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</p>

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

Applicable F/Y  
C/Y    B/Y

patients of the hospital or its affiliated hospital and non-hospital settings. SPA 05-023 that authorizes federal funding for this reimbursement was approved by CMS in December 2007. CMS approved the “Physician and Non-Physician Practitioner Time Study Implementation Plan” on December 15, 2008.

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

W 7	(PC-NA)	X	<u>MH/UCD—Distressed Hospital Fund</u>
			This assumption has been moved to the “Time Limited/No Longer Available” section.
W 8	(PC-105)	X	<u>MH/UCD&amp; BTR—MIA LTC Program– Safety Net Care Pool</u>
			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.
W 9	(PC-106)	X	<u>MH/UCD &amp; BTR—BCCTP – Safety Net Care Pool</u>
			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.
W 10	(PC-91)	X	<u>MH/UCD &amp; BTR—CCS AND GHPP – Safety Net Care Pool</u>
			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

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

Applicable F/Y  
C/Y    B/Y

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.

W 11 (PC-100) X

X

MH/UCD & BTR—DPH Interim and Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate

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 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 cost report.

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

- For DPHs that have been determined to be overpaid, the Department will recoup any overpayments.
- For DPHs that have been determined to be underpaid, the Department will make a payment equal to the difference between the DPH's computed Medi-Cal cost, and 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-99) 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;

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

Applicable F/Y  
C/Y    B/Y

- 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; and
- 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 **due to DPHs** will begin in FY ~~2012-13~~ **2013-14**.

W 13 (PC-102) X

### MH/UCD—Health Care Coverage Initiative

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

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

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

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

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

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			Income Health Program; see the Low Income Health Program assumption.
W 14 (PC-107)	X	X	<p><u>MH/UCD &amp; BTR—DPH Interim Rate</u></p> <p>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.</p>
W 15 (PC-97)	X	X	<p><u>MH/UCD &amp; BTR—DPH Interim Rate Growth</u></p> <p>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.</p>
W 16 (PC-NA)	X		<p><u>MH/UCD—Health Care Coverage Initiative – Administrative Costs</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
W 17 (OA-37)	X	X	<p><u>MMA –DSH Annual Independent Audit</u></p> <p>MMA requires an annual independent certified audit that primarily certifies:</p> <ul style="list-style-type: none"> <li>• That DSH (approximately 150+ hospitals) have reduced their uncompensated care costs by the amount equal to the total amount of claimed expenditures made under section 1923 of the MMA; and</li> <li>• That hospitals' DSH payments do not exceed the costs incurred by the hospitals in furnishing services during the year to Medicaid patients and the uninsured, less other Medicaid payments made to the hospital and payments made by uninsured patients.</li> </ul>

## 1115 WAIVER – MH/UCD &amp; BTR: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				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.
W 18	(PC-85) (PC-87)	X		<p><u>MH/UCD &amp; BTR—ARRA – DSH Allotment and DSH Replacement Payments</u></p> <p>California's annual allotment of federal funds for the Disproportionate Share Hospital (DSH) temporarily increased for FY 2008-09 and FY 2009-10 by 2.5%, due to the enactment of the ARRA. The distribution of the DSH allotment is determined by a formula specified in State statute and the State Medi-Cal Plan. When the DSH allotment is increased and more federal funds are available for distribution, the formula results in an increase in General Funds needed as the non-federal share of the DSH payments for NDPHs and DSH replacement payments to private hospitals.</p> <p>The remaining DSH ARRA payments cannot be paid to the hospitals until the entire original DSH allotment is paid out per federal rules, therefore the Department expects to continue to pay DSH ARRA payments in FY <del>2012-13</del> <b>2013-14</b>.</p>
W 19	(PC-NA)	X		<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool ARRA</u></p> <p>This assumption has been moved to the "Time Limited/No Longer Available" section.</p>
W 20	(PC-110)	X		<p><u>MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool</u></p> <p>The MH/UCD made available \$180 million in federal funds via the SNCP annually. This funding was contingent on the Department meeting specific milestones. In Demonstration Years 1 and 2, this funding was unused. The Department will utilize this funding in FY 2009-10, FY 2010-11, and FY 2011-12 to claim federal funds via certified public expenditures. The final reconciliations <del>is expected to begin</del> <b>began</b> in FY 2012-13.</p>
W 21	(PC-86) (PC-92)	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</p>

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

Applicable F/Y  
C/Y B/Y

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:

1. Infrastructure development;
2. Innovation and redesign;
3. Population-focused improvement
4. Urgent improvement in care; and
5. HIV Transition Projects.

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.

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 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.~~ **Incentive funding for these projects will be effective from July 1, 2012 through October 31, 2015.**

Intergovernmental transfers (IGTs) ~~will be~~ **are** used as the non-federal share to claim the federal funding **for DSRIP.**

W 22 (PC-84) X  
(PC-90)

### BTR—Low Income Health Program

The BTR was approved by CMS effective November 1, 2010. The BTR modified the 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.

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 the Affordable Care Act.** ~~Under the BTR waiver, the LIHP will expire on December 31, 2013.~~

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

Applicable F/Y  
C/Y B/Y

The counties use 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-95) 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:

- 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)

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

Applicable F/Y  
C/Y    B/Y

- 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
    - Steven M. Thompson Physician Corp Loan Repayment Program
    - 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  
 (PC-FI)

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.

**Most LIHP individuals will transition into Medi-Cal managed care beginning January 1, 2014. The Department will develop notices informing beneficiaries of the transition process. Beginning November 1, 2013, approximately 600,000 notices are scheduled to be mailed to beneficiaries. Due to the special mailing, there will be associated costs to the State beginning in FY 2013-14.**

W 25 (PC-96)    X

BTR - LIHP - Inpatient Hospital Costs for CDCR Inmates

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

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

Applicable F/Y  
C/Y B/Y

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.

W 26 (PC-109) X

### Hospital Stabilization

AB 1467 (Chapter 23, Statutes of 2012) provided the authority to redirect private and NDPH stabilization funding that ~~has not yet been paid~~ **was not paid prior to January 1, 2012 to the State General Fund. In FY 2012-13, A** portion of the GF savings achieved from this legislation ~~will be~~ **was** used to make payments to hospitals that incorrectly received underpayments in FY 2005-06 through FY 2006-07.

W 27 (PC-98) X  
(PC-108)  
(PC-112)

### BTR-Health Care Coverage Initiative Rollover Funds

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 received federal approval to reallocate the unspent DY 6, ~~and DY 7,~~ **DY 8, and DY 9** 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.

W 28 (PC-113) X X  
(PC-FI)

### 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~~ **replaces** 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

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

Applicable F/Y  
C/Y    B/Y

the previous cost-based reimbursement methodology. ~~The DRG implementation is scheduled to begin~~ **was implemented on July 1, 2013 for private hospitals and will be implemented on January 1, 2014 for NDPHs.**

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

W 29 (PC-101) X      X

**Uncompensated Care Payments for Tribal Health Programs**

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:

- Incomes up to 133% of the FPL, and
- Who are not ~~eligible for~~ **enrolled in** a Low Income Health Program (LIHP).

The demonstration ~~will provide~~ **provides** 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.

For Medi-Cal enrolled IHS eligible individuals, this demonstration ~~will provide~~ **provides** 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.

Services provided to non-IHS eligible individuals ~~will~~ **are** also ~~be~~ eligible for payment under the demonstration, if the individual receiving the services otherwise meets the demonstration requirements.

For services provided to IHS eligible individuals, reimbursement ~~will be~~ **is** 100% FFP. For services provided to non-IHS eligible individuals, reimbursement ~~will be~~ **is** claimed through certified public expenditures. There will be no GF impact.

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

Applicable F/Y  
C/Y B/Y  
W 30 (PC-111) X

Private Hospitals Supplemental Fund Savings

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.

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.

## 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 county specific rate is then developed for the Family/Adult rate and the SPD Medi-Cal only rate.

## MANAGED CARE

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 ~~2013-14~~ rates, ~~35%~~ **40%** of this county specific rate was taken and multiplied by each plan's respective risk score and ~~65%~~ **60%** of each plan's plan specific rate was retained and added to the ~~35%~~ **40%** 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%. **The risk adjustment policy will be examined in future years and adjusted if determined necessary.**

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 ~~0.7%~~ **3.63%** increase in FY 2012-13 ~~FY 2013-14~~ over the previous fiscal year rates (based on a fiscal year comparison). Rates for 2013-14 ~~2014-15~~ represent a ~~3.74%~~ **3.5%** increase over the 2012-13 ~~2013-14~~ fiscal year rates.

**MANAGED CARE: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

**MANAGED CARE: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
M 1	(PC-114) 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-115) X (PC-142)	X	<p><u>County Organized Health Systems</u></p> <p>Six County Organized Health Systems (COHSs) are operational in fourteen counties. <del>Effective February 1, 2010, Health Plan of San Mateo added long term care services to their contract.</del> 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. The Department is currently in discussions with all COHS plans to incorporate 1115 waiver requirements related to Seniors and Persons with Disabilities.</p> <p>Capitation rates include the annual rate redeterminations.</p>
M 3	(PC-116) X	X	<p><u>Geographic Managed Care</u></p> <p>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.</p> <p>Capitation rates include the annual rate redeterminations.</p>
M 4	(PC-129) X	X	<p><u>AIDS Healthcare Centers</u></p> <p>Managed Care Organization (MCO): Positive Healthcare Services (dba AIDS Healthcare Centers) is located in Los Angeles.</p> <p>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</p>

## MANAGED CARE: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

drugs which do not fit into one of the current therapeutic classes and for which ~~the Department does not have~~ **there is not** sufficient utilization data to determine the financial impact of the use of those drugs will have on the managed care plan. ~~New rates developed effective January 1, 2011, pending CMS approval, include all drugs used to treat HIV/AIDS approved by the FDA prior to January 1, 2007.~~

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

~~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-130) X    X

### Family Mosaic Capitated Case Management

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 was effective January 1, 2008 through December 31, 2012, and has been extended through June 30, 2014.

**MANAGED CARE: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

M 6 (PC-118) X X Managed Care Rate Range Intergovernmental Transfers

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

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

<u>COHS</u>	<u>Effective Date 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-135) X X Managed Care IGT Administrative and Processing Fee

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-120) X    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-136) X    X

General Fund Reimbursements from DPHs

Effective June 1, 2011, Seniors and Persons with Disabilities (SPDs) 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 were transitioned into managed care, GF expenditures increased for DPH services.

Beginning in ~~FY 2013-14~~ **June 2013**, 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.

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 10	(PC-NA)	X	X	<p><u>Increase in Capitation Rates for Gross Premium Tax</u></p> <p>This assumption has been moved to the "Time Limited/No Longer Available" section.</p>
M 11	(PC-NA)	X	X	<p><u>Funding Adjustment of Gross Premium Tax Funds to GF</u></p> <p>This assumption has been moved to the "Time Limited/No Longer Applicable" section.</p>
M 12	(PC-128) (PC-133) (PC-121) (PC-137) (PC-134)	X	X	<p><u>Extend Gross Premium Tax – Increase Capitation Rates</u></p> <p>ABX1 21 (Chapter 11, Statutes of 2011) extended the Gross Premium Tax through FY 2011-12. <del>The Administration Department is proposing legislation that would extend</del> <b><u>SB 78 (Chapter 33, Statutes of 2013) extended</u></b> the Gross Premium Tax sunset date on the total operating revenue of Medi-Cal Managed Care plans through June 30, 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:</p> <ul style="list-style-type: none"> <li>• Two Plan Model;</li> <li>• County Organization Health Systems;</li> <li>• Geographic Managed Care;</li> <li>• AIDS Healthcare Centers; and</li> <li>• SCAN.</li> </ul>
M 13	(PC-138)	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>

**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
M 14	(OA-36)	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-NA)	X	X	<p><u>Managed Care Cost-Based Reimbursement Clinics (CBRC)</u></p> <p>This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.</p>
M 16	(PC-NA)	X	X	<p><u>Align Managed Care Benefit Policies</u></p> <p>This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.</p>
M 17	(PC-123) (PC-143) (PC-197) (PC-119) (OA-17) (PC-FI)	X	X	<p><u>Transition of Dual Eligibles-Long-Term Care Savings</u></p> <p>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 <b><u>Enrollment notices</u></b> and packets <b><u>managed care guidebooks</u></b> will be mailed to beneficiaries. <b><u>Additional administrative costs will be required when enrolling beneficiaries into managed care health plans.</u></b></p> <p><del>The administrative costs to enroll beneficiaries into the managed care health plans include:</del></p> <ul style="list-style-type: none"> <li><del>• Mailing Medi-Cal and Medicare information,</del></li> <li><del>• Outreach services,</del></li> <li><del>• Rate setting for newly included long term services and supports (LTSS),</del></li> <li><del>• System design and modification needs,</del></li> <li><del>• Medicare and Medi-Cal data collection,</del></li> <li><del>• Development of quality metrics,</del></li> </ul>

## MANAGED CARE: OLD ASSUMPTIONS

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
				<ul style="list-style-type: none"> <li>• <del>Performance measures for rapid cycle quality improvement and long term quality assurance,</del></li> <li>• <del>Ombudsman services and reporting, and</del></li> <li>• <del>Monitoring by an External Quality Review Organization (EQRO).</del></li> </ul>
M 18	(PC-127) X (PC-FI)		X	<p><u>Managed Care Expansion to Rural Counties</u></p> <p>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.</p> <p><b><u>The transition to managed care in the 28 counties will phase in beginning September 1, 2013. There will be three different managed care models in the rural counties — County Organized Health Systems, Regional Models, and voluntary passive enrollment model with the ability to opt out.</u></b></p>
M 19	(PC-NA) X		X	<p><u>Potentially Preventable Admissions</u></p> <p>This assumption has been moved to the “Fully Incorporated Into Base Data/Ongoing” section.</p>
M 20	(PC-NA) X			<p><u>Retroactive Managed Care Rate Adjustments for FY 2011-12</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
M 21	(PC-NA) X		X	<p><u>Enrollment Stabilization Program</u></p> <p>This assumption has been moved to the “Discontinued Assumptions: Withdrawn” section.</p>
M 22	(PC-117) X (PC-139) (PC-140) (PC-18) (PC-21)		X	<p><del>Sales</del> <u>MCO Tax on Managed Care Plans</u></p> <p>The Administration has proposed legislation to impose <b>SB 78 (Chapter 33, Statutes of 2013) imposed</b> the statewide sales tax on Medi-Cal managed care plans effective July 1, 2014 <b>July 1, 2013</b>. One half of the proceeds of the tax <del>would</del> <b>will</b> be used to increase rates to the plans to reimburse them for the cost of the</p>

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**MANAGED CARE: OLD ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
			tax. The other half of the proceeds <del>would</del> <b>will</b> be used to offset General Fund cost in the Medi-Cal program.
M 23	(PC-124)	X	X
			<u>Retroactive Managed Care Rate Adjustments for FY 2012-13</u>
			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.
M 24	(PC-132)		X
			<u>Annual Redetermination of Capitation Rates</u>
			Capitation rates are rebased annually. Federal rules require that the rates be developed according to generally accepted actuarial principles and must be certified by an actuary as actuarially sound in order to ensure federal financial participation. The rates are implemented based on the rate year of the managed care model types. The rebasing process includes refreshed data and adjustments to trends. A placeholder is included in the November estimate until rates are finalized.
<u>M 25</u>	<u>(PC-22)</u>	<u>X</u>	<u>X</u>
			<u>Mental Health Services Expansion</u>
			<u>SBX1 1 (Hernandez, Chapter 4, Statutes of 2013) provides that Medi-Cal managed care plans (MCPs) must provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Waiver. In addition, mental health benefits will include group counseling.</u>

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## PROVIDER RATES

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

AB 1629 requires the Department to develop a cost-based, facility-specific reimbursement rate methodology for 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.

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.

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## PROVIDER RATES

### **Quality and Accountability Supplemental Payment Program**

SB 853 (Chapter 717, Statutes of 2010) requires the Department to implement a Quality and Accountability Supplemental Payment (QASP) Program for SNFs by August 1, 2010. The QASP Program 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.

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### **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.

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.

## PROVIDER RATES

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. **Effective August 1, 2012**, providers of services to developmentally disabled clients have rates set at the 65<sup>th</sup> percentile of their respective peer groups. **as follows: Each rate year, individual provider costs are rebased using cost data applicable for the rate year. Each ICF/DD, ICF/DD-H or ICF/DD-N will receive the lower of its projected costs plus 5% or the 65<sup>th</sup> percentile established in 2008-2009, with none receiving a rate no lower than 90% of the 2008-2009 65<sup>th</sup> percentile.**

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

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
PR 1			<p><u>NF-B Rate Changes and Quality Assurance (QA) Fee</u></p> <p>AB 1629 (Chapter 875, Statutes of 2004) required the Department to change the rate methodology for freestanding skilled nursing facilities (freestanding NF-Bs and freestanding adult subacute facilities, excluding pediatric subacute services and rural swing bed days), to provide an annual cost-of-living adjustment (COLA) and to collect a QA fee from these facilities. Effective January 1, 2012, ABX1 19 (Chapter 4, Statutes of 2011) includes Freestanding Pediatric Subacute facilities within the QA fee provider population. The rate methodology and QA fee provisions sunset on July 31, 2013. <del>AB 1489 (Chapter 631, Statutes of 2012) extends the QA fee, until July 31, 2015.</del></p>
(PC-24)	X	X	<p><u>Rate Changes due to Rate Methodology</u></p> <p>This assumption has been moved to "Provider Rates: AB 1629 Rate Adjustments due to QA Fee" section.</p>
(PC-145) (PC-24)	X	X	<p><del>Rate Adjustments</del> <b><u>AB 1629 Rate Adjustments</u></b> due to QA Fee</p> <p><b><u>AB 1629 (Chapter 875, Statutes of 2004) required the Department to implement a facility specific reimbursement rate for freestanding skilled nursing facilities (NF-Bs) and freestanding adult subacute facilities, collect a Quality Assurance (QA) fee from these facilities, and provide an annual rate adjustment. The annual rate adjustment may vary from year to year, dependent upon legislatively mandated adjustments. A QA fee is collected from (NF-Bs), including adult and pediatric subacute facilities, to offset the GF portion of the reimbursement rates.</u></b></p> <p>Assessment of the QA fee is based on revenues from Medi-Cal, Medicare and private pay sources. Effective October 1, 2011, the QA fee limit increased from 5.5% to 6%.</p> <p>QA fee amounts are calculated to be net of the L&amp;C fees in order to be within the federally designated cap, which provides for the maximum amount of QA fees that can be collected. L&amp;C fees shift from year to year, which impacts the amount of QA fee the Department can collect. The State uses a portion of the QA fee to draw down FFP and to fund rate increases <b><u>adjustments</u></b>.</p>

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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) implemented a rate freeze for the 2012-13 rate year, **provided a 3% rate increase for the 2013-14 and 2014-15 rate years.** and extended the QA fees sunset date to July 31, 2015.

(PC-146) X X

Quality and Accountability Supplemental 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. **The supplemental payments will be tied to demonstrated quality of care improvements.** Quality payments will be delayed a year by AB 1489 (Chapter 631, Statutes of 2012) **requires payments to be made by April 30, 2014.** Payments made under the program will begin in rate year 2013-14 as supplemental to the rates and

**Supplemental payments** will be paid through a special fund **the Skilled Nursing Facility Quality and Accountability 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-24) X X

AB 1629 Add-Ons

**The following are the add-on rates to AB 1629 facilities:**

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

**PROVIDER RATES: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

~~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.~~

~~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. **for the 2013-14 rate year.**~~

~~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. **for the 2013-14 rate year.**~~

~~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. An add-on to the rate to reimburse facilities will be effective for ~~2012-13 and~~ **the** 2013-14 rate year.

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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 the 2013-14 rate year.

**Under the Patient Protection and Affordable Care Act (ACA), two new fees are assessed on employers providing health insurance, an annual reinsurance fee and a Patient-Centered Outcomes Research Trust Fund Fee (PCORI) per covered life. This add-on will reimburse LTC facilities for compliance costs and will be effective for the 2013-14 and 2014-15 rate years.**

**Under The Patient Protection and Affordable Care Act (ACA) Skilled Nursing Facilities (SNF) are required to implement a compliance and ethics program. This add-on will reimburse LTC facilities for compliance costs and will be effective for the 2013-14 and 2014-15 rate years.**

**The Health Insurance and Portability and Accountability Act (HIPAA) issued new regulations regarding the use of electronic fund transfers (EFT) and electronic remittance advices (RA). This add-on will reimburse LTC facilities for compliance costs and be effective for the 2013-14 and 2014-15 rate years.**

PR 2 (PC-157) X X

10% Provider Payment Reduction

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 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.

On October 27, 2011, the Department received federal approval to reduce provider payments up to 10%.

The Department received CMS approval on September 11, 2012 to exempt Pediatric Day Health Care providers from the 10% payment reduction, effective April 1, 2012.

**PROVIDER RATES: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

The Department submitted a SPA to CMS on December 24, 2012, requesting approval **received CMS approval on August 29, 2013** 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 ~~1920~~, 2012.

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.

**On March 31, 2012, the Department submitted a SPA requesting CMS approval to exempt selected drugs and certain pharmacy providers due to access concerns from the 10% payment reduction effective March 31, 2012.**

**The Department will submit a SPA requesting CMS approval to exempt nonprofit dental pediatric surgery centers which provide at least 99% of their services under general anesthesia to children with severe dental disease under the age of 21 from the 10% payment reduction, effective August 31, 2013.**

**For-profit dental pediatric surgery centers that provide services to at least 95% of their Medi-Cal beneficiaries under the age of 21 will be exempt from the 10% payment reduction effective December 1, 2013, pending the federal approval.**

**Genetic disease screening program, administered by California Department of Public Health, is not subject to the 10% payment reduction. The Department will stop the 10% payment reduction in December 2013 and anticipates refunding the payment reduction for the period June 1, 2011 through November 30, 2013 in September 2014**

**Managed care reductions pursuant to AB 97 will be implemented prospectively effective October 1, 2013. Due to**

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

**access concerns, specialty physician services will be exempt from these reductions.**

**Due to access concerns, the Department will forgo the retroactive recoupments for the following providers:**

- **Physicians;**
- **Medical transportation;**
- **Dental;**
- **Clinics;**
- **Certain high-cost drugs; and**
- **CHDP.**

PR 3 (PC-149)	X	X	<p><b><u>Annual MEI Increase for FQHCs and RHCs</u></b></p> <p>The Department implemented the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) included in the 2000 Benefits Improvement and Protection Act on January 1, 2001. Clinics have been given the choice of a PPS rate based on either (1) the average of the clinic's 1999 and 2000 cost-based rate or (2) their 2000 cost-based rate. Whichever PPS rate the clinic has chosen will receive an annual rate adjustment. The annual rate adjustment is the percentage increase in the Medicare Economic Index (MEI) and is effective October 1st of each year.</p>
PR 4			<p><b><u>LTC Rate Adjustments and QA Fees</u></b></p>
(PC-148)	X	X	<p><b><u>Rate Adjustment</u></b></p> <p>Pursuant to the State Plan requirements, Medi-Cal rates for long-term care (LTC) facilities are adjusted after completion of an annual rate study.</p> <p>The following facilities are included in this assumption:</p> <ul style="list-style-type: none"> <li>• Intermediate Care Facilities/Developmentally Disabled (ICF-DD)</li> <li>• ICF/DD-Habilitative</li> <li>• ICF/DD-Nursing</li> <li>• Freestanding Nursing Facilities – Level A (NF-A)</li> <li>• Distinct Part Nursing Facilities (DP/NF) – Level B</li> <li>• DP/NF Subacute</li> <li>• Pediatric Subacute Care</li> <li>• Rural Swing Beds</li> </ul>

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

(PC-152) X X Non-AB 1629 LTC 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 **services rendered on or after February 24, 2010:**

- 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),
- 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. **On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunction. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

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

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

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

### The Department will submit a SPA to CMS to exempt:

- DP/NF-B providers located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rated as required by AB 97, effective September 1, 2013, and
- Non rural and frontier DP/NF-B providers from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rated as required by AB 97, effective October 1, 2013.

(PC-155) X X 10% Payment Reduction for LTC Facilities

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. **On June 25, 2013, the United States Court of Appeals for the Ninth Circuit vacated the injunction. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.** 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:

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

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- Hospice Room and Board Providers
- 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. **On February 27, 2013, CMS approved the revised rate-setting methodology, retroactive to August 1, 2012. The Department will utilize this methodology for the rate-year commencing August 1, 2013.**

**The Department will submit a request to CMS to exempt**

- **DP/NF-B providers located in rural and frontier areas from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rated as required by AB 97, effective September 1, 2013, and**
- **Non rural and frontier DP/NF-B providers from the rate freeze at the 2008-09 levels and the 10% payment reduction to those rated as required by AB 97, effective October 1, 2013.**

**Due to access concerns, the Department will forgo the retroactive recoupment for ICF DDs**

(PC-148) 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.

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y C/Y	B/Y	
(PC-148)	X	X	<u>Non-AB 1629 Add-Ons to the Rates</u>

### **The following are the add-on rates to Non-AB 1629 facilities:**

- 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 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~~

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

~~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. 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 to the rate to reimburse facilities will be effective for 2012-13 and 2013-14 rate year.
- ~~Under the Affordable Care Act § 6401(a), enrolled facilities have to revalidate their enrollment information under enrollment screening criteria. A CMS revalidation add-on 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 reimburses LTC facilities for compliance costs. This add-on will be effective for 2012-13 and 2013-14 rate year.
- **The Patient Protection and Affordable Care Act (ACA) assessed two new fees on employers providing health insurance, an annual reinsurance fee, effective January 1, 2014 and a Patient-Centered Outcomes Research Trust Fund Fee (PCORI) per covered life, effective December 6, 2012.**
- **Effective March 23, 2013, the Patient Protection and Affordable Care Act (ACA) requires Skilled Nursing and Nursing Facilities to implement a compliance and ethics program. An add-on will be provided to cover costs associated with implementing this program and will be**

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

**effective for the 2013-14 and 2014-15 rate years excluding ICF/DD, ICF/DD-H and ICF/DD-N facilities.**

- **The Health Insurance and Portability and Accountability Act (HIPAA) issued new regulations regarding the use of electronic fund transfers (EFT) and electronic remittance advices (RA). An add-on will be provided for associated training costs and will be effective for the 2013-14 and 2014-15 rate years excluding ICF/DD-H and ICF/DD-N facilities.**

PR 5 (PC-150) 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-BA) 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 **change** 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 change** in Diagnosis Related Groups base prices, **if there is a change.**

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
PR 7 (PC-156)	X	X	<p><u>Reduction to Radiology Rates</u></p> <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 July <b>December</b> 2013 with rate reductions retroactive to July 1, 2012 in order to protect beneficiary access to needed radiology services.</p>
PR 8 (PC-147)	X	X	<p><u>Air Ambulance Medical Transportation</u></p> <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> <p>The Department submitted two SPAs to CMS:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>

## PROVIDER RATES: OLD ASSUMPTIONS

	Applicable F/Y		
	C/Y	B/Y	
PR 9 (PC-NA)	X	X	<p><u>10% Payment Reduction Restoration and Supplemental Payments</u></p> <p>This assumption has been moved to the “Timed Limited/No Longer Available” section.</p>
PR 10 (PC-NA)	X	X	<p><u>Eliminate 2012-13 Rate Increase &amp; Supp. Payment</u></p> <p>This assumption has been moved to the “Timed Limited/No Longer Available” section.</p>
PR 11 (PC-154)	X	X	<p><u>Laboratory Rate Methodology Change</u></p> <p>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 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. <b><u>CMS is reviewing a SPA requesting approval for the additional 10% reduction. The Department will submit a subsequent SPA to CMS for the proposed rate methodology changes with a proposed implementation date of April 1, 2014.</u></b> The Family Planning, Access, Care, and Treatment Program shall be exempt from the payment reduction as specified in AB 1494.</p>
PR 12 (PC-151)	X	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"> <li>• Freestanding Nursing Facilities Level-B (FS/NF-Bs)</li> <li>• Freestanding Subacute Nursing Facilities level-B (FSSA/NF-Bs)</li> </ul>

## PROVIDER RATES: OLD ASSUMPTIONS

Applicable F/Y  
C/Y    B/Y

- Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs)
- Freestanding Pediatric Subacute Care Facilities (FS-PEDs)

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.

**SUPPLEMENTAL PAYMENTS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
SP 1 (PC-165)	X		X
			<u>Capital Project Debt Reimbursement</u>
			<p>SB 2665 (Chapter 1310, Statutes of 1990) and SB 1732 (Chapter 1635, Statutes of 1988) authorize Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. To qualify, a hospital must be a disproportionate share hospital, must have either a SPCP or County Organized Health Systems contract with the State of California, and must meet other specific hospital and project conditions specified in Section 14085.5 of the W&amp;I Code.</p> <p>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 <del>2012-13</del> <b>2013-14</b>. Only hospitals that met eligibility requirements set forth in Section 14085.5 of the W&amp;I Code will be eligible to participate.</p> <p>SB 1128 (Chapter 757, Statutes of 1999) authorizes a Distinct Part (DP) of an acute care hospital providing specified services to receive Medi-Cal reimbursement for debt service incurred for the financing of eligible capital construction projects. The DP must meet other specific hospital and project conditions specified in Section 14105.26 of the W&amp;I Code. Two DP facilities began submitting claims and received payments in FY 2011-12.</p>
SP 2 (PC-162)	X		X
			<u>Hospital Outpatient Supplemental Payments</u>
			<p>AB 915 (Chapter 747, Statutes of 2002) creates a supplemental reimbursement program for publicly owned or operated hospital outpatient departments. The supplemental amount, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of the costs of providing services to Medi-Cal beneficiaries incurred by the participating facilities. The non-federal share used to draw down FFP will be paid exclusively with funds from the participating facilities and will not involve General Fund dollars. Interim payments are expected to be made every year in June. Interim payment adjustments are made upon receipt and review of amended claims.</p> <p>The reconciliation mandated by AB 915 against audited cost reports is scheduled to begin in FY <del>2012-13</del> <b>2013-14</b>. Adjustments to interim payments, or recoupment of overpaid funds, are expected during FY <del>2012-13</del> <b>2013-14</b>. Reconciliation</p>

## SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
			of subsequent program fiscal years will commence following the initial reconciliation of FY 2002-03.
SP 3 (PC-167)	X	X	<p><u>IGT Payments for Hospital Services</u></p> <p>W&amp;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-166)	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-164)	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>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.</p> <p><b><u>AB 97 authorized the Department to reimburse Medi-Cal providers at the rates established in FY 2008-09, reduced by 10%, for services Distinct Part Nursing Facilities-Level B providers render on or after June 1, 2011. This payment reduction/freeze will increase the uncompensated costs eligible for supplemental reimbursement under this program.</u></b></p>

## SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
SP 6 (PC-168)	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-169)	X	X	<p><u>Medi-Cal Reimbursements for Outpatient SRH</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-160)	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 <del>July 1, 2006</del> <b><u>October 14, 2006</u></b>. The SPA for freestanding outpatient clinics was approved <del>October 14, 2012</del> <b><u>August 8, 2012</u></b>.</p>
SP 9 (PC-170)	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 supplemental payments. The non-federal match is paid from</p>

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
			public funds of the participating facilities. The SPA for state veterans' homes was approved March 3, 2011.
SP 10(PC-71)	X	X	<u>Specialty Mental Health Services Supplemental Reimbursement</u>
			This assumption has been moved to the "Mental Health" section.
SP 11(PC-163)	X	X	<u>NDPH IGT Supplemental Payments</u>
			AB 113 (Chapter 20, Statutes of 2011) establishes a supplemental payment program for Non-Designated Public Hospitals (NDPHs). These payments are funded with Intergovernmental Transfers (IGTs) and are distributed to the NDPHs based upon a formula in the statute. The State retains nine percent of the IGTs to fund administrative costs and Medi-Cal children's health programs.
SP 12(PC-158)	X		<u>Hospital QAF – Hospital Payments</u>
			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:
			<ul style="list-style-type: none"> <li>• Altering the methodology, timing, and frequency of supplemental payments,</li> <li>• Increasing capitation payments to Medi-Cal managed health care plans, and</li> <li>• Increasing payments to mental health plans.</li> </ul>
			AB 188 (Chapter 645, Statutes of 2009) established the Hospital Quality Assurance Revenue Fund to:
			<ul style="list-style-type: none"> <li>• Provide supplemental payments to hospitals,</li> <li>• Provide direct grants to DPHs,</li> <li>• Increase capitation payments to managed health care,</li> <li>• Increase payments to mental health plans,</li> <li>• Offset the state cost of providing health care coverage for children, and</li> <li>• Pay for staff and related administrative expenses required to implement the QAF program.</li> </ul>

**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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.

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.

**SB 920 (Chapter 452, Statutes of 2012) revised the amount of fees paid in the QAF program, supplemental payments and grant amounts paid to hospitals authorized in SB 335.**

SP 13(PC-93)    X

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, IGTs from designated public hospitals and funds from the Hospital Quality Assurance Revenue Fund will be paid to out-of-network hospitals.

SP 14(PC-161)    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~~ **The** supplemental reimbursement program will be retroactive to January 30, 2010. ~~The SPA is expected to be~~ was approved in FY 2012-13 **on September 4, 2013.**

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**SUPPLEMENTAL PAYMENTS: OLD ASSUMPTIONS**

		Applicable F/Y	
		<u>C/Y</u>	<u>B/Y</u>
SP 15 (PC-195)	X	X	<p><u>Hospital QAF – Children’s Health Care</u></p> <p>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.</p>
SP 16 (PC-198) (PC-159)	X	X	<p><u>Extend Hospital QAF</u></p> <p>The current Hospital QAF program will end on December 31, 2013. <del>The Department proposes to extend the program from January 1, 2014 through December 31, 2016.</del> <b><u>The Department is working with stakeholders and the Legislature to implement a new fee program effective January 1, 2014. The new program’s sunset date will be December 2016.</u></b></p>

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

Applicable F/Y  
C/Y    B/Y

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

A 1 (PC-189) <u>Lawsuits/Claims*</u>	Applicable F/Y	
	<u>C/Y</u>	<u>B/Y</u>
a. <u>Attorney Fees of \$5,000 or Less</u>		
1. Faucher, Douglas M.	<u>\$5,000</u>	
Total	<u>\$5,000</u>	
Fund Balance \$45,000	\$50,000	\$50,000
b. <u>Provider Settlements of \$75,000 or Less</u>		
1. CHA Hollywood Medical Center, LP	\$2,907	
2. Catholic Healthcare West.	\$8,860	
3. Little Company of Mary Health Services	\$1,839	
4. Providence Health System-Southern CA	\$24,370	
5. Catholic Healthcare West	\$2,601	
6. Alta Hospitals System	\$22,546	
7. Fresno Community Hospital	\$15,203	
8. Alta Hospitals System	\$14,367	
9. Catholic Healthcare West	\$10,121	
10. Alta Hospitals System	\$3,565	
11. Lifehouse, Inc.	\$9,324	
12. Garden Regional Hospital and Med Ctr.	<u>\$13,696</u>	
Total	<u>\$129,401</u>	
Fund Balance \$1,470,599	\$1,600,000	\$1,600,000
c. <u>Beneficiary Settlements of \$2,000 or Less</u>		
1. Ledezma, Chang, Chikanov, Yu	<u>\$1,438</u>	
Total	<u>\$1,438</u>	
Fund Balance \$13,562	\$15,000	\$15,000
d. <u>Small Claims Court Judgments of \$5,000 or Less</u>		
1. Daughters of Charity Health System	\$142	
2. Faucher, Douglas M.	<u>\$1,073</u>	
Total	<u>\$1,215</u>	
Fund Balance \$198,785	\$200,000	\$200,000
e. <u>Other Attorney Fees</u>		
1. Slote & Link	\$7,500	
2. San Francisco Unified School District	\$220,000	
3. Ledezma, Chang, Chikanov, Yu	\$200,000	
4. Legal Aid Foundation of Los Angeles	<u>\$47,440</u>	
Total	<u>\$474,940</u>	

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

Applicable F/Y  
C/Y    B/Y

f.	<u>Other Provider Settlements / Judgments</u>	
	Total	\$0
g.	<u>Other Beneficiary Settlements</u>	
	Winton and Geraldine O'Neill	\$17,000
	Victims Compensation Board	<u>\$139,000</u>
	Total	\$156,000

Amounts may exclude interest payments.

A 2	(PC-131)	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-16)	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.
A 4	(PC-58)	X		<u>Litigation Settlements</u>
				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 <del>2012-13</del> <b>2013-14</b> from <b><u>ISTA Pharmaceuticals; Kmart Corp.; Medtronic; Pacific Health Corporation; Pfizer, Inc.; Ranbaxy USA, Inc.; Sanofi-Aventis U.S., Inc.; Johnson &amp; Johnson; Johnson &amp; Johnson (Omincare); Victory Pharma</u></b> ; Seaclyff 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; KV Pharmaceuticals; Amgen <b>II</b> ; and Bio-Med Plus.

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

A 5 (PC-196) 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 was prohibited from implementing the rate freeze and 10% reduction for 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 services rendered June 1, 2011 through December 27, 2011 that were not reimbursed prior to December 28, 2011 at the unreduced level.
- December 28, 2011 – *Managed Pharmacy Care, et al. v. Sebelius, et al.*: The Department was prohibited from implementing the 10% payment reduction for prescription drugs. On March 12, 2012, the district court issued an order modifying the injunction to allow DHCS to apply the 10% payment reduction to prescription drugs provided from June 1, 2011 through December 27, 2011, that were not reimbursed prior to December 28, 2012 at the unreduced level.
- January 10, 2012 – *California Medical Transportation Association v. Douglas, et al.*: The Department was prohibited from implementing the 10% payment reduction 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 that had not been reimbursed prior to January 10, 2012 at the unreduced payment level
- January 31, 2012 – *California Medical Association v. Douglas, et al.*: The Department was prohibited from implementing a 10% payment reduction for physicians, clinics, dentists, pharmacists, ambulance providers, and providers of medical supplies and durable medical equipment except for services rendered June 1, 2011 through January 30, 2012 that had not been reimbursed prior to January 31, 2012 at the unreduced payment level.

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

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. **On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

A 6 (PC-187) X X

Audit Settlements

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 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.

**Federal audit A-09-11-02016 regarding unallowable Medi-Cal payments for items and services furnished, ordered, or prescribed by excluded providers. The OIG found Medi-Cal payments made to excluded providers that were not eligible for FFP.**

**Federal audit A-09-12-02047 regarding credit balances. OIG found credit balances with Medi-Cal providers. These claims contained overpayments to providers.**

**Federal audits A-09-09-92146 (2007), A-09-09-94256 (2008), A-09-10-13500 (2009), A-09-11-15988 (2010), and A-09-12-18730 (2011) evaluated the effectiveness of the Department's internal controls related to preventing or detecting material noncompliance with laws, regulations, contracts and grants applicable to each of the federal programs.**

**Federal audit A-09-07-00039 regarding claimed drug products not listed on the quarterly drug tapes and conclusive evidence that the drugs were eligible was not provided.**

**OTHER REIMBURSEMENTS: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

R 0.1 (PC-186)X

Reimbursement for IHS/MOA 638 Clinics

The Department will provide reimbursement to Indian Health Services/Memorandum of Agreement 638 clinics that did not receive the full federal per visit rate. The reimbursement for these clinics is for procedure code 02 services provided to Medicare/Medi-Cal beneficiaries between calendar years 2009 through 2012.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 1	(PC-NA)	X	X	<u>FMAP Changes</u>
<p>The Federal Medical Assistance Percentage (FMAP), which determines the federal Medicaid sharing ratio for each state, was 50% for the Medi Cal program effective for the federal fiscal year beginning October 1, 2002. Public Law 108-27, the federal Jobs and Growth Tax Relief Reconciliation Act of 2003, increased the FMAP to 54.35% from April 1, 2003, to September 30, 2003, and to 52.95% from October 1, 2003, to June 30, 2004.</p> <p>On February 17, 2009, the President signed the American Recovery and Reinvestment Act (ARRA) of 2009 (P.L. 111-5). Under ARRA, states are provided a temporary Federal Medical Assistance Percentage (FMAP) increase for a 27-month period beginning October 1, 2008 through December 31, 2010. Based on the formulas in the ARRA, California will receive an 11.59% FMAP increase for Medi-Cal program benefits during the eligible time period.</p> <p>On August 10, 2010, the President signed the Education, Jobs and Medicaid Assistance Act of 2010 that included a six-month extension through June 2011 of Medicaid's temporary enhanced FMAP for the states. California received an 8.77% FMAP increase for January 1, 2011 through March 31, 2011 and a 6.88% FMAP increase for April 1, 2011 through June 30, 2011. On July 1, 2011, Medi-Cal's FMAP returned to the 50% level. While most of Medi-Cal's expenditures receive the applicable FMAP in place on the date payment occurs, there will be some expenditures made in FY 2011-12 that receive ARRA. Expenditures may receive the applicable FMAP based on date of service, such as SNCP payments, or based on the date another department paid the initial expenditure and Medi-Cal draws the federal funds in a subsequent fiscal year.</p>				
R 2	(PC-175)	X	X	<u>Dental Contract</u>
<p>The dental rates are based on historical cost data and updated once a year.</p> <p>AB 97 requires a 10% provider payment reduction. CMS approved the reduction, effective June 1, 2011. The current rates remain in effect until the new rates, reflecting the reduction, are negotiated and approved by control agencies through the change order process.</p>				

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 3	(PC-125) (PC-153)	X	X	<p><u>Dental Geographic Managed Care</u></p> <p>The Geographic Managed Care (GMC) project in Sacramento County covers dental services for eligibles with mandatory aid codes and SSI/SSP on a voluntary basis. Since April 1994, dental managed care services to beneficiaries have been delivered through several dental plans.</p> <p><del>The Request for Proposal process for a new contract, effective January 1, 2013, began in January 2012.</del> In October 2012, the Department awarded contracts to <b>three</b> GMC dental plans, which took effect on January 1, 2013.</p>
R 4	(PC-125) (PC-153)	X	X	<p><u>Dental Managed Care within Medi-Cal Two-Plan Model Counties</u></p> <p>The 1997-98 Budget Act made a provision for the Department to enter into contracts with health care plans that provide comprehensive dental benefits to Medi-Cal beneficiaries on an at-risk basis.</p> <p>The Department <del>Department's</del> <del>has contracted</del> <b>contracts</b> with six dental plans that <del>are providing</del> <b>provided</b> services as voluntary PHPs in Los Angeles County; <del>and</del> <b>ended</b> on June 30, 2013. <del>The Request for Proposal process for a new contract began in January 2012.</del> In October 2012, the Department awarded <b>new</b> contracts to <b>three</b> PHP dental plans, which <del>take</del> <b>took</b> effect on July 1, 2013.</p>
R 5	(PC-NA)	X	X	<p><u>FI Cost Containment Projects – Program Savings</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
R 6	(OA-15)	X	X	<p><u>MIS/DSS Contract</u></p> <p>The Management Information System and Decision Support System (MIS/DSS) houses a variety of data and incorporates it into an 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 Optum</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

				Government Solutions, Inc. (formerly Integris, Inc. DBA OptumInsight), which is effective through February 14, 2014. The Department plans to continue contracting for MIS/DSS services after February 14, 2014. <b><u>The Department plans to extend the current MIS/DSS contract to continue services to June 30, 2015. The extension would allow sufficient time to release a Request for Proposal (RFP) that calls for a competitive procurement of services.</u></b>
R 7	(PC-191)	X	X	<p><u>Indian Health Services</u></p> <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-73)	X	X	<p><u>Kit for New Parents</u></p> <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-176)	X	X	<p><u>Developmental Centers/State Operated Small Facilities</u></p> <p>The Medi-Cal budget includes the estimated federal fund cost of the CDDS Developmental Centers (DCs) and two State-operated small facilities.</p>
R 10	(OA-63)	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>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 11	(PC-190) (OA-68)	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-192)	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-76)	X	X	<p><u>California Health and Human Services Agency HIPAA Funding</u></p> <p>A Health Insurance Portability and Accountability Act (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-6)	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>
R 15	(OA-2) (OA-52)	X	X	<p><u>CCS Case Management</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.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**Applicable F/Y  
C/Y    B/Y

The costs for CCS clients in Medi-Cal are budgeted in the Medi-Cal Estimate.

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.

R 16 (OA-41) X X

Postage and Printing – Third Party Liability

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.

R 17 (OA-53) X X

TAR Postage

Postage costs related to mailing treatment authorization request-related documents are budgeted in local assistance.

R 18 (PC-188) X X

HIPP Premium Payouts

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.

R 19 (PC-172) X X

Medicare Part A and Part B Buy-In

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.

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.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
R 20 (OA-79)	X	X	<p><u>PIA Eyewear Courier Service</u></p> <p>The Prison Industries Authority (PIA) fabricates the eyeglasses for Medi-Cal beneficiaries. Since July 2003, the Department has had an interagency agreement with PIA to reimburse them for one-half of the costs of the courier service that delivers orders between the optical providers and PIA.</p>
R 21 (OA-67)	X	X	<p><u>FFP for Department of Public Health Support Costs</u></p> <p>Title XIX federal Medicaid funding for Medi-Cal-related CDPH support costs are budgeted in the Medi-Cal local assistance budget and are shown as a reimbursement in the CDPH budget.</p>
R 22 (PC-178)	X	X	<p><u>ICF-DD Transportation and Day Care Costs - CDDS</u></p> <p>Beneficiaries that reside in Intermediate Care Facilities for the Developmentally Disabled (ICF/DDs) also receive active treatment services from providers located off-site from the ICF/DD. The active treatment and transportation is currently arranged for and paid by the local Regional Centers, which in turn bill the CDDS for reimbursement with 100% General Fund dollars.</p> <p>On April 15, 2011, CMS approved a SPA that allows FFP to be paid for these services retroactive back to July 1, 2007.</p>
R 23 (PC-183)	X	X	<p><u>Non-Contract Hospital Inpatient Cost Settlements</u></p> <p>All non-contract hospitals are paid their costs for services to Medi-Cal beneficiaries. Initially, the Department pays the non-contract hospitals an interim payment. The hospitals are then required to submit an annual cost report no later than five months after the close of their fiscal year. The Department reviews each hospital's cost report and completes a tentative cost settlement. The tentative cost settlement results in a payment to the hospital or a recoupment from the hospital. A final settlement is completed no later than 36 months after the hospital's cost report is submitted. The Department audits the hospitals' costs in accordance with Medicare's standards and the determination of cost-based reimbursement. The final cost settlement results in final hospital allowable costs and either a payment to the hospital above the tentative cost settlement amount or a recoupment from the hospital.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
R 24	(PC-144)	X	X	<u>FQHC/RHC/CBRC Reconciliation Process</u>
<p>The Medi-Cal reimbursement policy for Federally Qualified Health Centers/Rural Health Clinics and Cost-Based Reimbursement Clinics (FQHC/RHC/CBRCs) participating in the Medi-Cal PPS is applied as follows:</p> <p>Each FQHC/RHC has an individual PPS rate for its Medi-Cal clinic visits. For the FQHC/RHC visits from beneficiaries enrolled in managed care plans or dual eligible beneficiaries, an interim rate is established in order for the clinic to be reimbursed the difference between the Medi-Cal PPS rate and the payments received from managed care plans and Medicare. There is no established interim rate for CHDP visits.</p> <p>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.</p> <p>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 &amp; I Code § 14170, a final audit is performed and either a final settlement or recovery invoice is prepared.</p> <p>W &amp; 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.</p>				
R 25	(OA-30)	X	X	<u>HIPAA Capitation Payment Reporting System</u>
<p><del>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</del></p>				

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
 C/Y B/Y

~~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.~~

The new HIPAA transaction requirements (5010):

- ~~• 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.~~

**The Department implemented the CAPMAN system in July 2011. The HIPAA compliant transaction automated and improved the capitation calculation process. The CAPMAN system:**

- **Allows detailed reporting at the beneficiary level,**
- **Increases the effectiveness of monthly reconciliation between Medi-Cal and the contracted managed care plans, and**
- **Supports research efforts to perform recoveries.**

Due to the **Affordable Care Act and the expansion of Medi-Cal Managed Care, the Department must implement additional functionalities in CAPMAN to prepare for the influx of new beneficiaries. Modifications will be made to further enhance the system to incorporate a paperless accounting interface and accommodate the CCI Duals Demonstration project. The system will have to be maintained on an ongoing basis, as new functionality is required.** ~~The Department anticipates that a new five-year contract is required to bring vendor staff to work with the Department on CAPMAN system changes **A new five-year contract was executed in July 2013 to address these system changes.**~~

R 26 (OA-11) X X  
 (PC-177)  
 (PC-FI)

ARRA HITECH Incentive Program

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

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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).

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 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)~~ **professionals (EPs) and eligible hospitals (EHs)**.

CMS requires the Department to assess the usage of and barriers to AIU and MU by EPs **provider type**; 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-38) 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.

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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.

R 28 (PC-185) X    X

ICF-DD Administrative and QA Fee Reimbursement - CDDS

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).

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.

R 29 (PC-194) X    X

CLPP Fund

Medi-Cal provides blood lead tests to children who are at risk for lead poisoning and are full-scope Medi-Cal beneficiaries or are pre-enrolled in Medi-Cal through the Child Health and Disability Prevention (CHDP) Gateway program. The CHDP State-Only program provides lead screenings to Medi-Cal beneficiaries who are eligible for emergency and pregnancy related services. The lead tests are funded by the CLPP Fund which receives revenues from a fee assessed on entities formerly or presently engaged in commerce involving lead products and collected by the Board of

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

			Equalization. The expenditures for the lead testing are in Medi-Cal's FFS base trends and this policy change adjusts the funding.
R 30	(PC-127) X (PC-143)		<p><u>Payment Deferral</u> Since FY 2004-05, the last checkwrite in June of the fiscal year has been delayed until the start of the next fiscal year. <del>The Department is proposing language to delay an additional checkwrite for FY 2012-13. From then on, two checkwrites would be delayed at the end of each fiscal year.</del> <b><u>Beginning in FY 2012-13, an additional checkwrite will be delayed at the end of each fiscal year.</u></b></p> <p><del>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.</del></p> <p>In addition to delaying a checkwrite, the Department is also <del>proposing to delay</del> delaying one month of managed care capitation rates <b><u>beginning</u></b> in FY 2012-13. <del>This delay will result in a decrease in expenditures estimated to be \$1,230.0 million TF in FY 2012-13.</del></p>
R 31	(PC-173) X	X	<p><u>Part D—Phased-Down Contribution</u></p> <p>With the implementation of Medicare Part D, the federal government requires a phased down contribution from the states based on an estimate of the cost the state would have incurred for continued coverage of prescription drugs for dual eligibles under the Medi-Cal program. In 2006, the phased-down contribution was 90% of this cost estimate and will gradually decrease and be fully phased-in at 75% of the cost estimate in 2015. An annual inflation factor is also applied to the phased-down contribution. The phased-down contribution, annual CMS-determined inflation factor, and PMPM are adjusted annually.</p>
R 32	(OA-71) X	X	<p><u>CDPH I&amp;E Program and Evaluation</u></p> <p>AB 1762 (Chapter 301, Statutes of 2003) authorized the Department to require contractors and grantees under the Information and Education (I&amp;E) program to establish and implement clinical linkages to the Family PACT program, effective FY 2003-04. This linkage includes planning and development of a referral process for program participants, to ensure access to family planning and other reproductive health care services.</p>

**OTHER: REIMBURSEMENTS: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

				The Department budgets the Title XIX federal Medicaid funds for the contracts. The matching GF is budgeted in the CDPH budget.
R 33	(PC-NA)	X	X	<u>Operational Flexibilities</u>
				This assumption has been moved to the "Withdrawn" section.
R 34	(PC-41)	X	X	<u>Youth Regional Treatment Centers</u>
				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 35	(PC-NA)	X		<u>Cost Shift of CCS State-Only to Medi-Cal EPC</u>
				This assumption has been moved to the "Time Limited/No Longer Available" section.

**OTHER RECOVERIES: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

RC 0.1(PC-199)

X

Recovery of PCS/IHSS

SB 412 (Chapter 548, Statutes of 1995) permits the Department to seek estate recovery (ER) against the estate of the decedent, or any recipient of the property of the decedent, for health care services received. The Department proposed regulations to include Personal Care Services (PCS), a service offered under the In-Home Supportive Services (IHSS) program, in ER claims. The addition of PCS is expected to increase savings for the Department.

**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 (OA-22)	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 3 (PC-193)	X	X	<p><u>Anti-Fraud Activities for Pharmacy and Physicians</u></p> <p><del>In FY 2011-12, the</del> <b>The</b> Department expanded its anti-fraud activities. <del>The activities focus on pharmacy and physician services.</del></p>
RC 4 (PC-200) (OA-46)	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 assists the Department by auditing the invoices received from CMS to pay the Medicare premiums. The Department realized savings beginning in October 2012. Payments to UMASS are contingent upon recovery of overpayments from CMS and Medicare providers. The Department extended the contract through June 30, 2015.</p>

**FISCAL INTERMEDIARY: MEDICAL: NEW ASSUMPTIONS**

	Applicable F/Y		
	<u>C/Y</u>	<u>B/Y</u>	
FI 0.1 (PC-FI)	X	X	<p><u>Fiscal Intermediary Change Orders</u></p> <p>A change order is a documentable increase of effort identified as having a direct relation to the administration of the contract. The change order is above the volume of required work within the scope and normal fixed-price of the contract. The Department assesses all change orders and either approves, denies or requests additional information. If approved, the Department issues payment terms to the Fiscal Intermediary (FI).</p>
FI 0.2 (PC-FI)	X	X	<p><u>Provider Applications and Validation for Enrollment</u></p> <p>To comply with Medicaid Information Technology Architecture (MITA) and the Affordable Care Act (ACA) federal mandates, the Department has requested the FI to make system modifications to enhance the capabilities of the CA-MMIS Health Enterprise Provider Enrollment functionality. The Department will reimburse the FI for increased costs related to the system changes including any required licensing, maintenance and support.</p>
FI 0.3 (PC-FI)	X	X	<p><u>Telephone Service Center – Customer Service Improvement Project</u></p> <p>The Department anticipates a high volume of calls received by the Telephone Service Center (TSC) as a result of the ACA, Medi-Cal expansion, and newly eligible individuals represented under Covered California. The increased call volume will move the total expected calls above the maximum band for the bid rate per call in the FI contract. Exceeding the maximum band will increase the rate per call, resulting in an increase in the total cost for the TSC. The Department is in negotiation with the FI to amend the contract and expand the maximum band and set a new bid rate per call.</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

		Applicable F/Y		
		<u>C/Y</u>	<u>B/Y</u>	
FI 1	(PC-NA)	X	X	<p><u>Cost Containment Proposals – Savings Sharing</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
FI 2	(PC-NA)	X	X	<p><u>HIPAA UPN Exception Request</u></p> <p>This assumption has been moved to the “Time Limited/No Longer Available” section.</p>
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. 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"> <li>• Privacy (Completed)</li> <li>• Transactions and Codes (Completed)</li> <li>• Unique Employer Identifier (Completed)</li> <li>• Security (In Progress)</li> <li>• National Provider Identifier (Completed)</li> <li>• Electronic Signature (Future Project)</li> <li>• Enforcement (Completed)</li> <li>• National Health Plan Identifier (Future Project)</li> <li>• Claims Attachments (Future Project)</li> <li>• First Report of Injury (Future Project)</li> <li>• Transactions and Code Sets Revisions (In Progress)</li> </ul>

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

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

provider impact) transactions and code sets first, without interrupting payments to providers or services to beneficiaries. The first phase of implementation began in October 2003 and the remaining transactions and code conversions will continue to be phased-in and implemented. The January 16, 2009 published HIPAA rules will require MMIS changes in order to incorporate updated transactions for Medi-Cal and prescription drug claims by the federal compliance date of January 1, 2012. The final rules also require the implementation of a new diagnosis and inpatient hospital procedure coding standard, ICD-10, by October 1, 2013. CMS recently extended the October 1, 2013 deadline to October 1, 2014 for ICD-10.

FI 4 (PC-NA) X

Extension of the HP Contract

This assumption has been moved to the "Time Limited/No Longer Available" section.

FI 5 (OA-35) X X

Medicaid Information Technology Architecture

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.

The Department completed the CMS-required MITA State Self-Assessment (SS-A) of business processes to determine the current and long-term business requirements **in 2008 utilizing the then-current MITA Framework Version 2.0. MITA Framework Version 3.0 was released in March 2012. A new SS-A effort using the MITA 3.0 version is currently underway.** The Department must complete an annual SS-A that **which will** contain 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. **Information Architecture standards and activities are currently underway.**

**In June 2013, an advance planning document update (APDU) and draft Request for Offer (RFO) were submitted to CMS.**

## FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS

Applicable F/Y  
C/Y B/Y

### The plan outlines the effort necessary to perform the annual SS-A submission and updates the initial roadmap.

FI 6	(OA-19)	X	X	<p><u>CA-MMIS Takeover <b>System</b> 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 to address new business and legislative requirements and, as a result, is extremely complex, difficult to maintain, and nearing the end of its useful life cycle. CA-MMIS is a mission critical system that must assure timely and accurate claims processing for Medi-Cal providers. Given the business critical nature of CA-MMIS, a detailed assessment was completed by a specialty vendor which recommends that modernization of CA-MMIS begin immediately. The Department contracts with various vendors to assist with FI oversight activities, documentation of business rules, <u>technical architecture, federal certification management</u>, project management, <u>change transition</u> management and <u>IV&amp;V independent validation &amp; verification</u> services during transition and replacement of the CA-MMIS <u>system</u>.</p>
FI 7	(PC-NA)	X		<p><u>CA-MMIS Takeover by New FI Contractor</u></p> <p>This assumption has been moved to the "Time Limited/No Longer Available" section.</p>
FI 8	(OA-18)	X	X	<p><u>CA-MMIS Takeover/ <b>System</b> Replacement Other State Transition Costs</u></p> <p>CA-MMIS is the claims processing system used for Medi-Cal. <del>The previous FI contract will expire on June 30, 2013.</del> Additional <u>The transition</u> costs <del>will be</del> incurred for CA-MMIS Takeover and Replacement activities <del>which</del> include interfacing with other Departmental mission critical systems such as MEDS, EMBER, SCO, MIS/DSS, <u>CalHEERS</u> and PCES applications that <del>will</del> 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, <u>user acceptance</u> 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</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

new environments in support of transition activities during the ~~Takeover and Replacement phases.~~ **phase.** The CA-MMIS system must ensure timely and accurate claims processing for Medi-Cal providers, without interruption during ~~both phases~~ **the Replacement phase.** ~~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

CA-MMIS System Replacement Project

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 recommended that the 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 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~~ **began** 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).

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

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~~ **a** TAR Processing ~~Centers~~ **Center**, and
- Consolidate existing Field Office Automation Group (FOAG) activities.

~~The Department scheduled Phase II to begin~~ **planning began** in February 2013, **with an expected implementation date of July 2015**. Based on the existing pay schedule, actual costs will be incurred in FY ~~2013-14~~ **2014-15**.

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 to replace:

- 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 **of planning** to begin in FY ~~2013-14~~ **2014-15**.

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

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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. 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 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 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 was completed, with implementation into CA-MMIS 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

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

				continue to make additional modifications that are anticipated to result in additional costs carrying over into FY 2013-14.
FI 12 (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 RAIS hardware has reached its end of life. The refresh is expected to begin in FY <del>2012-13</del> <b>2013-14</b>.</p>
FI 13 (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 March 2014.</p>
FI 14 (OA-47)	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 <del>will contract</del> <b>contracted</b> 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</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y

				Feasibility Study Report and APD to achieve required state and federal level approvals.
FI 15 (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 <del>will help</del> <b>helps</b> the Department manage the various <b>business and</b> 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>
FI 16 (PC-FI)	X		<u>Additional CA-MMIS Office Space</u>	<p>The Department has <del>decided to locate</del> <b>consolidated</b> 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 <b>was</b> <del>expected to be completed by</del> <b>in</b> FY 2012-13. <b><u>Final payment is anticipated to be made in FY 2013-14.</u></b></p>
FI 17 (OA-31)	X	X	<u>SDMC System M&amp;O Support</u>	<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. <b><u>The current contract ends on June 30, 2014.</u></b> <del>This contract will be for a two year period beginning June 29, 2013, with three one-year optional extensions.</del> <b><u>The Department plans to enter in a two-year contract beginning July 1, 2014, with two one-year optional extensions.</u></b></p>
FI 18 (OA-50)	X	X	<u>Annual EDP Audit Contractor</u>	<p>The Department plans to procure an independent Certified Public Accounting firm to provide a contractually required annual</p>

**FISCAL INTERMEDIARY: MEDICAL: OLD ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

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.

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

Applicable F/Y  
C/Y    B/Y

HO 0.1 (PC-FI)    X        X        Fiscal Intermediary Change Orders

A change order is a documentable increase of effort identified as having a direct relation to the administration of the contract. The change order is above the volume of required work within the scope and normal fixed-price of the contract. The Department assesses all change orders and either approves, denies or requests additional information. If approved, the Department issues payment terms to the FI.

HO 0.2 (PC-FI)        X        Beneficiary Dental Exception

AB 1467 (Chapter 23, Statutes of 2012) was enacted July 1, 2012, to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental managed care plans in Sacramento County. The intent of the legislation is to improve access to dental care by implementation of the Beneficiary Dental Exception (BDE) process. The BDE is available to beneficiaries in Sacramento County who are unable to secure services through their dental plan, in accordance with applicable contractual timeframes and the Knox-Keene Health Service Plan Act of 1975. The BDE allows a beneficiary to opt-out of Medi-Cal Dental Managed Care and move into fee-for-service (Denti-Cal).

The BDE notifications will be mailed to beneficiaries in Sacramento County. New enrollees will receive a BDE notification after they have been enrolled in a dental plan for 90 days based on the initial effective date of the enrollment transaction. The effective date for the first mailing for the 90 day BDE notification is August 1, 2013. Thereafter, currently enrolled beneficiaries will receive a BDE notification on an annual basis. The first mailing for the annual notification is September 1, 2013. The Department will incur additional costs for these mailings.

**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>Health Care Options (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. At the end of the pilot project period, 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. Based upon the assessment, the Department decided to continue the pilot.</p>
HO 2 (PC-NA)	X	X	<p><u>Health Care Options Consultant Costs</u></p> <p>This assumption has been moved to the "Withdrawn" section.</p>
HO 3 (PC-FI)	X	X	<p><u>Updates to Existing HCO Informing Materials</u></p> <p>Existing HCO informing materials will be reviewed and revised to reflect changes associated with the current health care environment. These include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Current managed care requirements,</li> <li>• New program needs and modifications, <ul style="list-style-type: none"> <li>○ Shifts from voluntary to mandatory eligibility requirements</li> <li>○ Changes in plan or provider eligibility</li> </ul> </li> <li>• Compliance with Federal Health Care Reform law.</li> </ul> <p>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.</p>

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

Applicable F/Y  
C/Y    B/Y

HO 4 (PC-BA) X

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

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

**FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y B/Y

DD 0.1 (PC-FI)	X	X	<p><u>Fiscal Intermediary Change Orders</u></p> <p>A change order is a documentable increase of effort identified as having a direct relation to the administration of the contract. The change order is above the volume of required work within the scope and normal fixed-price of the contract. The Department assesses all change orders and either approves, denies or requests additional information. If approved, the Department issues payment terms to the FI.</p>
DD 0.2 (OA-54)	X	X	<p><u>Department of Managed Health Care Inter-Agency Agreement</u></p> <p>SB 853 (Chapter 717, Statutes of 2010) authorized the Department to enter into an interagency agreement with the Department of Managed Health Care (DMHC) to ensure compliance with the Medi-Cal contract by conducting financial audits, dental surveys, and a review of the provider networks of the managed care plans participating in Medi-Cal. The projected implementation of the inter-agency agreement with the DMHC is September 2013.</p>
DD 0.3 (OA-33)	X	X	<p><u>Business Rules Extraction (BRE) Software and Services</u></p> <p>The Department plans to procure a new dental MMIS contract that meets CMS's requirements.</p> <p>In order to provide an equal advantage to all participating bidders, the Department plans to purchase a Business Rules Extraction suite of tools and services for use in the creation and maintenance of a modernized automated comprehensive procurement library. Bidders will gain a better understanding of the functionality and complexity of the legacy system CD-MMIS enabling them to complete an informed more competitive bid.</p> <p>This modernized procurement library will provide the following:</p> <ul style="list-style-type: none"> <li>• Full disclosure of graphic and logical views of the applications/programs.</li> <li>• Update business rules periodically, allowing viewing of the latest versions of process diagrams, source code flow charts, and source code details.</li> <li>• Ability to electronically store documentation.</li> </ul>

## **FISCAL INTERMEDIARY: DENTAL: NEW ASSUMPTIONS**

Applicable F/Y  
C/Y    B/Y

- Utilize extracted business rules to support future system enhancements, replacement, or the migration to one enterprise-wide system.

**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) were submitted to CMS and were approved for enhanced funding for Transactions. 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)
- Adoption of Rules for a Unique Health Plan Identifier (HPID) (In Progress)
- Claims Attachments (Pending)
- First Report of Injury (Completed)
- Transaction Revisions (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)
- **Adoption of Operation Rules for Connectivity (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 July 8, 2011 published HIPAA rules require changes to the Claim Status 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.

**FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS**

	Applicable F/Y		
	C/Y	B/Y	
DD 2 (PC-FI)	X	X	<p><u>Medi-Cal Dental FI Contract Turnover</u></p> <p>CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department <del>is seeking</del> <b>received</b> approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract. The extension <del>begins</del> <b>began</b> July 1, 2013 <b>and goes</b> 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.</p> <p>The Department has instructed the FI contractor to resume turnover support services and all activities in accordance with the contract requirements. 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.</p>
DD 3 (PC-FI)	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 of June 1, 2012 through June 30, 2013. <b><u>Additionally, the Department received approval for a two-year Non Competitive Bid Sole Source extension of the 2004 contract, extending operations of the current Dental FI contract for the period of July 1, 2013 through June 30, 2015.</u></b> 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. <b><u>The Department has determined that the FI contractor should be reimbursed and is currently working with CMS to determine if FFP will be available for these costs.</u></b></p>

**FISCAL INTERMEDIARY: DENTAL: OLD ASSUMPTIONS**Applicable F/Y  
C/Y B/Y**Takeover Activities for the new FI contractor are expected to begin October 1, 2014.**

DD 4 (PC-FI) X X

**Extension of the Current Medi-Cal Dental FI Contract**

CMS determined the new Medi-Cal Dental FI contract fails to meet the regulatory criteria and conditions as a MMIS. The Department ~~is seeking~~ **received** 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.

DD 5 (OA-48) X X

**Dental PAPD Project Manager**

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~~ **Effective June 10, 2013, the** Department ~~plans to procure~~ **procured** a Certified Project Manager (CPM) to develop and obtain CMS approval of a 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.

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**INFORMATION ONLY**
**REVENUES**1. Revenues

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

FY 2012-13: \$ 23,170,000	ICF-DD Quality Assurance Fee
\$ <del>510,264,000</del> <b><u>510,265,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 6,620,000	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ <del>4,090,000</del> <b><u>1,218,000</u></b>	Freestanding Pediatric Subacute Quality Assurance Fee
\$ <del>204,694,000</del> <b><u>383,441,000</u></b>	Gross Premium Tax (AB 1422)
\$2,915,076,000	Hospital Quality Assurance Revenue Fund (4260-610-3158)
\$ <del>42,806,000</del> <b><u>10,246,000</u></b>	Emergency Medical Air Transportation Fund (EMATA)
\$3,673,720,000 <b><u>3,850,036,000</u></b>	Total
FY 2013-14: \$ 23,153,000 <b><u>25,511,000</u></b>	ICF-DD Quality Assurance Fee
\$ <del>494,096,000</del> <b><u>504,407,000</u></b>	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 6,620,000 <b><u>7,653,000</u></b>	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ <del>4,257,000</del> <b><u>1,204,000</u></b>	Freestanding Pediatric Subacute Quality Assurance Fee
\$ <del>884,454,000</del> <b><u>783,818,000</u></b>	MCO Tax
\$3,181,559,000 <b><u>3,364,557,000</u></b>	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)
\$ <del>42,806,000</del> <b><u>10,246,000</u></b>	Emergency Medical Air Transportation Fund (EMATA)
\$4,603,945,000 <b><u>4,697,396,000</u></b>	Total
FY 2014-15: \$ 25,515,000	ICF-DD Quality Assurance Fee
\$ 509,837,000	Skilled Nursing Facility Quality Assurance Fee (AB 1629)
\$ 7,653,000	ICF-DD Transportation/Day Care Quality Assurance Fee
\$ 1,218,000	Freestanding Pediatric Subacute Quality Assurance Fee
\$ 1,252,660,000	MCO Tax
\$ 4,103,128,000	Hospital Quality Assurance Revenue Fund (Item 4260-611-3158)

**INFORMATION ONLY**

\$ 10,246,000	Emergency Medical Air Transportation (EMATA) Fund
\$ 5,910,257,000	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 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

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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, 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.

### 5. 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

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## INFORMATION ONLY

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.

### 6. Ledezma v. Shewry Lawsuit

The Department 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 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.

### 7. Electronic Asset Verification Program

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

### 8. 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. 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.

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**INFORMATION ONLY****AFFORDABLE CARE ACT****9. Realignment**

**Under the Affordable Care Act, county costs and responsibilities for indigent care are expected to decrease as uninsured individuals obtain health coverage. The State, in turn will bear increased responsibility for providing care to these newly eligible individuals through the Medi-Cal expansion. The budget sets forth two mechanisms for determining county health care savings that, once determined, will be redirected to fund local human services programs. The 12 public hospital counties and the 12 non-public /non-County Medical Services Program counties will have the option to select one of two mechanisms. Option 1 is a formula that measures health care costs and revenues for Medi-Cal and the uninsured, option 2 is redirection of 60% of a county's health realignment allocation plus maintenance of effort. Assembly Bill (AB) 85 (Chapter 24, Statutes of 2013) lays out the methodology for the formula in option 1, and requires the department to perform the calculation. AB 85 also lays out new county enrollment requirements, including enrollment targets, and requires the Department to administer these new requirements.**

**The redirected amounts will be calculated by the Department, but will not be included in the Department's budget. Savings are estimated to be \$300 million in FY 2013-14, and \$900 million in FY 2014-15.**

**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.

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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. **Instead, the Department is exploring ways to serve this population through the Assisted Living Waiver.**

#### 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. **The Department is currently working with CMS to expand provision of ALW services into additional counties, and to serve eligible beneficiaries living with brain injuries.**

### BREAST AND CERVICAL CANCER TREATMENT

### PHARMACY

#### 14. 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 (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.

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**INFORMATION ONLY****15. 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.

**DRUG MEDI-CAL****16. Naltrexone Treatment Services**

Naltrexone Treatment provides outpatient Naltrexone services to detoxified persons with opioid dependency and substance use disorder diagnoses. 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.

**1115 WAIVER—MH/UCD & BTR****MANAGED CARE****PROVIDER RATES****SUPPLEMENTAL PAYMENTS****17. 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.

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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.

**18. 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****19. 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 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. **On April 30, 2013, the trial court issued a final judgment that specified the Department was not required to recalculate rates that were originally determined based on the SB 1103 limit.** However, the **80 of the hospitals that were** plaintiffs **in the 2005 lawsuit**, 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. **A judgment is expected in the new lawsuit later in FY 2013-14.**

**20. 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.

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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
- There was insufficient evidence to support the Department's finding that access to 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 adequate access consistent with the March 2012 Court of Appeal decision. ~~The Department is currently conducting the further rate review required by the court.~~ **In March 2013, the Department completed a further rate review, in which it determined that the rates paid to HHAs during 2001-2005 were sufficient to comply with the Access requirement of federal Medicaid law. The plaintiffs have filed a motion challenging the validity of the Department's further rate review. They seek a court order to invalidate the rates and to require the Department to pay HHAs damages for the period since 2001 equal to the difference between the rates paid and each HHA's usual and customary charges. The Department is opposing this motion. A court judgment in this matter is expected later in FY 2013-14.**

21. 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

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**INFORMATION ONLY**

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.

22. *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. 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 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,
- 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),
- 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.

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**INFORMATION ONLY****23. 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)
- 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, and further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

**24. 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.

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**INFORMATION ONLY**

- 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 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. Further appellate briefing in the Ninth Circuit has been stayed pending Ninth Circuit mediation, in which the parties are exploring a possible settlement.

#### 25. AB 97 Litigation

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

- *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 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.~~ **On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally**

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**INFORMATION ONLY****vacating the four court injunctions. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

- *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 14<sup>th</sup> Amendment, the Fifth Amendment, and the Privileges and Immunities Clause of the U.S. Constitution.

On December 28, 2011, the district court issued a preliminary injunction 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. 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.~~ **On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

- *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. On

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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.~~ **On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

- *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. 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.~~ **On May 24, 2013, the Ninth Circuit denied the plaintiffs' request for rehearing and on June 25, 2013 issued an order formally vacating the four court injunctions. The Department will implement AB 97 payment reduction and rate freeze retroactive to June 1, 2011.**

26. *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,

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**INFORMATION ONLY**

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.

27. 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.~~ **On May 23, 2011, CMS approved the SPA eliminating the Medi-Cal optional benefits for all providers, including FQHCs and RHCs.**

**On July 5, 2013, the Ninth Circuit Court of Appeals found that the statutory definition of physician services for FQHCs and RHCs includes the eliminated services. Although these services are optional under Medi-Cal, in FQHCs and RHCs, they are mandatory and Medi-Cal must reimburse for them. The Ninth Circuit further found that the Department was obligated to obtain SPA approval before implementing it.**

**The Department has filed a petition for rehearing and rehearing en banc on two grounds, including that the Court's finding that CMS must approve a SPA before its implementation conflicts with CMS's interpretation of its own regulation. The Court ordered Plaintiffs to file a response, which they have done. There is no specific time frame within which the Court must decide the petition.**

28. 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 County Health Authority dba Santa Clara Family Health Plan v. DHCS*
- *Health Net of California, Inc. v. DHCS*

**INFORMATION ONLY**

- *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 plaintiff Santa Clara County Health Authority 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. **On November 2, 2012, the Department and Health Net entered into a settlement agreement resolving the Health Net lawsuit.** The Department is **presently engaged** in appellate mediation on damages and interest for each of these cases, but mediation has not been completed **in the Santa Clara, Blue Cross, and Molina cases.**

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.~~

**29. 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 a 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~~ **appealed**. On November 3, 2011, the Ninth Circuit U.S. Court of

**INFORMATION ONLY**

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~~ **proceeded**. 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 filed a motion to continue the stay, ~~in the AIDS Healthcare case to be heard on February 25, 2013~~ **but on February 25, 2013, the court lifted the stay.**

**After the stay was lifted, the parties filed cross-motions for summary judgment. On March 18, 2013, the court found in favor of the Department on the Equal Protection claims, but ruled in favor of Plaintiff on their cross-motion for summary judgment on the (a)(30)(A) and SPA approval causes of action. The court held that:**

- **The Department was required to obtain SPA approval prior to implementation and did not do so, and**
- **Neither the legislature nor the Department considered the relevant factors under (a)(30)(A). The court enjoined the Department from implementing the 340B drug program, effective May 3, 2013.**

**The Department has filed a Notice of Appeal with the Ninth Circuit Court of Appeals. The Department's opening brief is due November 12, 2013. Pharmacy staff continue to seek CMS approval of the SPA.**

30. *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~~ **March 31, 2012**, and established Community-Based Adult Services (CBAS) as a Medi-Cal benefit effective ~~March~~ **April** 1, 2012. The settlement agreement will be in effect until August **31**, 2014, with the court retaining jurisdiction during the pendency of the settlement.

31. *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,

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**INFORMATION ONLY**

- 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,
- 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.

**32. 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.

**33. 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~~

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**INFORMATION ONLY**

the remaining Equal Protection cause of action. **Petitioners then dismissed their equal protection claim.**

**On May 23, 2013, Petitioners moved to enforce the writ, claiming that the Department's rate review was inadequate. At a hearing on June 21, 2013, the Court found that the Department's rate review was generally adequate, but had failed to adequately compare Medi-Cal's rates to those of other third party payers, as required by the statute. The Court set a hearing for October 24, 2013 at which the Department must either submit a revised report or show cause why it should be excused from doing so.**

34. 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.

35. 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**

36. 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.

37. 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

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**INFORMATION ONLY**

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~~ **implemented** a new payment system, which ~~will replace~~ **replaced** the SPCP and existing non-contract payment system.

**38. 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~~ **2012-13**), the June 30, ~~2012~~ **2013** Medi-Cal accrual amounts were estimated to be \$1.95 **\$2.23** billion state General Fund, and \$7.42 **\$5.09** billion federal funds, **and \$1.47 billion special fund**, for a total of ~~\$9.37~~ **\$8.79** billion.

**39. 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.

**40. 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

**INFORMATION ONLY**

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**

**FISCAL INTERMEDIARY: MEDICAL**

**FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

**FISCAL INTERMEDIARY: DENTAL**

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated into Base Data/Ongoing

#### ELIGIBILITY

##### 1. 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.

#### BENEFITS

##### 1. Family PACT Retroactive Eligibility

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.

The Department implemented the following:

- Retroactive eligibility certification procedure,
- Claim process for newly-enrolled clients, and
- Procedures to ensure reimbursement for retroactive period.

#### HOME & COMMUNITY-BASED SERVICES

#### BREAST AND CERVICAL CANCER

#### PHARMACY

##### 1. Sunset of Specialty Drug Contracts

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.

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

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## DISCONTINUED ASSUMPTIONS

### Fully Incorporated into Base Data/Ongoing

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.

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.

The Department is proposing Trailer Bill Language to eliminate this sunset date.

#### 2. Physician-Administered Drug Reimbursement

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. The new rates were implemented on September 1, 2012, with savings being generated under this methodology.

Erroneous Payment Corrections will be performed for the period of September 1, 2011 through August 31, 2012 on all claims that were reimbursed under the old methodology.

### 1115 WAIVER—MH/UCD & BTR

#### MANAGED CARE

##### 1. Managed Care Cost-Based Reimbursement Clinics (CBRC)

The Department is required to reimburse CBRCs and hospital outpatient departments, except for emergency rooms, owned or operated by Los Angeles County, at 100% of reasonable and allowable costs for services rendered to Medi-Cal beneficiaries. Currently, tentative settlements are prepared by the Department after review of reconciliation requests and final settlements or recoveries are invoiced within three years after the submission of the original reconciliation reports.

Effective 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.

##### 2. Align Managed Care Benefit Policies

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.

## DISCONTINUED ASSUMPTIONS

### Fully Incorporated into Base Data/Ongoing

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.

#### 3. Potentially Preventable Admission

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.

#### PROVIDER RATES

#### SUPPLEMENTAL PAYMENTS

#### OTHER: AUDITS AND LAWSUITS

#### OTHER: REIMBURSEMENTS

#### OTHER: RECOVERIES

#### FISCAL INTERMEDIARY: MEDICAL

#### FISCAL INTERMEDIARY: HEALTH CARE OPTIONS

#### 1. 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

**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available****ELIGIBILITY**1. 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.

Effective January 1, 2013, HFP subscribers 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 in FY 2012-13.

2. 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.

3. Bridge to HFP

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.

Effective January 1, 2013, HFP subscribers began transitioning into Medi-Cal through a phase-in methodology, which reduces the need for the bridge from Medi-Cal to the HFP.

4. Reduction of CNI-Based COLA to Counties

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.

## **DISCONTINUED ASSUMPTIONS**

### **Time Limited/No Longer Available**

#### **AFFORDABLE CARE ACT**

#### **BENEFITS**

#### **HOME & COMMUNITY-BASED SERVICES**

#### **BREAST AND CERVICAL CANCER**

#### **PHARMACY**

#### **MENTAL HEALTH**

##### 1. Specialty Mental Health Lawsuits

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:

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

The 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.

#### **1115 WAIVER—MH/UCD & BTR**

##### 1. MH/UCD—Federal Flexibility and Stabilization – Safety Net Care Pool ARRA

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.

Interim claims were completed in FY 2010-11. The Department will conduct the final reconciliation for Demonstration Year 5 in FY 2012-13.

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## DISCONTINUED ASSUMPTIONS

### Time Limited/No Longer Available

#### 2. MH/UCD—Health Care Coverage Initiative – Administrative Costs

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.

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.

#### 3. 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

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**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available**

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

**MANAGED CARE****1. Increase in Capitation Rates for Gross Premium Tax**

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:

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

**2. Funding Adjustment of Gross Premium Tax Funds to GF**

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

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

**3. 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 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.

**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available****PROVIDER RATES**1. 10% Payment Reduction Restoration and Supplemental Payments

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:

- 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 and 2014-15.

2. Eliminate 2012-13 Rate Increase & Supp. Payment

AB 1489 (Chapter 631, Statutes of 2012) authorizes the Department to:

- Redirect funding for rate increases and the Quality and Accountability Payments Program 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 75<sup>th</sup> percentile to remain in the General Fund rather than being transferred to the Quality and Accountability Supplemental Payment (QASP) Fund.

**SUPPLEMENTAL PAYMENTS****OTHER: AUDITS AND LAWSUITS****OTHER: REIMBURSEMENTS**1. FI Cost Containment Projects – Program Savings

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.

2. 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.

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**DISCONTINUED ASSUMPTIONS****Time Limited/No Longer Available**

The Department is currently completing the first stage of the Erroneous Payment Correction (EPC) to adjust the funding shift.

**OTHER: RECOVERIES****FISCAL INTERMEDIARY: MEDICAL****1. Extension of the HP Contract**

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

**2. 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 completed contractually required activities necessary for the AOO from the 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.

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## DISCONTINUED ASSUMPTIONS

### Time Limited/No Longer Available

Takeover plans were completed in FY 2011-12; however, final documentation and payment for Takeover will occur in FY 2012-13.

#### 3. HIPAA UPN Exception Request

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

The Department received 90% funding approval from CMS to revise the scope of the UPN pilot in order to reduce costs and to leverage system changes needed to comply with the Federal Deficit Reduction Act of 2005 which mandates the collection of rebates for physician administered drugs using the National Drug Code (NDC). 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 government requires the Department to discontinue the use of the UPN.

#### 4. Cost Containment Proposals – Savings Sharing

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.

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.

### **FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**

### **FISCAL INTERMEDIARY: DENTAL**

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**DISCONTINUED ASSUMPTIONS****Withdrawn****AFFORDABLE CARE ACT****ELIGIBILITY****BENEFITS**1. **Physician and Clinic Seven Visits Soft Cap**

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.

**HOME & COMMUNITY-BASED SERVICES****BREAST AND CERVICAL CANCER****PHARMACY****1115 WAIVER—MH/UCD & BTR****MANAGED CARE**1. **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****SUPPLEMENTAL PAYMENTS****OTHER: AUDITS AND LAWSUITS**

**DISCONTINUED ASSUMPTIONS****Withdrawn****OTHER: REIMBURSEMENTS**1. Operational Flexibilities

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

**OTHER: RECOVERIES****FISCAL INTERMEDIARY: MEDICAL****FISCAL INTERMEDIARY: HEALTH CARE OPTIONS**1. Health Care Options Consultant Costs

The Department will contract with a health care consultant to 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.

Operations for the current enrollment broker contracts ends on September 30, 2012, with three one-year extension options. The Department exercised a one-time extension option of the current contract for the period of September 30, 2012 through September 30, 2013.

**FISCAL INTERMEDIARY: DENTAL**